WESTERN SYDNEY
UNIVERSITY

Evidence Bank Rapid Review

A Rapid Evidence Review of Early Childhood Programs to Reduce Harm and Maltreatment and Improve School Readiness

December 2022

Research Team

Prof. Brian Stout
School of Social Sciences
Prof. Pru Goward
Adjunct Professor, School of Social Sciences
A/Prof. Ann Dadich
School of Business
Institute for Culture and Society
Translational Health Research Institute
A/Prof Rebekah Grace
School of Nursing and Midwifery
Translational Health Research Institute
A/Prof Neil Perry
School of Business
Dr Jenny Knight
School of Social Sciences
Ms Cris Townley
Translational Health Research Institute

Research Assistants

Mr Jonathan Ng
Dr Taf Mugadza

Corresponding Applicant

Project Lead:	Prof. Brian Stout
Telephone:	+61 02 9772 6139
Email:	B.Stout@westernsydney.edu.au
Address:	Locked Bag 1797 Penrith NSW 2751

Table of Contents

A Rapid Evidence Review of Early Childhood Programs to Reduce Harm and Maltreatment and Improve School Readiness 1

Executive Summary 1

1. Introduction 3

2. Methods 7

3. Results: Harm Reduction 13

4. Results: School Readiness 24

5. Discussion 28

References 30

Appendices 33

Tables

Table 1: Key Definitions 5

Table 2: Inclusion and Exclusion Criteria 7

Table 3: Domains, Items, and Response Choices for the Risk of Bias Tool used for Randomised Controlled Trial and/or Quasi-Experimental Design (NSW Department of Communities and Justice, 2021) 9

Table 4: Categorising Level of Risk of Bias in Randomised Controlled Trial and Quasi-Experimental Design (NSW Department of Communities and Justice, 2021) 9

Table 5: Effect Direction Criteria (NSW Department of Communities and Justice, 2021) 10

Table 6: Evidence Rating Scale (NSW Department of Communities and Justice, 2021) 10

Table 7: Direction of Effect (NSW Department of Communities and Justice, 2021) 11

Table 8: Characteristics of Harm Reduction Programs 15

Table 9: Harm Reduction Programs' Evidence Ratings 20

Table 10: Harm Reduction Programs' Core Components and Flexible Activities 21

Table 11: Characteristics of School Readiness Programs 25

Figures

Figure 1: PRISMA Flowchart for the Harm Reduction Review 13

Figure 2: PRISMA Flowchart for the School Readiness Review 24

Appendices

Appendix 1: Evidence Portal Decision Form: Harm Reduction Rapid Review 33

Appendix 2: Evidence Portal Decision Form: School Readiness Rapid Review 33

Appendix 3: Search Strategy: Harm Reduction Rapid Review 34

Appendix 4: Database Searches: Harm Reduction Rapid Review 36

Appendix 5: Search Strategy: School Readiness Rapid Review 37

Appendix 6: Search Strategy: School Readiness Rapid Review 41

Appendix 7: Outcome Domains, Client Outcomes, and Measures: Harm Reduction Rapid Review 42

Appendix 8: Program Ratings and Direction of Effect: Harm Reduction Interventions 47

Appendix 9: Evidence-Informed Program Summaries: Harm Reduction Interventions 55

Appendix 10: Summaries of Core Components: Harm Reduction Interventions 109

Appendix 11: Summaries of Flexible Activities: Harm Reduction Interventions 111

Appendix 12: School Readiness Outcome Domains, Client Outcomes, and Measures: School Readiness Review 138

Appendix 13: Program Ratings and Direction of Effect: School Readiness Interventions 139
Appendix 14: Evidence-Informed Program Summaries: School Readiness Interventions 141
Appendix 15: Summaries of Core Components: School Readiness Interventions 159
Appendix 16: Summaries of Flexible Activities: School Readiness Interventions 160

Executive Summary

This report details the methods and the results of two rapid evidence reviews undertaken by Western Sydney University for the NSW Department of Communities and Justice (DCJ) in 2021 to build the body of evidence about how to improve outcomes for priority vulnerable populations in NSW. The reviews are intended to be an input to policy and program decision-making in the context of the NSW Government's six-year commitment to an investment approach to human services. The investment approach has identified priority groups who are at increased risk of experiencing future negative outcomes and of high government expenditure. One priority group which is the focus of these rapid evidence reviews is vulnerable young children aged 5 or younger with identified risk factors related to their parents, perinatal factors or significant involvement in the child protection system. The investment approach aims to understand and improve the effectiveness of current programs and services in delivering social and health outcomes for this group and other vulnerable groups.

Methodology and Scope of the Reviews

The rapid evidence reviews were guided by the following questions:

- **Which interventions have been found to be effective in reducing harm and/or maltreatment for vulnerable children aged zero to five years?**
- **Which interventions have been found to be effective in improving school readiness for vulnerable children aged six years or younger?**

They were conducted following the technical specifications for the conduct of reviews for DCJ's early intervention Evidence Portal. The technical specifications ensure a rigorous and consistent approach to the assessment of program effectiveness (NSW Department of Communities and Justice 2021). Only systematic reviews, meta-analyses or studies that used a randomised control trial (RCT) or quasi-experimental design (QED) were included. The methodology involved developing and executing a systematic search strategy to select and screen studies; assessing studies for risk of bias; extracting data of studies that received a moderate or low risk of bias score; assessing the direction of effect; rating the evidence for effectiveness; and identifying the core components and flexible activities of those programs rated as effective.

Summary findings are provided in the main body of the report. More detailed information about the identified programs, core components and flexible activities for each review are provided in the Appendices to this report. Information about the programs identified in the reviews will also be made available through the DCJ early intervention Evidence Portal.

Although extensive systematic searching and screening of the available literature was undertaken to identify an evidence base, there may be additional research addressing a variety of program outcomes that is not included. The search strategy was tested before deployment, but might have failed to identify all relevant publications relating to the programs included in each review. 'Grey literature', unpublished materials and non-peer reviewed research papers were outside the scope of the reviews, as was research that did not directly inform the guiding research questions.

Key Findings from the Reduction of Harm Rapid Review

The reduction of harm rapid review identified 15,981 initial records and screened these to ensure that they fell within scope and were directly relevant to the guiding research question. As a result, 45 studies were included in this review. These 45 studies described 34 different intervention programs. Of these programs, **two were supported by research evidence, there was promising research evidence for a further 17, and mixed research evidence with no adverse effects for six programs**. Of the remaining nine, five had mixed research evidence with adverse effects, and four had no effect. Therefore, 25 programs were identified as contributing to a reduction in harm for young vulnerable children. The programs collectively point to an improvement in relevant indicators such as hostile parenting, out-of-home care rates, and substantiated allegations of child abuse and neglect.

Five different program models were identified during data extraction, including: home visiting programs; programs that gave centrality to early childhood education services; therapeutic parent-child programs; programs delivered in clinical settings; and family therapy programs. Four common core components embedded within programs that contribute to a reduction in harm were identified: engagement; building supportive relationships and social networks; building parental capacity; and case management. Thirteen flexible activities related to these core components were identified. Details of these are in Appendix 11.

The standard of evidence required to achieve the highest evidence ratings is considerable, and it is noteworthy that none of the intervention programs that met the criteria for inclusion in this review achieved a "well supported by evidence" rating. This is likely to be due in large part to the technical specifications for the review,

which limited inclusion to programs that have at least been subject to a RCT, or to have had a high quality QED. Care must be taken not to confuse a lack of evidence with a lack of program effectiveness. Requiring RCT evidence also inadvertently results in a positive bias towards US-based programs: 22 of the 34 programs reviewed relied exclusively on US-based research, and only four programs included Australian research. Overall, there were only two studies that directly reported on outcomes for First Nations families (one for Aboriginal families and one for Maori families). There is a clear need for more rigorous Australian research, including specifically with Aboriginal families. If high levels of evidence are required, as they should be, it is essential that the Australian government and service organisations invest in rigorous evaluation.

Key Findings from the School Readiness Rapid Review

The school readiness rapid review identified 1,718 initial records and screened these to ensure that they fell within scope and were directly relevant to the guiding research question. As a result, seven studies were included in this review. These seven studies described six different school readiness programs. **Two of these programs had promising research evidence, and four had mixed research evidence with no adverse effects**. The programs represented a range of different approaches, including embedding learning sessions with children on self-regulation and other behaviours into early childhood settings, home visiting sessions, and video feedback approaches to support positive parent-child learning interactions. There were also a range of different approaches in relation to the age of the child, with approaches to supporting the learning and development of young children delivered with a focus on parent involvement, and approaches for older children focused on early childhood settings. All but two of the programs were focused on working with parents and/or children.

The research demonstrates a conceptual understanding that schools must be willing to adapt to meet the needs of new school starters, yet practical focus remains on assessing the preparedness of children and families for school. Three common core components of programs contributing to school readiness were identified: relationship building; academic preparedness; and readiness of the child for the classroom. Eight flexible activities associated with these three core components were also identified. All of the research included in the school readiness review was conducted in the US.

Limitations of the Evidence Base

These reviews are limited by the paucity of Australian research, particularly relating to children who experience marginalisation and adversity, including Aboriginal children, children from culturally and linguistically diverse (CALD) backgrounds and children who experience poor mental health. There is a clear need for more Australian research examining the effectiveness of childhood interventions and the implementation of programs that were developed overseas in diverse Australian contexts.

Implementation Considerations

The report discusses some considerations for delivery of the identified programs in NSW. The first is the extent to which the program is appropriate for families and children from Aboriginal communities and CALD communities. Programs should only be implemented after careful consideration and consultation with stakeholders. This is particularly important for programs with Aboriginal or CALD communities. In these cases, extensive consultation with practitioners and community members with cultural knowledge should be undertaken before a program is considered. Other considerations include:

- whether the program has been adequately manualised to support fidelity in scale-up;
- whether the program can be adapted to meet the needs of different groups while remaining effective;
- detailed information on the required skills and qualifications of the service provider;
- how the program is connected and will work with other available services;
- the purpose for implementing the program and how this aligns with current funding priorities;
- program dosage, and;
- the target group for whom the program has demonstrated effectiveness.

The reviews have also applied a core components approach, which seeks to overcome some of the implementation challenges posed by manualised programs, such as subscription costs and staff training requirements. By identifying the core components and flexible activities of effective programs, the reviews contribute to the creation of a common evidence-informed framework that DCJ-funded providers can use to develop and implement flexible, tailored services.

1. Introduction

a. *Background*

This report presents the results of two rapid evidence reviews. The first focuses on interventions or programs designed to reduce harm and maltreatment of children five years of age or younger in vulnerable populations. The second focuses on interventions or programs designed to support the transition to school of children who experience adversity or disadvantage.

The reviews were commissioned by the NSW DCJ to help build the body of evidence in NSW about how to improve outcomes for priority vulnerable populations. They build on the work of DCJ and partner agencies to support children and families who are at risk of poor outcomes and were informed by the NSW Human Outcomes Framework. The reviews are intended to be an input to policy and program decision-making in the context of the NSW Government's six year commitment to an investment approach to human services.

The rapid reviews were conducted using systematic methods by a team of researchers from Western Sydney University. Information about the programs identified through these reviews will be made available through the NSW DCJ early intervention Evidence Portal. For this reason, and to ensure a rigorous and consistent approach to the assessment of program effectiveness across DCJ, the reviews have been conducted following the technical specifications for reviews shared through the portal (NSW Department of Communities and Justice 2021).

i. The NSW Government Investment approach

In 2018, the NSW Government released the landmark *Forecasting Future Outcomes – Stronger Communities Investment Unit 2018 Insights Report*. The report drew on an unprecedented amount of data from across NSW and Commonwealth government agencies to better understand what services people receive, the factors that affect people's use of human services and project future service use. The report identified that 7% of children and young people in NSW are expected to experience the poorest outcomes later in life and make up about 50% of the estimated future cost for NSW and Commonwealth services.

Six subgroups with a variety of risk indicators were identified to be at high risk for high government expenditure and associated with future negative outcomes. While the investment approach has since expanded to incorporate further vulnerable cohorts, one priority group was the focus of these reviews: vulnerable young children aged 5 or younger with identified risk factors related to their parents, perinatal factors or significant involvement in the child protection system. The investment approach aims to understand and improve the effectiveness of current programs and services in delivering social and health outcomes for these vulnerable groups. It recognises that what happens early in a child's life will have an impact on their entire life and that intervening early with evidence-based approaches works best in the long term. The evidence-informed interventions identified through these reviews contribute to the NSW Government's work to build an evidence bank around 'what works' and how to best drive improvements for these vulnerable groups. This complements other work underway to build evidence across the service continuum in NSW.

ii. The NSW Human Servcies Outcomes Framework

The NSW Human Services Outcomes Framework supports the design, delivery, and evaluation of services delivered by non-government organisations and government departments. It includes seven outcome domains that are critical to wellbeing:

- **Education and Skills**: All people in NSW can learn, contribute, and achieve
- **Economic**: All people in NSW can contribute to and benefit from our economy
- **Health**: All people in NSW can live a healthy life
- **Home**: All people in NSW can have a safe and affordable place to live
- **Safety**: All people in NSW can be safe
- **Empowerment**: All people and communities in NSW can contribute to decision-making that affects them and live fulfilling lives
- **Social and Community**: All people in NSW can participate and feel culturally and socially connected (Department of Finance, Services and Innovation 2017)

In the context of this review, identifying outcome domains and specific outcomes for each program allows non-government organisations and government departments to align their work with the evidence and identify gaps in knowledge. As per Appendix 7, the outcome domains related to the review of harm reduction programs focus on the NSW Human Services Outcomes Framework outcome domain of Safety, and specifically, on the outcomes: all children are safe from harm; and all people are safe from domestic and family violence (NSW Department of Finance, 2017).

The NSW Human Services Outcomes Framework recognises the interdependence of its seven domains, with short-term outcomes aligned to one domain potentially improving outcomes in other domains over the medium and long-term. Reducing harm and maltreatment among children, five years of age or younger, directly aligns with the Safety domain but can have long-term, indirect impacts on Economic, Education and Skills, Social and Community, Home, Empowerment, and Health domains. It can also improve safety for future generations.

The outcome domains related to school readiness focus on the NSW Human Services Outcomes Framework outcome domain of Education and Skills and specifically, on the outcomes: children receive high quality early childhood education and care to give them a great start in life and at school, and all children are engaged in and benefiting from school (NSW Department of Finance, 2017; see Appendix 11). Program beneficiaries can include children, their parents, and teachers. Improved school readiness for the cohorts provides long-term, indirect impacts under each of the other six domains – Economic, Education and Skills, Social and Community, Home, Empowerment, and Health.

iii. Core Components of Programs

In working to build evidence of 'what works' and how best to achieve positive outcomes for vulnerable groups. some DCJ program areas are taking what is known as a 'core components' approach. The approach has the benefit of increasing the accessibility, translation and uptake of evidence to support evidence-informed decision making. Core components are "the fixed elements or functions of a program. They are the common activities that make up evidence-informed programs", whereas flexible activities are "the variable aspects within core components. They can take on different forms according to local context, which achieve the same objective" (NSW Department of Communities and Justice 2021, p. 9).

Following the NSW DCJ Evidence Portal: Technical Specifications (NSW Department of Communities and Justice 2021), this review applies a core components approach only to programs that have been found to demonstrate positive effects for specific outcomes ('evidence-informed programs'). The approach involves reviewing these programs to identify broad categories or themes under which specific activities can be grouped. A content analysis of each evidence-informed program is then conducted to determine which core components it has, as well as to refine the proposed core components and/or identify new ones. This iterative process is undertaken by two reviewers and any inconsistencies between them resolved by discussion or a third reviewer. Only those core components mentioned five or more times may be considered common across the evidence base. The names of the final core components are reviewed to ensure they are useful and accurate representations of the content of the evidence-informed programs.

This approach was applied to the programs included in this review to identify the core components that underpin the programs and cannot be compromised, and the flexible activities that operationalise the core components and can potentially be adapted depending on the intervention implementation context. The core components and flexible activities of child harm reduction programs are listed in Table 10. The core components and flexible activities of school readiness programs are listed in Table 14. Further details of the core components and flexible activities are provided in the Appendices.

b. Review Questions

The evidence reviews in this report were guided by the following questions:

1. Which interventions have been found to be effective in reducing harm and/or maltreatment among:

   - Vulnerable children aged five years or younger?
   - Children aged five years or younger affected by mental health issues?

2. Which interventions have been found to be effective in improving school readiness for vulnerable children aged six years or younger?

The target populations and outcomes of interest align with priority populations for the NSW Government Investment approach and the NSW Human Services Outcomes Framework, in particular the Safety and Education domains.

c. Rating the Evidence

In line with the technical specifications provided by DCJ, the programs were categorised according to the strength of the supporting evidence that was identified for this review – specifically:

- Well-supported by research evidence
- Supported research evidence
- Promising research evidence
- Mixed research evidence (with no adverse effects)
- Mixed research evidence (with adverse effects)
- Evidence fails to demonstrate effect
- Evidence demonstrates adverse effects

The process did not serve to identify any programs that fell into the 'well-supported by research evidence' category, or the 'evidence demonstrates adverse effects' category. The characteristics of the harm reduction programs and the evidence relating to them are summarised in Table 8. The characteristics of the school readiness programs and the evidence relating to them are summarised in Table 11. Further details of the programs can be found in the program summaries in the Appendices.

d. Key Definitions

Definitions were drawn from several sources including relevant NSW state legislation (see Table 1). The focus of the review was on identifying interventions that would support particular cohorts of people who had been identified as priority cohorts by DCJ. The definitions that guided this review were impactful in determining which papers and programs were included or excluded. Research papers needed to explicitly align with these definitions to be included. For example, clear boundaries were placed around what constituted a 'vulnerable child' in line with how this was defined in DCJ policy documents. A broader definition of vulnerability would potentially have expanded the number of programs eligible for inclusion in this rapid review.

Table 1: Key Definitions

Term	Definition
Program	A 'combination of program elements or strategies designed to produce behaviour changes or improve health status among individuals or an entire population. Programs may include educational programs, new or stronger policies, improvements in the environment, or a health promotion campaign. Programs that include multiple strategies are typically the most effective in producing desired and lasting change' (NSW Department of Family and Community Services, 2019).
Harm	'(A)ny detrimental effect of a significant nature on a child's physical, psychological or emotional well-being. Harm may be caused by physical or emotional abuse, neglect, and/or sexual abuse or exploitation' (NSW Department of Family and Community Services, 2019). The Children and Young Persons (Care and Protection) Act 1998 (NSW) No 157 provides further detail on: • Child or young person at risk of significant harm –section 23 • Child and young person abuse – section 227 • Neglect of children and young persons – section 228
Maltreatment	Any non-accidental behaviour by adults or young people towards children, which is outside generally accepted norms of conduct, and which constitutes a significant risk of causing physical and/or emotional harm. Although not accidental, such behaviours need not be intended to cause harm. Maltreatment includes acts of omission (neglect) and commission (abuse). Forms of maltreatment include neglect and any form of abuse: physical, sexual, psychological harm, exploitation, and failure to adequately meet the child's needs (NSW Department of Family and Community Services, 2019).
Vulnerable children	Children aged up to five years with identified risk factors relating to their parents, perinatal factors, or involvement with the child protection system. Identified risk factors include: • Parental risk factors: interaction with the justice system; an alcohol or other drug related offence or hospital admission; a proven perpetrator or victim of domestic violence; or treatment for mental health issues in a hospital or ambulatory service. • Perinatal risk factors: maternal smoking during pregnancy; admission to a special care nursery or neonatal intensive care; a gestational age

Term	Definition
	between zero and 36 weeks (inclusive) or greater than 41 weeks; a birth weight of under 2,500g; an Apgar score at five minutes of between zero and six (inclusive); or the first visit to antenatal care was later than 14 weeks into pregnancy. • Assessed as being at risk of significant harm (NSW Department of Family and Community Services, 2019), meaning that a child or young person is likely to, or may suffer physical, psychological or emotional harm as a result of what is being done (physical, sexual or psychological abuse) or not done (neglect) by another person.
School readiness	'School readiness is defined by two characteristic features on three dimensions. The characteristic features are 'transition' and 'gaining competencies'. The three dimensions of school readiness are: 1. Ready children, focusing on children's learning and development. 2. Ready schools, focusing on the school environment along with practices that foster and support a smooth transition for children into primary school and advance and promote the learning of all children. 3. Ready families, focusing on parental and caregiver attitudes and involvement in their children's early learning, development and transition to school. All three dimensions are important and must work in tandem, because school readiness is a time of transition that requires the interface between individuals, families and systems. While the interdependence of these three dimensions is acknowledged, the focus of the review will be the child's readiness, which involves a child's physical health and wellbeing, social competence, emotional maturity, language and cognitive development, communication skills and general knowledge. However, the program might target the child, their parent or carer, or other aspects of the child's environment (NSW Department of Family and Community Services, 2019).

e. Report Structure and Content

The report provides an overview of the review methodology and synthesises key findings across the evidence base. More detailed information about the search strategies, identified programs, as well as core components and flexible activities are presented in the report Appendices. The main body of the report presents the review outcomes and the programs identified in the search that are supported by evidence of effectiveness.

2. Methods

The following section describes the methods employed to conduct the rapid evidence reviews for both the harm reduction and school readiness research questions. Details of the processes are outlined, including: selecting and screening studies; assessing risk of bias; data extraction; assessing the direction of effect; rating the evidence for effectiveness; and identifying the core components and flexible activities of those programs rated as effective. The methods were aligned with the DCJ Evidence Portal: Technical Specifications (NSW Department of Communities and Justice 2021).

In accordance with these specifications, all changes to the research questions and method were recorded in the Evidence Portal Decision Form (see Appendixes 1 and 2).

a. *Search Strategy*

i. Search Strategy for Harm Reduction Review

A search strategy was developed to identify publications relevant to the research question (see Appendix 3 for search strings employed). Searches were initially conducted in January 2021, and revised and re-run in May/July 2021 (see Appendix 4 for an overview of the database searches). Publications that reported on an evaluation of a program to reduce harm in children five years of age and younger were identified by searching major electronic databases available on the EBSCO platform including PsycINFO, Medline, SocINDEX, PsycARTICLES, ERIC, CINAHL, Business Source Complete, Health Business Elite, Health Source Nursing/Academic, Psychology and Behavioral Sciences Collection.

ii. Search Strategy for School Readiness Review

A search strategy was developed to identify publications relevant to the research question (see Appendix 5). Searches were initially conducted in June 2021 and revised and re-run the following month (see Appendix 6). Publications that reported on an evaluation of a school readiness program for children aged six years and younger were located by searching major electronic databases available on the EBSCO platform including PsycINFO, SocINDEX, PsycARTICLES, CINAHL, Business Source Complete, Health Business Elite, Health Source Nursing/Academic, Psychology and Behavioral Sciences Collection, ERIC, and Education Research Complete.

b. *Eligibility Criteria*

Inclusion and exclusion criteria pertaining to study scope and design were used during screening to determine eligibility (see Table 2).

Table 2: Inclusion and Exclusion Criteria

Criteria	Inclusion Criteria	Exclusion Criteria
Study scope	Citation is complete	Citation is incomplete
	Written in English language	Written in a language other than English
	Published as a peer-reviewed publication	Published as a non-peer review publication such as a thesis dissertation, review, commentary, letter, editorial, a descriptive publication, a conceptual publication, a commentary, letter, editorial, a methodological publication or research/study protocol. All grey literature was excluded.
	Study was conducted in a high-income country	Study was conducted in a low- or middle-income country
	Study that tested the effectiveness of at least one program or practice	Study did not test the effectiveness of a relevant program or practice
	Study included a valid counterfactual	Study did not include a valid counterfactual
	Study targeted vulnerable children	Study did not target vulnerable children

Criteria	Inclusion Criteria	Exclusion Criteria
Study design	Study design incorporated an RCT, a QED, a systematic review, or a meta-analysis	Study design was not an RCT, a QED, a systematic review, or a meta-analysis
Specific to harm reduction review	Study evaluated at least one prevention or early intervention program for children aged five years or younger	Study evaluated a prevention or early intervention program for children older than five years
	Study's intervention aimed to reduce harm and/or maltreatment of vulnerable children	Study's intervention aims was other than the reduction of harm/maltreatment (i.e. improve academic achievement, sporting ability, manage a medical condition, or manage a specific psychological disorder)
Specific to school readiness review	Study considered programs designed to improve school readiness among vulnerable children aged six years or younger	Study did not consider programs that improved school readiness among vulnerable children aged older than six years

c. *Screening Processes*

Once the search was complete, all publications were screened to ensure they were relevant to the research question and met the inclusion criteria. Those that did not meet the inclusion criteria were excluded from the review. The title and abstract of each publication was screened and assessed for study scope and study design, with those assessed as not within scope excluded at this state. Afterwards, the full-texts of the remaining relevant publications were screened to ensure they met the remaining inclusion criteria.

The title, abstract, and full-text of each publication was by two reviewers. The two reviewers screened ten studies together to support the development of shared understanding and inter-rater reliability. The reviewers then screened another ten studies independently and compared their results. When an inter-rater reliability score of more than 80% was attained, both reviewers independently screened a further ten studies. On each occasion, an inter-rater reliability score of greater than 80% was obtained following the second round. In those instances where reviewers disagreed about whether a study should be included, this was resolved by discussion or with a third reviewer.

d. *Assessing Risk of Bias*

Following the full-text review, all publications were assessed for risk of bias using different tools depending on study designs. The AMSTAR-2 (Shea et al. 2017) was used to assess systematic reviews and meta-analyses; and the Evidence Project Risk of Bias tool was used to assess randomised controlled trials and quasi-experimental designs (NSW Department of Communities and Justice, 2021).

i. Assessing Risk of Bias in Systematic Reviews and Meta-Analyses

AMSTAR-2 includes 16 items to assess methodology quality. The reviewers assigned a rating to each item and then identified whether the systematic review had critical flaws in key methodological areas. Where one or more critical flaw was identified, the review was assessed as having low or critically low levels of confidence (that is, high or critically high risk of bias). Data were not extracted from these publications. Systematic reviews deemed to have moderate or high levels of confidence proceeded to the data extraction stage and were included in the review.

ii. Assessing Risk of Bias in Randomised Controlled Trials and Quasi-Experimental Designs

A slightly amended version of the Evidence Project Risk of Bias tool (Kennedy et al. 2019) was used to assess the quality of those studies that involved a randomised controlled trial or quasi-experimental design. In addition to the eight items in this tool, the tool used in this assessment added a ninth item to consider the selective reporting of outcomes (see Table 3).

Table 3: Domains, Items, and Response Choices for the Risk of Bias Tool used for Randomised Controlled Trial and/or Quasi-Experimental Design (NSW Department of Communities and Justice, 2021)

Risk of Bias Tool Domains	Items	Response Choice
Study design	1. Cohort	Yes, No, NA, NR*
	2. Control or comparison group	Yes, No, NA, NR
	3. Pre/post intervention data	Yes, No, NA, NR
Participant representativeness	4. Random assignment of participants to the intervention	Yes, No, NA, NR
	5. Random assignment of participants for assessment	Yes, No, NA, NR
	6. Follow-up rate of 80% or more	Yes, No, NA, NR
Evidence of comparison groups	7. Comparison groups equivalent on socio-demographics	Yes, No, NA, NR
	8. Comparison groups equivalent on outcome measures	Yes, No, NA, NR
Selective reporting of outcomes	9. All outcomes measured	Yes, No, NA, NR

* *NA = not applicable, NR = not reported*

Categories were used to determine the level of risk of bias when rating the evidence for each program (see Table 4). A final summary score was reached by adding the number of criteria that had been met (Kennedy et al. 2019). This method allows for a quick assessment of quality across the studies identified in the review. Data were not extracted from publications that involved an RCT or QED deemed to have a high risk of bias (score: 0-3); these studies were excluded from this review. Studies deemed to have a moderate risk of bias (score: 4-6) or low risk of bias (score: 7-9) were included. In other words, the risk of bias score for each study had to reach a threshold of 4 in order for the study to be included in the review.

Table 4: Categorising Level of Risk of Bias in Randomised Controlled Trial and Quasi-Experimental Design (NSW Department of Communities and Justice, 2021)

Risk of Bias Tool Score	Risk of Bias
0 to 3	High risk of bias
4 to 6	Moderate risk of bias
7 to 9	Low risk of bias

One reviewer assessed the risk of bias for systematic reviews, meta-analyses, RCTs, and/or QEDs. A second reviewer checked these assessments. When the reviewers disagreed, this was resolved by discussion between the two reviewers or consultation with a third reviewer.

e. Data Extraction

After full-text screening and risk of bias assessment, data were extracted from each publication that scored a moderate or low risk of bias score. All team members extracted these data. DCJ provided the data extraction tool (NSW Department of Communities and Justice 2021). Extracted data included:

- General information (e.g. title, study design, risk of bias score)
- Sample size (e.g. original and final sample sizes)
- Sample characteristics (e.g. demographic information or risk factors)
- Program characteristics (e.g. name, program description, dosage and mode)
- Outcomes and results (e.g. client outcomes [i.e. the specific outcome the study measured], outcomes domains [i.e. the domain used to group similar client outcomes], direction of effect and effect size).

f. Assessing Direction of Effect

Following the identification of the relevant outcomes reported by each publication, a category was assigned to each client outcome to represent the direction of the reported effect (see Table 5).

Table 5: Effect Direction Criteria (NSW Department of Communities and Justice, 2021)

Effect	Description Based on Single Outcome Measure	Description Based on Grouped Outcome Measure
Positive	The estimated effect is positive and statistically significant (e.g. statistical significance is at the $p < 0.05$ level, two-sided test).	The grouped outcome measure has statistically significant, positive effects (for a meta-analysis: an average treatment effect, such as standardised mean difference, for synthesised outcome measures across multiple studies; statistical significance is at the $p < 0.05$ level, two-sided).*
Negative	The estimated effect is negative/adverse and statistically significant (e.g.statistical significance is at the $p < 0.05$ level, two-sided test).	The grouped outcome measure has statistically significant negative/adverse effects (for a meta-analysis: an average treatment effect, such as standardised mean difference, for synthesised outcome measures across multiple studies; statistical significance is at the $p < 0.05$ level, two-sided).
Not observed	The estimated effect is not statistically significant. (Statistical significance is at the $p > 0.05$ level, two-sided test.)	

** For odds ratios (OR) the effect is only significant if it does not include 1.0 in the confidence interval.*

g. *Rating Evidence for Program Effectiveness*

A three-step process was used to rate the evidence for every program:

1. **Rate the evidence for each program by outcome domain**: Using the evidence rating scale (see Table 6), a rating was assigned to each outcome domain identified in the data extraction process for every publication.
2. **Rate the overall evidence for each evidence-informed program**: Once the evidence for each outcome domain was determined, each program was given an evidence rating using the evidence rating scale.
3. **Rate the overall direction of effect for each program**: Direction of effect was assigned once overall program ratings were determined (see Table 7).

Table 6: Evidence Rating Scale (NSW Department of Communities and Justice, 2021)

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

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

Table 7: Direction of Effect (NSW Department of Communities and Justice, 2021)

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

Evidence Rating	Direction of Effect
Well-supported by research evidence	Positive
Supported research evidence	
Promising research evidence	
Mixed research evidence (with no adverse effects)	Mixed
Mixed research evidence (with adverse effects)	
Evidence fails to demonstrate effect	No effect
Evidence demonstrates adverse effects	Negative

h. Identifying Core Components and Flexible Activities

The final step was the identification of program core components and flexible activities. Core components are fixed program elements or functions; they are often broad categories that can be used to group specific activities. Flexible activities are the variable aspects within core components. Flexible activities can take on different forms according to local context, to achieve the same objective.

The DCJ Evidence Portal: Technical Specifications (NSW Department of Communities and Justice 2021, p. 49-50), specify that the following steps should be taken to identify core components:

1. Review the information in the data extraction template about each program.
2. Generate a list of potential core components based on understanding of the programs.
3. Conduct a content analysis of each evidence-informed program in the data extraction template.
4. Repeat the content analysis of each evidence-informed program, this time conducted by a second reviewer, and resolve any inconsistencies in the two reviewers' conclusions via discussion or consultation with a third reviewer.

5. Identify a final list of components.

Similarly, the following steps should be taken to identify flexible activities:

1. Select the first core component to identify flexible activities for.
2. Review the information that was coded for that core component and identify specific activities that were implemented in different programs.
3. Complete the flexible activity template to describe the activity and how it is implemented.
4. Repeat the first three steps for each core component.

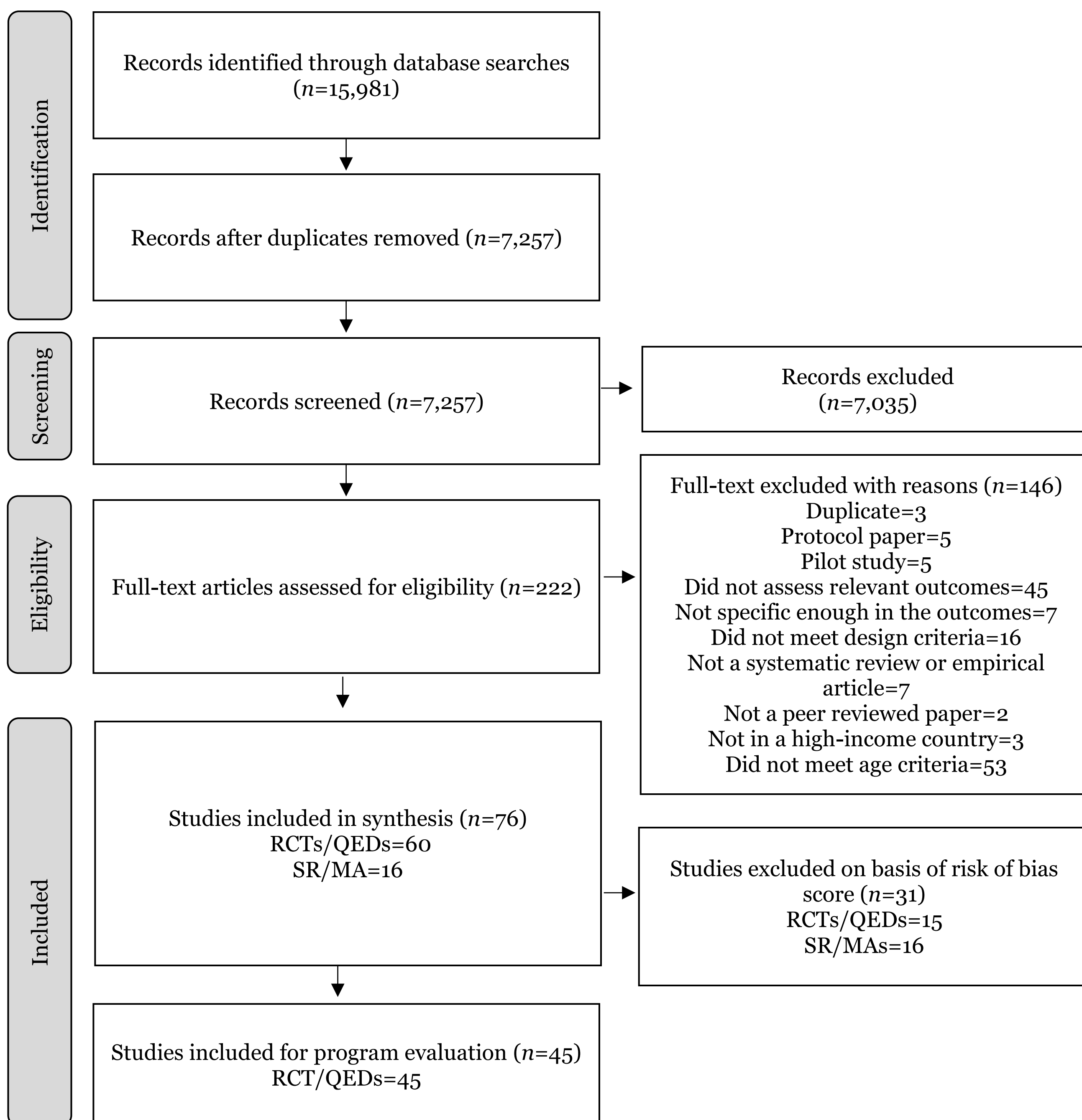
As per the Technical Specifications, the process of identifying core components was carried out iteratively, with team members developing, reviewing, refining and updating the core components. The process has a subjective element, including in how terms are defined, how language is used and how sets of activities are grouped. This subjective element can be seen across international studies that apply a core components approach, where there is considerable variation in how the analysis is conducted and the resulting categories. This review determined the final categories with reference to terminology used in the DCJ Evidence Portal. This approach has the benefit of creating common categories across the evidence base.

3. Results: Harm Reduction

a. *Study Selection and Screening*

Using the search strategy outlined in Section 2a, the database search yielded 15,981 publications for screening and review. First, duplicate publications that were indexed in more than one database were excluded (*n*=8,724). Second, the review's inclusion and exclusion criteria were applied to the titles and abstracts of the remaining 7,257 publications, which excluded 7,035 publications. Third, the full-text of the remaining 222 publications were assessed for eligibility. An additional 146 publications were excluded at this stage. The remaining 76 publications were assessed for risk of bias at which point a further 31 were excluded. The final sample that proceeded to data extraction was made up of 45 publications (see Figure 1).

Figure 1: PRISMA Flowchart for the Harm Reduction Review



b. *Assessment of Risk of Bias*

To systematically examine methodological rigour and overall quality of the publications, an assessment of risk of bias was conducted on the 76 publications that met the inclusion criteria. A total of 31 publications, including those that presented systematic reviews and/or meta-analyses, had high risk of bias scores. These were

excluded from the subsequent program evaluation stage and were not used to rate the evidence for identified programs.

Nine publications scored between 7-9, suggesting a low risk of bias, while 36 scored between 4-6, suggesting a moderate risk of bias. For the purpose of this review, publications with a risk of bias score of 4 or more were considered to have sufficient quality to be included in the data extraction process (NSW Department of Communities and Justice, 2021).

c. *Data Extraction*

Following full-text screening and risk of bias assessment, data were extracted from each publication using a template provided by DCJ (NSW Department of Communities and Justice, 2021). The publications were drawn from a wide geographic base, including North America, Europe, Asia and, of particular relevance to this review, New Zealand (Fergusson et al. 2005) and Australia (Goldfeld et al. 2019; Segal et al. 2018; Thomas & Zimmer-Gembeck 2012; Markie-Dadds & Sanders 2006).

During the process of reviewing eligible programs, it became clear that the programs could be grouped together according to five different models of harm reduction, including:

- home visiting programs: programs that required a sustained program of home visits, with most of the program content delivered in these home visits
- programs that gave centrality to early childhood education services: programs that were mostly delivered in early childhood education settings, involved teachers, often involved working directly with both children and parents in these settings, and were particularly focused on educational outcomes
- therapeutic parent-child interaction programs: programs that were focused on healing underlying difficulties such as those associated with dysfunctional parent-child attachment
- programs delivered in clinical settings: programs delivered as complementary programs in medical settings or community hubs
- family therapy: therapeutic programs focused on providing therapy to address broad whole-of-family issues.

It is important to note that these categories are not mutually exclusive, and there were programs that included two or more of the above elements (see Table 8). However, all of the programs included in this review could be allocated to one of these categories based on their primary focus, including key service delivery approaches and theoretical underpinnings. The grouping of programs according to these five models was helpful to organising the subsequent analysis and information-sharing processes. Following the technical specifications, adaptations of programs (e.g., enhanced intervention with additional component) were considered as a different program and rated separately.

Table 8: Characteristics of Harm Reduction Programs

Model	Program (Study used to rate the program)	Design		Risk of Bias Score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT	QED			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Home visiting programs	**Early Start** (Fergusson et al. 2005) *A home visiting program designed in New Zealand, which assesses family needs, issues, challenges, strengths, and resources and develops a positive partnership between the family support worker and client.*	✓		6	391	✓						✓				✓	Mixed research evidence (with no adverse effects)
	e-Parenting Program (Ondersma et al. 2017) *A multi-component computerised supplement to be used in home visiting programs such as Healthy Families America.*	✓		5	413	✓				✓						✓	Evidence fails to demonstrate effect
	Hamilton Nurse Home Visiting Program (MacMillan et al., 2005) *A Canadian nurse home visiting program delivered to families who have been subject to a reported incidence of physical abuse or neglect.*	✓		4	163 F*	✓					✓					✓	Mixed research evidence (with adverse effects)
	Nurse-Family Partnership (Eckenrode et al., 2000) *A home visiting program for first-time mothers designed to address risk factors for child maltreatment.*	✓		5	324 M/I	✓					✓					✓	Supported research evidence
	Nurse-Family Partnership (Eckenrode et al., 2017)	✓		4	324 M/I	✓					✓					✓	
	Nurse-Family Partnership (Olds et al. 1994)	✓		5	324 M/I	✓					✓					✓	
	Nurse-Family Partnership (Olds et al. 1999)	✓		5	995 M/I	✓					✓					✓	
	Australian Nurse-Family Partnership Program (Segal et al. 2018) *An Australian adaptation of the program based on Olds' model, designed to be culturally sensitive to the needs of Indigenous families.*		✓	7	854	✓			Not reported				Not reported				Promising research evidence
	Healthy Steps for Young Children (Minkovitz et al. 2007) *This model introduces a child development expert into the paediatric primary care practice for an integrated approach to child development.*	✓		5	3,165	✓	✓	✓				✓				✓	Promising research evidence
	Johns Hopkins Children and Youth Program (Hardy & Streett 1989) *A community-based home visiting service providing health and parenting education for inner city mothers and their infants.*	✓		5	263 M/I	✓					✓			✓			Promising research evidence
	Healthy Families America (Green et al. 2017) *A home visiting program designed to assist new parents with their parenting needs and personal issues, review the child's developmental progress, ensure safety in the home, and support successful adaptation to parenthood.*	✓		7	636	✓			✓				✓				Mixed research evidence (with adverse effects)
	Healthy Families America (DuMont et al., 2008)	✓		6	971	✓						✓				✓	
	Healthy Families America (LeCroy and Lopez, 2020)	✓		5	165	✓				✓						✓	

Model	Program (Study used to rate the program)	Design		Risk of Bias Score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT	QED			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
	Healthy Families America (Rodriguez et al. 2010)	✓		6	522	✓						✓				✓	
	Right@Home (Goldfeld et al. 2019) *An Australian nurse home visiting program based on the maternal early childhood sustained home-visiting (MECSH) program.*	✓		7	596	✓					✓					✓	Promising research evidence
	Parents as Teachers (Jonson-Reid et al. 2018) *A home visiting program promoting optimal early development, learning and health of children by supporting and engaging their parents/caregivers.*	✓		5	122	✓					✓					✓	Promising research evidence
	Parents as Teachers + SafeCare at Home (PATSCH) (Guastaferro et al., 2018) *A combination of the SafeCare and Parents as Teachers programs. The goals of the program are to improve parent-child relationships, improve school readiness and reduce risk of maltreatment through pedagogical approaches and skills-based learning.*	✓		7	93 F	✓			✓				✓				Mixed research evidence (with adverse effects)
	Pride in Parenting (Katz et al., 2011) *A community-based program targeting African American mothers who have not accessed adequate prenatal care.*	✓		5	286	✓	✓			✓						✓	Promising research evidence
	Promoting First Relationships (Oxford et al., 2016) *A relationship- and strengths-based home visiting service that aims to help families facing adversity to meet their children's social and emotional needs, including a sense of safety and security.*	✓		8	228	✓			✓				✓				Mixed research evidence (with no adverse effects)
	SafeCare (Gershater-Molko et al., 2002) *A structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect.*	✓		6	82 F	✓			✓				✓				Promising research evidence
	SafeCare (Whitaker et al., 2020)	✓		6	193 P	✓			✓				✓				
	SafeCare Dad to Kids Program (Dad2K) (Self-Brown et al., 2017) *An adaptation of the standard SafeCare training program designed specifically for fathers of children aged 0 to 5 years, reported for child abuse and/or neglect.*	✓		4	99 FA	✓				✓			✓				Mixed research evidence (with no adverse effects)
	SafeCare+ (Silovsky, 2011) *An adaptation of the standard SafeCare structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect. The main adaptation in SafeCare+ is the addition of motivational interviewing and training home visitors on identification and response to imminent child maltreatment and various risk factors.*	✓		4	105 P	✓			Not reported				Not reported				Promising research evidence
Programs that gave centrality to early	**Chicago Parent Program** (Gross et al., 2009) *A parenting program that builds on the strengths of the Webster-Stratton Incredible Years model. The goals of the program are to improve parent self-efficacy, discipline strategies, and parent behaviour during free play and clean-up sessions, and to reduce the frequency of child behaviour problems.*	✓		5	292 F		✓		✓				✓				Promising research evidence
	Family Support Program (Calheiros et al., 2017)	✓		5	36 F	✓	✓		✓							✓	Mixed research evidence (with

Model	Program (Study used to rate the program)	Design		Risk of Bias Score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT	QED			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
	A program based on the Comprehensive Child Development Program, following the principles of cognitive and behavioural parenting programs based on social learning models.																no adverse effects)
	HeadStart (Green et al., 2020) *The largest publicly supported childcare program in the USA targeted at low-income children, and children with disabilities, two groups at high risk for maltreatment. The goals of the program are to improve parenting, reduce maltreatment including the use of abusive discipline or neglectful behaviours, and promote parental involvement and parent education.*	✓		5	2,794 M/I			✓				✓				✓	Promising research evidence
	HeadStart (Zhai et al. 2013)		✓	4	2,807 F			✓	Not reported				Not reported				
	ParentCorps (Dawson-McClure et al., 2015) *A program utilising school personnel (mental health professionals and teachers) as the facilitators of a parenting program and a concurrent group for children.*	✓		6	1050 C		✓		✓				✓				Promising research evidence
	Relief Nursery Program (Eddy et al., 2020) *Designed for and targeted at economically vulnerable families, with the aim of decreasing instances of child maltreatment.*	✓		5	180P 180C	✓	✓	✓				✓	Not reported				Mixed research evidence (with no adverse effects)
Therapeutic parent-child interaction programs	**Parent-Child Interaction Therapy (PCIT)** (Leung et al., 2009) An *individualised, evidence-based treatment program for preschool children displaying disruptive, oppositional, and defiant behaviour.*		✓	4	110 P			✓	Not reported				✓				Supported research evidence
	Parent-Child Interaction Therapy (PCIT) (Thomas & Zimmer-Gembeck, 2012)	✓		6	152 M/I			✓	✓				✓				
	Self-Directed Triple P (Markie-Dadds & Sanders, 2006) *A behavioural family program based on the Triple P program.*	✓		6	47 F			✓	✓				✓				Promising research evidence
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Negrão et al., 2014) *This program was developed in the Netherlands to address disruptive behaviour in very young children.*	✓		6	43	✓			✓							✓	Mixed research evidence (with adverse effects)
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Stolk et al., 2007)	✓		6	237 F	✓				✓						✓	
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Yagmur et al., 2014)	✓		7	76 M/I	✓			✓							✓	
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-SD-FC) (Schoemaker et al., 2020)	✓		9	55 F	✓			✓							✓	Evidence fails to demonstrate effect

Model	Program (Study used to rate the program)	Design		Risk of Bias Score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT	QED			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
	An adaptation of a program developed in the Netherlands to address disruptive behaviour in very young children, targeted at foster care families.																
Programs delivered in clinical settings	**Adults and Children Together Against Violence: Parents Raising Safe Kids** (Portwood et al., 2011) *A universal approach to prevention, incorporating education aimed at parents and primary caregivers.*	✓		4	197			✓	✓				Not reported				Mixed research evidence (with adverse effects)
	Child-Adult Relationships Enhancement in Primary Care (PriCARE) (Schilling et al., 2017) *A trauma-informed group training program to teach caregivers techniques to support the social and emotional growth of children.*	✓		5	120 P		✓		✓				✓				Promising research evidence
	Group Attachment-Based Intervention (GABI) (Steele et al., 2019) *This program aims to improve the mother-child relationship and prevent abuse for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child.*	✓		5	78 P		✓		✓				✓				Promising research evidence
	The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits (Karjalainen et al., 2019) *The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others in the USA. The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits is an adaptation of the program involving additional sessions and home visit. It is intended for children aged 2-8 years with disruptive behavioural problems.*	✓		8	98 P	✓	✓		✓				✓				Promising research evidence
	The Incredible Years Shortened Basic Version (Reedtz et al., 2011) *The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others in the USA. The Incredible Years Shortened Basic Version is a shortened version designed for children aged 2-8 years with disruptive behavioural problems.*	✓		7	189 P		✓		✓				✓				Promising research evidence
	Parent Training Program (Li et al., 2013) *A program that aims to improve the parent–child relationship and decrease parental stress by reducing harsh parenting at the time of school transition.*	✓		6	120 F		✓		✓				✓				Mixed research evidence (with no adverse effects)
	Safe Environment for Every Kid (SEEK) (Dubowitz et al. 2009) *A face-to-face program delivered as clinic care in a paediatric clinic.*	✓		4	558 F			✓			✓		✓				Promising research evidence
Family Therapy	**Family Group Conferencing** (Hollinshead et al., 2017) *A family-centered practice intended to elevate the voice and the role of participants in the decision-making process and address the power differential between agency staff and families inherent in child welfare practice.*	✓		8	503 F			✓	Not reported				Not reported				Evidence fails to demonstrate effect

Model	Program (Study used to rate the program)	Design		Risk of Bias Score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT	QED			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
	Together We Can (Adler-Baeder et al., 2018) *This is a relationship and marriage education program that aims to develop relationship skills for adults in couple and co-parenting relationships and thus reduce harm in the family.*		✓	5	154 P		✓		✓				✓				Evidence fails to demonstrate effect

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

d. *Harm Reduction Outcome Domains and Client Outcomes*

Data extraction included the identification of outcome domains and client outcomes that were essential to determine program effectiveness. Following the DCJ Evidence Portal: Technical Specifications. A total of six outcome domains and 66 unique client outcomes were identified. These included:

- Child abuse and neglect (24 client outcomes)
- Parenting (23 client outcomes)
- Discipline/punishment (9 client outcomes)
- Child health (5 client outcomes)
- Child safety (4 client outcomes)
- Domestic violence (1 client outcome)

Details of the harm reduction studies outcome domains, client outcomes and measures used as outcome indicators are found in Appendix 7. The table in Appendix 7 lists the wide range of tools and measures used to assess the harm reduction client outcomes across studies, including quantitative and qualitative measures. While some of the measures were commonly employed instruments which have previously demonstrated strong reliability and validity in research (e.g. the Edinburgh Postnatal Depression Scale and the HOME Inventory), a number of others were non-standardised measures designed specifically for the program being evaluated and the population group of interest, which have not undergone psychometric testing.

e. *Evidence Ratings*

Extracted data were compiled to form ratings for the strength and direction of evidence for the harm reduction programs. Detailed information about the programs and their evidence ratings is contained in Table 9 and Appendix 8. The number of programs for each level of the evidence rating scale is as follows:

- Well-supported by research evidence: 0 programs
- Supported research evidence: 2 programs
- Promising research evidence: 17 programs
- Mixed research evidence (with no adverse effects): 6 programs
- Mixed evidence (with adverse effects): 5 programs
- Evidence fails to demonstrate effect: 4 programs
- Evidence demonstrates adverse effects: 0 programs

Table 9: Harm Reduction Programs' Evidence Ratings

Evidence Rating	Program
Supported research evidence	• Parent-Child Interaction Therapy (Leung, 2009; Thomas and Zimmer-Gembeck, 2012) • Nurse-Family Partnership (Eckenrode et al., 2017, 2020; Olds et al., 1994, 1999)
Promising research evidence	• Australian Nurse-Family Partnership Program (Segal et al., 2008) • Chicago Parent Program (Gross et al., 2009) • Child-Adult Relationships Enhancement in Primary Care (Schilling et al., 2017) • Group Attachment-Based Intervention (Steele et al., 2019) • HeadStart (Green et al., 2020, Zhai et al., 2013) • Healthy Steps for Young Children Program (Minkovitz et al., 2007) • Johns Hopkins Children and Youth Program (Hardy and Streett, 1989) • ParentCorps (Dawson-McClure et al., 2015) • Parents as Teachers (Jonson-Reid et al., 2018) • Pride in Parenting Program (Katz et al., 2011) • Right@Home (Goldfeld et al., 2019) • SafeCare (Gershater-Molko et al., 2002; Whitaker et al., 2020) • SafeCare+ (Silovsky et al., 2011) • Safe Environment for Every Kid (Dubowitz et al., 2009) • Self-Directed Triple P (Markie-Dadds and Sanders, 2006) • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits (Karjalainen et al., 2019) • The Incredible Years Shortened Basic Version (Reedtz et al., 2011)

Evidence Rating	Program
Mixed research evidence (with no adverse effects)	• Early Start (Fergusson et al., 2005) • Family Support Program (Calheiros et al., 2017) • Parent Training Program (Li et al., 2013) • Promoting First Relationships (Oxford et al., 2016) • Relief Nursery Program (Eddy et al., 2020) • SafeCare Dad to Kids (Dad2K) (Self-Brown et al., 2017)
Mixed research evidence (with adverse effects)	• Adults and Children Together against Violence: Parents Raising Safe Kids Program (Portwood et al., 2011) • Hamilton Nurse Home Visiting Program (Macmillan et al., 2005) • Healthy Families America Program (DuMont et al., 2008; Green et al., 2017; LeCroy and Lopez, 2020; Rodriguez et al., 2010) • Parents as Teachers + SafeCare at Home (Guastaferro et al., 2018) • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (Negrão et al., 2014; Yagmur et al., 2014; Stolk et al., 2007)
Evidence fails to demonstrate effect	• Together We Can (Adler-Baeder et al., 2018) • Family Group Conferencing (Hollinshead et al., 2017) • e-Parenting Program (Ondersma et al., 2017) • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (Schoemaker et al., 2020)

To be considered potentially effective, programs needed to attain an evidence rating of 'supported', 'promising' or 'mixed research evidence (with no adverse effects)'. Programs that received a rating of 'mixed research evidence (with adverse effects)' or 'evidence failed to demonstrate an effect' were not deemed effective. Summaries of the 34 programs can be found in Appendix 9. These summaries include information about the program including target group, client outcomes, strength of the evidence and implementation considerations.

f. Core Components and Flexible Activities

A key outcome of this review is the identification of the core components and flexible activities of effective programs. A content analysis identified four core components: engagement; building supportive relationships and social networks; building parental capacity; and case management. In addition, thirteen related flexible activities were identified (see Table 10 and Appendices 10 and 11).

Table 10: Harm Reduction Programs' Core Components and Flexible Activities

Core Components	Flexible Activities
Engagement	• Home visits • Engaging delivery of curriculum material • Practical support for attendance • Flexible curriculum for individuals for cultural appropriateness • Overcoming barriers
Building supportive relationships and social networks	• Building the parent – child relationship • Building the parent – service provider relationship
Building parental capacity	• Standard curriculum of parenting skills • Trained service providers • Life skills
Case management	• Recruitment and screening • Integration with other services and onward referrals • Appropriate referrals

g. Reflections on Findings and Processes for the 'Risk of Harm' Rapid Review

The standard of evidence required to achieve the highest evidence ratings is considerable, and it is noteworthy that none of the intervention programs that met the criteria for inclusion in this rapid review achieved a "well supported by evidence" rating. Two of the 34 programs (Nurse-Family Partnership and Parent-Child Interaction Therapy) received the second highest rating of "supported research evidence". In large part, this finding is a reflection of the volume and type of research that exists and the research rigour that has been applied in this review. To be included in this review, programs needed to have at least been subject to a randomised controlled trial (RCT), or to have had a high quality QED. RCTs and QEDs are resource-intensive, and are often met with resistance by practitioners within the social service field because of widespread

discomfort with the notion of a 'control' group. For these reasons, there are fewer RCTs in social services research than in other fields, such as in health services research. Care must be taken not to conflate a lack of evidence with a lack of program effectiveness.

Requiring RCT evidence also inadvertently results in a positive bias towards US-based programs. Of the 34 programs reviewed, 22 relied exclusively on US-based research. This is because of the significantly higher investment in research in the US and larger population numbers, making RCTs more feasible. The US is also a nation in which there are fewer free universal social services than in countries like Australia where there is a stronger national commitment to social welfare. This means that RCT control groups in the US are often made up of families who receive no formal support services at all. Control groups in the Australian context are generally 'services as usual' groups – meaning that the control groups are also receiving a range of universal supports. Therefore, studies based in the US can design studies with a genuine counterfactual (a group which receives no intervention), whereas studies based in Australia use control groups which may be receiving a range of additional services, which become extraneous variables in the study. This can create spurious correlations in research. The difference between the intervention and control groups is not as wide, and it is harder for Australian studies to achieve statistically significant findings.

For the purposes of program implementation, it is not sufficient to only implement programs that received the highest scores in this evidence review. It is essential to consider the context in which programs are developed and trialled. Careful consideration is required in the adaptation of an international program to be relevant to diverse Australian contexts, and programs that have been developed within the Australian context should not be overlooked. For example, the Nurse-Family Partnership (NFP) Home Visiting Program was developed over 40 years ago in the US for first-time mothers. There is now a very large body of high quality evidence to support this program. NFP was selected to be rolled out to Aboriginal families in the Northern Territory. The program was adapted for Aboriginal people by including Aboriginal Health Workers in the implementation teams, and also for delivery both to first-time mothers and to multigravida mothers. This adaptation was called the Australian Nurse-Family Partnership. Research demonstrated positive findings in the Australian context, but only for first-time mothers, making it clear that the program's design only serves those with little to no parenting experience. Right@Home is an Australian home visiting program that has been designed and trialled within the Australian context. It has demonstrated positive outcomes (and no adverse outcomes to date), including with both first time and multigravida mothers. It has also been trialled with Aboriginal families. While NFP may currently have a larger collection of RCT studies to support its claims of effectiveness, it is certainly worth considering that perhaps an Australian program designed to address the needs of all mothers requiring additional support regardless of the number of children they have may have aligned more closely with the goals of the service delivery team.

There is a clear need for more rigorous Australian research. Only four of the 34 programs included Australian research. RCTs are still the gold standard for research effectiveness trials. If high levels of evidence are required, as they should be, it is essential that the Australian government and service organisations invest in highly rigorous evaluation.

Sixteen home visiting programs – some of them adaptations of standard programs - were included in this review. The majority of these programs focused on the first 2-3 years of life, reflecting the understanding that the home is the primary environment for an infant, holding both the greatest risk of harm and the greatest opportunity for nurturing and healing. Three of the included programs demonstrated mixed evidence with adverse effects (Healthy Families America, Parent as Teachers + SafeCare at Home, and Hamilton Nurse Home Visiting Program). Service decision-making must take into account the extent to which these adverse effects outweigh the positive, and whether or not to take the position of "first do no harm". Right@Home was the only one of the home visiting programs that was developed in Australia. Overall, there were only two studies (Australian Nurse-Family Partnership Program and Early Start) that directly reported on outcomes relevant to First Nations families. The ANFPP research was conducted with Aboriginal families, and the Early Start research was conducted with Maori families. There is a clear need for more research that explores the appropriateness of a home visiting approach for Australian Aboriginal families.

Five programs gave centrality to early childhood education progams. These were generally programs that targeted children in the preschool years, and worked closely with early childhood educators. Most required parents to attend group sessions in early childhood education centres. Outcomes largely focused on child learning and development, and encouraging parent engagement with the child's learning. None of this research was Australian or conducted with First Nations peoples. This research raises issues relevant to the challenges of parent engagement in intervention programs. For example, the Relief Nursery Program experienced significant program attrition, which was not as high for the parents who were provided with transport. ParentCorps provided dinner and raffled gift certificates to encourage attendance. The engagement of vulnerable families with intervention services is a well known and ongoing challenge for service providers.

The four therapeutic parent-child interaction programs identified in this review represent a shift in focus from community and family characteristics broadly (e.g. "low income" families), to highly targeted programs with a focus on child behaviour, such as being at risk of disruptive, oppositional or defiant behaviour. Two of these programs included Australian evidence (Self-Directed Triple P and Parent-Child Interaction Therapy). One program (Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline) included a culturally adapted version that was piloted with and successfully delivered to Turkish families in the Netherlands. It was made culturally appropriate by changing some of the stimulus materials and activities to ensure that they were meaningful to participants; delivering the intervention in appropriate languages; and extending the duration of each home visit to allow the visitors to engage in conversation before the intervention commenced, as per Turkish cultural norms.

Seven programs were delivered in clinical settings, such as paediatric clinics, public health care centres, counselling centres, etc. Five programs had promising evidence. One program had mixed evidence with no adverse effects and one had mixed evidence including adverse effects. None of these studies included an Australian trial. The present review of this research brought to light the interesting challenge that arises when a negative outcome could, in fact, signal positive change. For the Adults and Children Against Violence: Parents Raising Safe Kids program, there was a demonstrable increase in parenting stress over time for the intervention group. However, the change this group experienced was a change from being below normal levels of parenting stress at baseline, to experiencing normal levels of parenting stress at follow-up. It is possible that the increase in stress reflected growing awareness of their children's needs and their role in supporting their child. Understanding the detail underlying significant results is critical to the interpretation of findings.

Two family therapy programs were included in the review (Family Group Conferencing and Together We Can). Neither program demonstrated any effect.

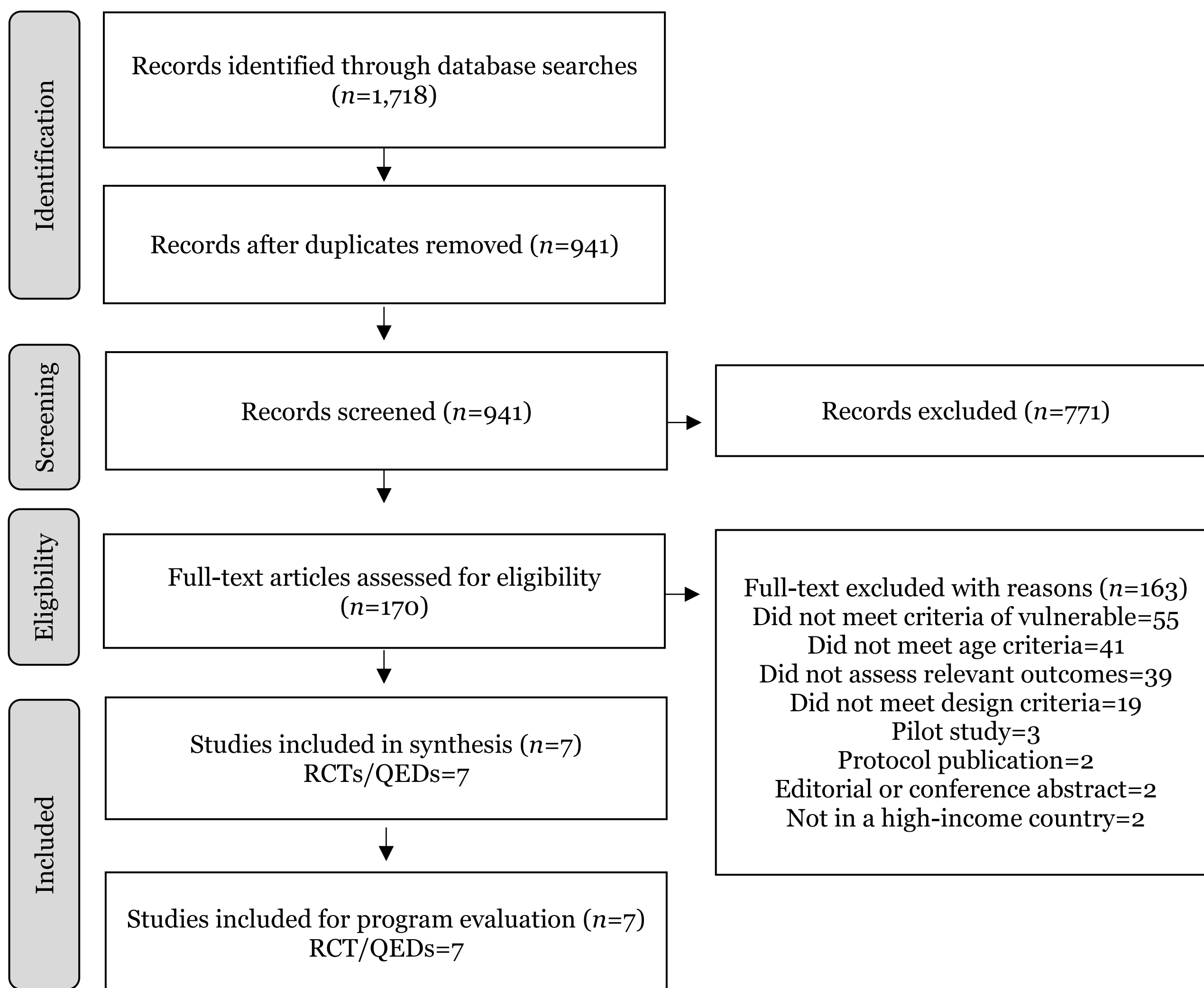
Overall, the review identified a number of high quality programs with a compelling evidence base. There was a strikingly small number of Australian studies and research with First Nations families. The findings also drew attention to the importance of careful interpretation of research, and consideration of implementation context and program adaptation. There are many other studies that were not included due to the limitations of the search criteria or excluded following risk of bias assessments. Nonetheless, this rapid review provides a useful starting point and contributes to a growing body of research that is intended to guide informed program decision-making.

4. Results: School Readiness

a. *Study Selection and Screening*

Using the search strategy identified in Section 2a, the search of ten electronic databases resulted in 1,718 publications for screening and review. The screening and review process outlined in Sections 2b and 2c was followed: duplicates were excluded (*n*=777); the inclusion and exclusion criteria (see Table 2) were applied to each publication title and abstract and those that did not meet these were excluded (*n*=771); the inclusion and exclusion criteria were applied to the full-text and publications that did not meet these criteria were excluded (n=163). Seven publications proceeded to a risk of bias assessment and data extraction (see Figure 2). Importantly, this review sought to identify programs targeting vulnerable children. There are many universal transition to school programs, however studies evaluating these programs were not included unless they specifically stated that the program aimed to improve outcomes for children who were vulnerable or at risk.

Figure 2: PRISMA Flowchart for the School Readiness Review



b. *Assessment of Risk of Bias*

As the seven publications that met the inclusion criteria were all RCTs, the risk of bias assessment tool described in Section 2d was employed. All publications scored between 4-6, suggesting a moderate risk of bias and therefore, high-quality.

c. *Data Extraction*

Data were extracted from the seven publications deemed by the risk of bias assessment to be of high quality. The programs covered a range of settings including school (e.g., The Incredible Years and Roots of Resilience) and home (e.g., Family Check-Up). They also represented the three dimensions in the review's definition of school readiness: child ready (e.g., Kids in Transition to School); school ready (e.g., Roots of Resilience); and family ready (e.g., Family Check-Up). The characteristics of these programs are found in Table 11.

Table 11: Characteristics of School Readiness Programs

Program (Study used to rate program)	Design		Risk of bias score	Sample size	Mode				Duration				Dosage				Evidence rating
	RCT	QED			Classroom	Home	Online	Health care	< 6 months	6-12 months	1-2 years	3+ years	Daily/ Weekly	Fortnightly	Monthly	Variation over time	
The Incredible Years Teacher and Child Training Program (IY) (Webster-Stratton et al., 2008) *This universal prevention curriculum trains teachers to promote children's social competence and emotional self-regulation, reduce conduct problems, and involve parents in their children's learning.*	✓		5	120 classes 14 schools	✓							✓	✓				Promising
Family Check-Up (Lunkenheimer et al., 2008) *FCU is a brief, motivational intervention that supports parents' existing strengths as well as their engagement in additional parent training services when needed.*	✓		5	731 families		✓				✓						✓	Mixed (with no adverse effects)
Roots of Resilience (Lipscomb et al., 2021) *This program is an online professional development program for early childhood education (ECE) teachers in home and centre-based programs to strengthen resilience with children impacted by trauma.*	✓		5	17 classes 23 teachers 61 children			✓		✓							✓	Mixed (with no adverse effects)
Smart Beginnings (Roby et al., 2021) *SB integrates universal (primary) and targeted (secondary) prevention programs, each focused on promoting positive parent-child interactions.*	✓		6	403 families		✓		✓		✓			✓				Promising
Second Step Early Learning (SSEL) (Upshur et al., 2019) *SSEL is a commercially available early learning kit for the classroom environment which seeks to develop children's social emotional competence and self-regulation to improve school readiness.*	✓		5	67 classes 187 teachers 770 students	✓				✓				✓				Mixed (with no adverse effects)
Kids in Transition to School (KITS) (Pears et al., 2012) *KITS provides a focused, short-term program to increase school readiness prior to kindergarten entry and to promote better subsequent school functioning in children in foster care.*	✓		4	192 families	✓					✓			✓				Mixed (with no adverse effects)
Kids in Transition to School (KITS) (Pears et al., 2013)	✓		5	192 families	✓					✓			✓				Mixed (with no adverse effects)

d. School Readiness Outcome Domains and Client Outcomes

Data extraction included the identification of outcome domains and client outcomes that were essential to determine program effectiveness. Two outcome domains were identified along with 19 related client outcomes These included:

- School readiness (18 client outcomes)
- Positive parenting (1 client outcome)

Details of the school readiness studies outcome domains, client outcomes and measures used as outcome indicators are found in Appendix 12.

e. Program Effectiveness Ratings

Following data extraction, the effectiveness of the programs was assessed. Based on the rating scale in Table 6, six programs were deemed effective. Of these, two programs were rated as 'promising research evidence', and four were rated as having 'mixed research evidence (with no adverse effects)' (see Table and Appendix 12).

Table 12: School Readiness Programs' Evidence Ratings

Evidence Rating	Program
Promising research evidence	• The Incredible Years Teacher and Child Training Program (Webster-Stratton et al., 2001) • Smart Beginnings (Roby et al., 2021)
Mixed research evidence (with no adverse effects)	• Second Step Early Learning (Upshur et al., 2019) • Kids in Transition to School (KITS) (Pears et al., 2012, Pears et al., 2013) • Roots of Resilience (Lipscomb et al., 2021) • Family Check-Up (Lunkenheimer et al., 2008)

Summaries of the six effective programs can be found in Appendix 13.

f. Core Components and Flexible Activities

A content analysis identified three commonalities across the six programs found to improve the school readiness of vulnerable children aged six years or younger: relationship building; academic preparedness; and classroom readiness. Eight related flexible activities were also identified (see Table 13 and Appendices 14 and 15).

Table 13: School Readiness Programs' Core Components and Flexible Activities

Core Components	Flexible Activities
Relationship building	• Building educator – parent relationships • Nurturing educator – child relationships • Enhancing parent-child relationships
Academic preparedness	• Building executive functioning capacity • Progressing language and preliteracy capacities
Readiness of the child for the classroom	• Developing skills in self-regulation • Cultivating social-emotional skills • Learning classroom protocols and behaviours

g. Reflections on Findings and Processes for the 'School Readiness' Rapid Review

Six school readiness programs met the inclusion criteria for this review, only two of which demonstrated promising levels of evidence (The Incredible Years Teacher and Child Training Program and Smart Beginnings). The programs that were included in this report represented a range of different approaches, including embedding learning sessions with children on self-regulation and other behaviours into early childhood settings (e.g. Second Step), home visiting (e.g. Family Check-Up) and video feedback approaches to support positive parent-child learning interactions (e.g. Smart Beginnings). There was also a range of different approaches in relation to the age of the child, from supporting the learning and development of younger children through building parent capacity and involvement, to early childhood setting approaches for older children.

All but two of the programs were focused on working with parents and/or children. This was noteworthy given that the school readiness research literature argues that school readiness requires three components: child readiness, family readiness, and readiness of the educators and school (as per the definition in Table 1). The readiness of the school environment for children and the willingness of schools to adapt their environment and practices and reflect on school culture to meet the needs of children is given very little attention by researchers. The research included in this review demonstrates a conceptual understanding that schools must be willing to adapt, yet practical focus remains on assessing the preparedness of children and families. The two studies that do address school preparedness in the form of educator training still largely base their measures of success on child outcomes, rather than educator or school outcomes. There is a need for research that gives focus to how schools can create a supportive environment for children to be ready to learn, and the approaches that are effective in supporting flexibility in response to specific child needs.

All of the research included in the school readiness review was from the US, once again highlighting the need for Australian research and research with First Nations peoples.

5. Discussion

a. Key Findings

The identified programs have undergone rigorous evaluation that was published in peer reviewed journals, and demonstrate different levels of effectiveness in reducing harm or improving school readiness among vulnerable children. In the case of reducing harm, the programs collectively point to an improvement in indicators such as hostile parenting, out-of-home care rates, or substantiated allegations of child abuse and neglect. For children preparing to transition to school, improvements pertain to behaviour regulation, the development of language, preliteracy, and social-emotional skills, as well as positive one-on-one interactions. The length of time over which improvements were measured varies from one study to the next.

Five different models of child harm reduction programs were identified during data extraction: home visiting programs; programs that gave centrality to early childhood education services; therapeutic parent-child programs; programs delivered in clinical settings; and family therapy programs. Sometimes, programs were combined to meet an identified need. For example, Parents as Teachers was combined with SafeCare to create Parents as Teachers + SafeCare at Home (PATSCH), a safety-based parent training curriculum with a home visiting program (Guastaferro et al., 2018). Another example is the combination of The Incredible Years parent education curriculum with additional home visits (Karjalainen et al., 2019).

Regarding programs that gave centrality to early childhood education services, US-based programs such as HeadStart may not align directly to the needs of Austalian communities broadly, especially because Australia has universal subsidised access to preschool and day care, with the Universal Access National Partnership delivered in accordance with the National Quality Framework (NQF) and the Early Years Learning Framework. Nonetheless, given the existing gap between fees and government subsidies for quality early childhood in Australia, Australia shares with the US a concern that attendance at quality early childhood centres may be out of reach for families who experience disadvantage.

In relation to the school readiness literature, this review did not group the programs together according to program model because there were only seven programs that met the eligibility criteria for the review. However, there were three approaches evident in the included studies: programs that focus on educator capacity building; programs than embed modules within the early childhood curriculum delivered to children (child capacity building); and programs that focus on the parent's role in supporting their child's learning and behavioural development (parent capacity building). It was noteworthy that the strong focus was on looking for change in children and families to support school readiness. There was much less attention given to preparing educators, and no attention at all to school culture and the role of organisational culture in supporting children during this pivotal time in their lives.

b. Limitations of the Evidence Base

Universal programs and a range of early intervention programs are not well represented due to the narrow inclusion criteria of both reviews. For example, there are a number of well-established early intervention programs supported by a large number of research studies, including Triple P, Nurse-Family Partnership, and The Incredible Years. Only a relatively small proportion of these studies was captured by the reviews, which is partly due to the conservative study inclusion parameters including age range, vulnerability status, and the specific focus on harm reduction or school readiness.

Requiring evidence from RCTs also inadvertently results in a positive bias towards US-based programs: 22 of the 34 child harm reduction programs reviewed relied exclusively on US-based research; only four of the 34 programs included Australian research. Overall, there were only two studies that directly reported on outcomes relevant to First Nations families (one with Aboriginal families and one with Maori families). There is likely to be further research evidence and implementation detail that was not captured in the studies that met the inclusion criteria. For example, there may have been additional studies that were conducted in Australia, including with Aboriginal families, or were implemented in CALD communities. Further detailed investigation for each program is required to fully understand the breadth of available literature. This would need to be conducted prior to a decision to implement any of these programs.

c. Implementation Considerations

When implementing programs in NSW, several factors warrant consideration. These include: whether there is a curriculum with a program manual that can support adaptation to diverse contexts whilst maintaining program fidelity; the degree of flexibility in the program for individual families or cultural groups; the skills and qualifications required of a service provider; how a program is connected to other services; the purpose of the program; program length; the target group; and program cost. The publications included in this review offered limited detail on most of these factors.

The program impact was assessed for target groups and outcomes. Most of the identified publications reported on studies that were not conducted in Australia. Relative to the countries represented in this review, Australia has a different ecological framework for families and children. Therefore it remains to be determined whether the programs included in this review can be readily used in Australia. Programs should only be implemented after careful consideration and consultation with all relevant stakeholders. This is particularly important for programs with Aboriginal or CALD communities. In these cases, extensive consultation with practitioners and community members with cultural knowledge should be undertaken before a program is considered (see the Appendices for program detail).

Following the approach taken by some NSW Government program areas, this review has applied a core components approach. This approach seeks to overcome some of the implementation challenges posed by manualised programs, such as subscription costs and staff training requirements. By identifying the core components and flexible activities of effective programs, the approach aims to contribute to the creation of a common evidence-informed framework that DCJ-funded providers can use to develop and implement their services.

d. Limitations

This report has presented the findings of a rapid review of publicly available, peer-reviewed research papers. The evidence base was identified through extensive systematic searching and screening of the available literature in accordance with the DCJ Evidence Portal: Technical Specifications (NSW Department of Communities and Justice 2021). This is not a systematic review. The search strategy limited the publications relating to the programs included in the review; for many of the programs, there may be additional research addressing a variety of program outcomes. It was beyond the scope of this review to include research that did not directly inform the guiding research questions, or to include grey literature. This review is also limited by the paucity of Australian research, particularly as this relates to children who experience marginalisation and adversity, and to children from specific groups including Aboriginal children, children from CALD backgrounds, and children who experience poor mental health. There is a clear need for more research examining the effectiveness of childhood interventions and the implementation of programs that were developed overseas in diverse Australian contexts.

References

ADLER-BAEDER, F., GARNEAU, C., VAUGHN, B., MCGILL, J., HARCOURT, K. T., KETRING, S. & SMITH, T. 2018. The Effects of Mother Participation in Relationship Education on Coparenting, Parenting, and Child Social Competence: Modeling Spillover Effects for Low-Income Minority Preschool Children. *Family process,* 57, 113-130.

CALHEIROS, M. M., PATRÍCIO, J. N., GRAÇA, J. & MAGALHÃES, E. 2017. Evaluation of an Intervention Program for Families with Children at Risk for Maltreatment and Developmental Impairment: A Preliminary Study. *Journal of Child and Family Studies,* 27, 1605-1613.

DAWSON-MCCLURE, S., CALZADA, E., HUANG, K. Y., KAMBOUKOS, D., RHULE, D., KOLAWOLE, B., PETKOVA, E. & BROTMAN, L. M. 2015. A population-level approach to promoting healthy child development and school success in low-income, urban neighborhoods: impact on parenting and child conduct problems. *Prev Sci,* 16, 279-90.

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, 858-64.

DUMONT, K., MITCHELL-HERZFELD, S., GREENE, R., LEE, E., LOWENFELS, A., RODRIGUEZ, M. & DORABAWILA, V. 2008. Healthy Families New York (HFNY) randomized trial: effects on early child abuse and neglect. *Child Abuse Negl,* 32, 295-315.

ECKENRODE J, GANZEL B, HENDERSON C, SMITH E, OLDS D, POWERS J, COLE R, KITZMAN H & SIDORA K 2000. Preventing child abuse and neglect with a program of nurse home visitation. *JAMA,* 284, 1385.

ECKENRODE, J., CAMPA, M. I., MORRIS, P. A., HENDERSON, C. R., JR., BOLGER, K. E., KITZMAN, H. & OLDS, D. L. 2017. The Prevention of Child Maltreatment Through the Nurse Family Partnership Program: Mediating Effects in a Long-Term Follow-Up Study. *Child Maltreat,* 22, 92-99.

EDDY, J. M., SHORTT, J. W., MARTINEZ, C. R., JR., HOLMES, A., WHEELER, A., GAU, J., SEELEY, J. & GROSSMAN, J. 2020. Outcomes from a Randomized Controlled Trial of the Relief Nursery Program. *Prev Sci,* 21, 36-46.

FERGUSSON, D. M., GRANT, H., HORWOOD, L. J. & RIDDER, E. M. 2005. Randomized trial of the Early Start program of home visitation. *Pediatrics,* 116, e803-9.

GERSHATER-MOLKO R, LUTZKER J & WESCH D 2002. Using recidivism data to evaluate Project Safecare: Teaching bonding, safety and health care skills to parents. *Child Maltreatment,* 7, 277-285.

GOLDFELD S, PRICE A, SMITH C, BRUCE T, BRYSON H, MENSAH F, ORSINI F, GOLD L, HISCOCK H, BISHOP L, SMITH A, PERLEN S & KEMP L 2019. Nurse home visiting for families experiencing adversity: A randomized trial. *Pediatrics,* 143, e20181206.

GOLDFELD, S., PRICE, A., SMITH, C., BRUCE, T., BRYSON, H., MENSAH, F., ORSINI, F., GOLD, L., HISCOCK, H., BISHOP, L., SMITH, A., PERLEN, S. & KEMP, L. 2019. Nurse Home Visiting for Families Experiencing Adversity: A Randomized Trial. *Pediatrics,* 143, 1-12.

GREEN, B., SANDERS, M. B. & TARTE, J. M. 2020. Effects of Home Visiting Program Implementation on Preventive Health Care Access and Utilization: Results from a Randomized Trial of Healthy Families Oregon. *Prevention Science,* 21, 15-24.

GREEN, B. L., SANDERS, M. B. & TARTE, J. 2017. Using administrative data to evaluate the effectiveness of the Healthy Families Oregon home visiting program: 2-year impacts on child maltreatment & service utilization. *Children and Youth Services Review,* 75, 77-86.

GROSS, D., GARVEY, C., JULION, W., FOGG, L., TUCKER, S. & MOKROS, H. 2009. Efficacy of the Chicago parent program with low-income African American and Latino parents of young children. *Prev Sci,* 10, 54-65.

GUASTAFERRO, K., LAI, B. S., MILLER, K., CHATHAM, J. S., WHITAKER, D. J., SELF-BROWN, S., KEMNER, A. & LUTZKER, J. R. 2018. Braiding Two Evidence-based Programs for Families at-risk: Results of a Cluster Randomized Trial. *J Child Fam Stud,* 27, 535-546.

HARDY J & STREETT R 1989. Family support and parenting education in the home: An effective extension of clinic-based preventive health care service for poor children. *Journal of Pediatrics,* 115, 927-931.

HARDY, J. B., STREETT, R., HARDY, J. B. & STREETT, R. 1989. Family support and parenting education in the home: an effective extension of clinic-based preventive health care services for poor children. *Journal of Pediatrics,* 115, 927-931.

HATFIELD, B.E., WILLIFORD, A.P. 2017. Cortisol Patterns for Young Children Displaying Disruptive Behavior: Links to a Teacher-Child, Relationship-Focused Intervention. *Prev Sci* 18, 40–49.

JONSON-REID, M., DRAKE, B., CONSTANTINO, J. N., TANDON, M., PONS, L., KOHL, P., ROESCH, S., WIDEMAN, E., DUNNIGAN, A. & AUSLANDER, W. 2018. A Randomized Trial of Home Visitation for CPS-Involved Families: The Moderating Impact of Maternal Depression and CPS History. *Child Maltreat,* 23, 281-293.

KARJALAINEN, P., KIVIRUUSU, O., ARONEN, E. T. & SANTALAHTI, P. 2019. Group-based parenting program to improve parenting and children's behavioral problems in families using special services: A randomized controlled trial in a real-life setting. *Children and Youth Services Review,* 96, 420-429.

KATZ, K. S., JARRETT, M. H., EL-MOHANDES, A. A., SCHNEIDER, S., MCNEELY-JOHNSON, D. & KIELY, M. 2011. Effectiveness of a combined home visiting and group intervention for low income African American mothers: the pride in parenting program. *Matern Child Health J,* 15 Suppl 1, S75-84.

KENNEDY C, FONNER V, ARMSTRONG K, DENISON J, YEH P, O'REILLY K & SWEAT M 2019. The Evidence Project risk of bias tool: Assessing study rigor for both randomized and non-randomized intervention studies. *Systematic Reviews,* 8, 3.

LECROY, C. W. & LOPEZ, D. 2020. A Randomized Controlled Trial of Healthy Families: 6-Month and 1-Year Follow-Up. *Prev Sci,* 21, 25-35.

LEUNG, C. 2009. Effectiveness of Parent-Child Interaction Therapy (PCIT) among Chinese families. *Research on Social Work Practice,* 19, 3-4-313.

LI, H. C. W., CHAN, S. S., MAK, Y. W., LAM, T. H. & CHAN, S. S. C. 2013. Effectiveness of a parental training programme in enhancing the parent-child relationship and reducing harsh parenting practices and parental stress in preparing children for their transition to primary school: a randomised controlled trial. *BMC Public Health,* 13, 1079-1079.

LIPSCOMB, S. T., HATFIELD, B., GOKA-DUBOSE, E., LEWIS, H. & FISHER, P. A. 2021. Impacts of Roots of Resilience professional development for early childhood teachers on Young children's protective factors. *Early Childhood Research Quarterly,* 56, 1-14.

LUNKENHEIMER, E. S., DISHION, T. J., SHAW, D. S., CONNELL, A. M., GARDNER, F., WILSON, M. N. & SKUBAN, E. M. 2008. Collateral benefits of the family check-up on early childhood school readiness: Indirect effects of parents' positive behavior support. *Developmental Psychology,* 44, 1737-1752.

MACMILLAN H, THOMAS H, JAMIESON E, WALSH C, BOYLE M, SHANNON H & GAFNI A 2005. Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial. *Lancet,* 365, 1786-93.

MARKIE-DADDS C & SANDERS, M. R. 2006. Self-directed Triple P (Positive Parenting Program) for mothers of children at-risk of developing conduct problems. *Behavioural and Cognitive Psychotherapy,* 34, 259-275.

MINKOVITZ, C. S., STROBINO, D., MISTRY, K. B., SCHARFSTEIN, D. O., GRASON, H., HOU, W., IALONGO, N. & GUYER, B. 2007. Healthy Steps for Young Children: sustained results at 5.5 years. *Pediatrics,* 120, e658-68.

NEGRAO, M., PEREIRA, M., SOARES, I. & MESMAN, J. 2014. Enhancing positive parent-child interactions and family functioning in a poverty sample: a randomized control trial. *Attach Hum Dev,* 16, 315-28.

NSW DEPARTMENT OF COMMUNITIES AND JUSTICE 2021. The Evidence Portal: Technical Specifications, 14 April 2021, https://evidenceportal.dcj.nsw.gov.au/content/dam/dcj/evidence-portal/documents/evidence-portal-technical-specifications.pdf.

NSW DEPARTMENT OF FAMILY AND COMMUNITY SERVICES 2019. Prevention and early intervention strategies. *In:* NSW DEPARTMENT OF FAMILY AND COMMUNITY SERVICES (ed.). Sydney: NSW Government.

NSW DEPARTMENT OF FINANCE, S. A. I. 2017. Human Services Outcomes Framework Guide. . *In:* NSW DEPARTMENT OF FINANCE, S. A. I. (ed.). Sydney: NSW Government.

OLDS D, HENDERSON C, KITZMAN H, ECKENRODE J, COLE R & TATELBAUM R 1999. Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children,* 9, 44-65.

OLDS, D. L., HENDERSON, C. R., JR. & KITZMAN, H. 1994. Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? *Pediatrics,* 93, 89-98.

ONDERSMA, S. J., MARTIN, J., FORTSON, B., WHITAKER, D. J., SELF-BROWN, S., BEATTY, J., LOREE, A., BARD, D. & CHAFFIN, M. 2017. Technology to Augment Early Home Visitation for Child Maltreatment Prevention: A Pragmatic Randomized Trial. *Child Maltreat,* 22, 334-343.

OXFORD, M. L., SPIEKER, S. J., LOHR, M. J. & FLEMING, C. B. 2016. Promoting First Relationships ® : Randomized Trial of a 10-Week Home Visiting Program With Families Referred to Child Protective Services. *Child maltreatment,* 21, 267-277.

PEARS, K., FISHER, P., KIM, H., BRUCE, J., HEALEY, C. & YOERGER, K. 2013. Immediate Effects of a School Readiness Intervention for Children in Foster Care. *Early Education & Development,* 24, 771-791.

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 & Youth Services Review,* 34, 2361-2366.

PORTWOOD, S. G., LAMBERT, R. G., ABRAMS, L. P. & NELSON, E. B. 2011. An evaluation of the Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids program. *J Prim Prev,* 32, 147-60.

REEDTZ, C., HANDEGÅRD, B. H. & MØRCH, W.-T. 2011. Promoting positive parenting practices in primary pare: outcomes and mechanisms of change in a randomized controlled risk reduction trial. *Scandinavian journal of psychology,* 52, 131-137.

ROBY, E., MILLER, E. B., SHAW, D. S., MORRIS, P., GILL, A., BOGEN, D. L., ROSAS, J., CANFIELD, C. F., HAILS, K. A., WIPPICK, H., HONOROFF, J., CATES, C. B., WEISLEDER, A., CHADWICK, K. A.,

RAAK, C. D. & MENDELSOHN, A. L. 2021. Improving Parent-Child Interactions in Pediatric Health Care: A Two-Site Randomized Controlled Trial. *Pediatrics,* 147**,** 1-12.

RODRIGUEZ, M. 2010. Effects of Healthy Families New York on the Promotion of Maternal Parenting Competencies and the Prevention of Harsh Parenting. *Child Abuse & Neglect: The International Journal,* 34**,** 711-723.

SCHILLING, S., FRENCH, B., BERKOWITZ, S. J., DOUGHERTY, S. L., SCRIBANO, P. V. & WOOD, J. N. 2017. Child-Adult Relationship Enhancement in Primary Care (PriCARE): A Randomized Trial of a Parent Training for Child Behavior Problems. *Acad Pediatr,* 17**,** 53-60.

SCHOEMAKER, N. K., JUFFER, F., RIPPE, R. C. A., VERMEER, H. J., STOLTENBORGH, M., JAGERSMA, G. J., MARAS, A. & ALINK, L. R. A. 2020. Positive parenting in foster care: Testing the effectiveness of a video-feedback intervention program on foster parents' behavior and attitudes. *Children and Youth Services Review,* 110.

SEGAL, L., NGUYEN, H., GENT, D., HAMPTON, C. & BOFFA, J. 2018. Child protection outcomes of the Australian Nurse Family Partnership Program for Aboriginal infants and their mothers in Central Australia. *PloS one,* 13**,** e0208764.

SELF-BROWN, S., OSBORNE, M. C., LAI, B. S., DE VEAUUSE BROWN, N., GLASHEEN, T. L. & ADAMS, M. C. 2017. Initial Findings from a Feasibility Trial Examining the SafeCare Dad to Kids Program with Marginalized Fathers. *J Fam Violence,* 32**,** 751-766.

SHEA B, REEVES B, WELLS G, THUKU M, HAMEL C, MORAN J, TUGWELL P, WELCH V, KRISTJANSSON E & HENRY D 2017. AMSTAR 2: A critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ,* 358(j4008)**,** 1-9.

SHEAD, D. M., CORWIN, T. W., MAHER, E. J., MERKEL-HOLGUIN, L., ALLAN, H. & FLUKE, J. D. 2017. Effectiveness of family group conferencing in preventing repeat referrals to child protective services and out-of-home placements. *Child abuse & neglect,* 69**,** 285-294.

SILOVSKY, J. F., BARD, D., CHAFFIN, M., HECHT, D., BURRIS, L., OWORA, A., BEASLEY, L., DOUGHTY, D. & LUTZKER, J. 2011. Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review,* 33**,** 1435-1444.

STEELE, H., MURPHY, A., BONUCK, K., MEISSNER, P. & STEELE, M. 2019. Randomized control trial report on the effectiveness of Group Attachment-Based Intervention (GABI(c)): Improvements in the parent-child relationship not seen in the control group. *Dev Psychopathol,* 31**,** 203-217.

STOLK, M. N., MESMAN, J., VAN ZEIJL, J., ALINK, L. R. A., BAKERMANS-KRANENBURG, M. J., VAN IJZENDOORN, M. H., JUFFER, F. & KOOT, H. M. 2007. Early Parenting Intervention: Family Risk and First-time Parenting Related to Intervention Effectiveness. *Journal of Child and Family Studies,* 17**,** 55-83.

THOMAS, R. & ZIMMER-GEMBECK, M. J. 2012. Parent-child interaction therapy: an evidence-based treatment for child maltreatment. *Child Maltreat,* 17**,** 253-66.

UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. & SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. *Journal of Applied Developmental Psychology,* 62**,** 145-159.

WEBSTER-STRATTON, C., REID, M. J. & HAMMOND, M. 2001. Preventing Conduct Problems, Promoting Social Competence: A Parent and Teacher Training Partnership in Head Start. *Journal of Clinical Child Psychology,* 30**,** 283-302.

WEBSTER-STRATTON, C., JAMILA REID, M. & STOOLMILLER, M. 2008. Preventing conduct problems and improving school readiness: evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology & Psychiatry,* 49**,** 471-488.

WHITAKER, D. J., SELF-BROWN, S., HAYAT, M. J., OSBORNE, M. C., WEEKS, E. A., REIDY, D. E. & LYONS, M. 2020. Effect of the SafeCare(c) intervention on parenting outcomes among parents in child welfare systems: A cluster randomized trial. *Prev Med,* 138**,** 106167.

YAGMUR, S., MESMAN, J., MALDA, M., BAKERMANS-KRANENBURG, M. J. & EKMEKCI, H. 2014. Video-feedback intervention increases sensitive parenting in ethnic minority mothers: a randomized control trial. *Attach Hum Dev,* 16**,** 371-86.

ZHAI, F., WALDFOGEL, J. & BROOKS-GUNN, J. 2013. Estimating the Effects of Head Start on Parenting and Child Maltreatment. *Child Youth Serv Rev,* 35**,** 1119-1129.

Appendices

Appendix 1: Evidence Portal Decision Form: Harm Reduction Rapid Review

ID	Date	Step	Description of Decision / Change	Resolution	Impact
1	December 2020	Step 1: Define research question and scope	Revised the research question by directing attention from child safety to harm reduction	Interventions that reduce harm for vulnerable children included in the rapid review	The rapid review focused on harm reduction rather than the broader concept of safety
2	December 2020	Step 1: Define research question and scope	Aligned the phrase "reduction of harm" to relevant NSW legislation	Ensure an alignment between the rapid review's use of the phrase "reduction of harm" and relevant NSW legislation	Greater relevance of the rapid review to the NSW context
3	May 2021	Step 2: Search for evidence	Broadened the "study design" search string	Re-run the search strategy to incorporate revised "study design" search string	A more complete rapid review
4	May 2021	Step 1: Define research question and scope	Revised the research question by limiting its scope to children aged 5 years and under	Target the rapid review to interventions for children aged 5 years and younger	Review evidence is focused on the age group most responsive to early interventions
5	May 2021	Step 1: Define research question and scope	Revised the scope of mental health by limiting the review to children rather than children of parents with mental health issues	Interventions for the children of parents with mental health issues not to be included in the rapid review	A more focused rapid review
6	May 2021	Step 1: Define research question and scope	Reduced the expanse of the search by limiting it to select high-income nations	Limit the rapid review to select high-income nations	Reduce the likelihood of sourcing articles with limited contextual relevance to NSW

Appendix 2: Evidence Portal Decision Form: School Readiness Rapid Review

ID	Date	Step	Description of Decision / Change	Resolution	Impact
1	May 2021	Step 1: Define research question and scope	Changed the target age from 5 years and under to 6 years and under	Target the rapid review to interventions for children aged 6 years and younger	Broaden the scope of the rapid review to a great number of children transitioning to school
2	May 2021	Step 1: Define research question and scope	Reduced the expanse of the search by limiting it to select high-income countries	Limit the rapid review to select high-income countries	Reduce the likelihood of sourcing articles with limited contextual relevance to NSW

Appendix 3: Search Strategy: Harm Reduction Rapid Review

Nº	Search
1	AB(Checklist OR Intervention* OR Model* OR Prevention* OR Program* OR "Professional development" OR Service* OR Training) OR TI(Checklist OR Intervention* OR Model* OR Prevention* OR Program* OR "Professional development" OR Service* OR Training) Limiters: scholarly (peer reviewed) journals; Language: English
2	AB(Abuse* OR Anxi* OR at-risk OR Attachment OR Depress* OR distress OR "family service*" OR grandchild OR grandparent* OR "high risk" OR "ill treat*" OR insecure* OR low-risk OR Maltreatment OR "mental health" OR Neglect OR OOCH OR "out of home care" OR "out of home placement*" OR Parent* OR Psycholog* OR Risk OR Safe* OR Secur* OR Sensitivity OR "social work service*" OR Stress* OR "treatment outcome*" OR Violen* OR vulnerab* OR Welfare) OR TI(Abuse* OR Anxi* OR at-risk OR Attachment OR Depress* OR distress OR "family service*" OR grandchild OR grandparent* OR "high risk" OR "ill treat*" OR insecure* OR low-risk OR Maltreatment OR "mental health" OR Neglect OR OOCH OR "out of home care" OR "out of home placement*" OR Parent* OR Psycholog* OR Risk OR Safe* OR Secur* OR Sensitivity OR "social work service*" OR Stress* OR "treatment outcome*" OR Violen* OR vulnerab* OR Welfare) Limiters: scholarly (peer reviewed) journals; Language: English
3	AB(Baby OR Babies* OR Child* OR Infant* OR "preschool age" OR "pre-school age" OR Toddler*) OR TI(Baby OR Babies* OR Child* OR Infant* OR "preschool age" OR "pre-school age" OR Toddler*) Limiters: scholarly (peer reviewed) journals; Language: English
4	AB(Blinded OR "clinical trial" OR "comparison group" OR "control group*" OR "control condition*" OR "difference in difference*" OR "double blind*" OR doubleblind* OR "doubly robust estimat*" OR experiment* OR "instrumental variable*" OR "Meta anal*" OR meta-anal* OR metaanal" OR "propensity score" OR "quasi experimental" OR "quasi-experimental" OR quasiexperiment* OR random* OR RCT OR "regression adjustment estimate*" OR "regression discontinuity*" OR "step* wedge" OR "systematic review*" OR "systematic synthes*" OR "treatment condition" OR "treatment group" OR trial OR wait list" OR wait-list OR waitlist) OR TI(Blinded OR "clinical trial" OR "comparison group" OR "control group*" OR "control condition*" OR "difference in difference*" OR "double blind*" OR doubleblind* OR "doubly robust estimat*" OR experiment* OR "instrumental variable*" OR "Meta anal*" OR meta-anal* OR metaanal" OR "propensity score" OR "quasi experimental" OR "quasi-experimental" OR quasiexperiment* OR random* OR RCT OR "regression adjustment estimate*" OR "regression discontinuity*" OR "step* wedge" OR "systematic review*" OR "systematic synthes*" OR "treatment condition" OR "treatment group" OR trial OR wait list" OR wait-list OR waitlist) Limiters: scholarly (peer reviewed) journals; Language: English
5	AB(USA OR Europe OR UK OR Ireland OR United States OR Canada OR Great Britain OR Australia OR California) OR TI(USA OR Europe OR UK OR Ireland OR United States OR Canada OR Great Britain OR Australia OR California)
6	S1 AND S2 AND S3 AND S4 AND S5
7	AIDS OR "Air safety" OR BMI OR "Body mass index" OR Cancer OR "Cerebral palsy" "CP" OR "Chronic disease" OR Dental OR Dentistry OR Diabetes OR Diarrh* OR Diet* OR "Eating disorder" OR "Eating disorders" OR Flu OR HIV OR Infection OR Influenza OR In-patient OR

Nº	Search
	Inpatient OR Laboratory OR Medication OR Obes* OR Oncology OR Pain OR Patient* OR Prescription* OR Psychopath* OR “Road safety” OR Schizophreni* OR “Test anxiety” OR “Water safety” OR Wound* OR “Wound care” OR “Wound-care” OR “Pool safety” OR “Seat belt safety” OR “Seatbelt safety” OR ADD OR ADHD OR ASD OR “Attention deficit hyperactivity disorder” OR “Attention-deficit hyperactivity disorder” OR Autis* OR “Developmental delay” OR “Developmental delays” OR “Developmental disabilities” OR “Developmental disability” OR Disabilit* OR Dyslexi* OR “Language delay” OR “Language delays” OR “Language disabilities” OR “Language disability” OR “Learning disabilities” OR “Learning disability”
8	S6 NOT S7

Appendix 4: Database Searches: Harm Reduction Rapid Review

Database	PsycINFO	SOCIndex	APA PsycArticles	Psychology and Behavioral Sciences Collection	CINAHL	Business Source Complete	Health Business Elite	Health Source: Nursing/ Academic Edition	Medline	ERIC
Searched	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Search date	31.05.21	31.05.21	31.05.21	31.05.21	31.05.21	31.05.21	31.05.21	31.05.21	26.07.21	26.07.21
Search string	See Appendix 3									
Documented changes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Citations	5,259	151	458	1,679	4,579	145	1,164	1,831	390	325
Exported to reference management library	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote
Exported to specialised systematic review management system	No	No	No	No	No	No	No	No	No	No

Appendix 5: Search Strategy: School Readiness Rapid Review

Database	Nº	Search
PsychInfo	1	(“school readiness” or “school transition”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
SOCIndex	1	(“readiness for school”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
APA PsycArticles	1	(“school readiness” or “school transition”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab

Database	Nº	Search
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
ERIC	1	(“school readiness”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
CINAHL	1	“school readiness” as a keyword (no equivalent subject term)
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
Business Source Complete	1	(“school readiness”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-

Database	Nº	Search
		anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
Health Business Elite	1	(“readiness for school”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
Health Source: Nursing/Academic Edition	1	(“readiness for school”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal prevention trial” OR “Randomi?ed dismantling field trial” OR “Randomi?ed effectiveness trial” OR “Randomi?ed experimental design” OR “Randomi?ed intervention” OR “Randomi?ed trial” OR “Regression adjustment estimate*” OR “Regression discontin*” OR “Step* wedge*” OR “Systematic review*” OR “Systematic synthesis” OR “Treatment condition*” OR “Treatment group” OR “Wait list” OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults
Psychology and Behavioral Sciences Collection	1	(“Readiness for school” and “readiness for school research”) SU
	2	(“Clinical trial” OR “Comparison group” OR “Control condition*” OR “Control group*” OR “Control* trial” OR “Difference in difference*” OR “Double blind*” OR “Doubly robust estimat*” OR “Instrumental variable*” OR “Meta anal*” OR “Propensity score” OR “Quasi experimental” OR “Quasi-experimental” OR “Random* assign*” OR “Randomi?ed clinical trial*” OR “Randomi?ed cluster experiment” OR “Randomi?ed control” OR “Randomi?ed control* study” OR “Randomi?ed control* trial” OR “Randomi?ed controlled experimental study” OR “Randomi?ed controlled universal

Database	Nº	Search
		prevention trial" OR "Randomi?ed dismantling field trial" OR "Randomi?ed effectiveness trial" OR "Randomi?ed experimental design" OR "Randomi?ed intervention" OR "Randomi?ed trial" OR "Regression adjustment estimate*" OR "Regression discontin*" OR "Step* wedge*" OR "Systematic review*" OR "Systematic synthesis" OR "Treatment condition*" OR "Treatment group" OR "Wait list" OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list).ti.ab
	3	S1 AND S2, Limit to peer reviewed, English language, and exclude high school and adults

Supplementary Search on 07.07.2021

Nº	Search
1	AB(Checklist OR intervention* OR model* OR prevent* OR program* OR "professional development" OR service* OR "support service*" OR training) Limiters: scholarly (peer reviewed) journals; Language: English
2	AB("Early literacy" OR "Early numeracy" OR "Home learning environment" OR "kindergarten transition" OR Pre-literacy OR Pre-numeracy OR "Reading readiness" OR "School readiness" OR School-readiness OR "School transition" OR readiness OR "Early learning" OR Prep-year OR "Step up into education") Limiters: scholarly (peer reviewed) journals; Language: English
3	AB(Infan* OR infants OR toddler* OR Child* OR "Pre school" OR Pre-school OR Preschool OR Kindergarten OR Kindy OR "School age" OR "School-age" OR Parent* OR "Early childhood" OR "early education") Limiters: scholarly (peer reviewed) journals; Language: English
4	AB("Clinical trial" OR "Comparison group" OR "Control condition*" OR "Control group*" OR "Control* trial" OR "Difference in difference*" OR "Double blind*" OR "Doubly robust estimat*" OR "Instrumental variable*" OR "Meta anal*" OR "Propensity score" OR "Quasi experimental" OR "Quasi-experimental" OR "Random* assign*" OR "Randomi?ed clinical trial*" OR "Randomi?ed cluster experiment" OR "Randomi?ed control" OR "Randomi?ed control* study" OR "Randomi?ed control* trial" OR "Randomi?ed controlled experimental study" OR "Randomi?ed controlled universal prevention trial" OR "Randomi?ed dismantling field trial" OR "Randomi?ed effectiveness trial" OR "Randomi?ed experimental design" OR "Randomi?ed intervention" OR "Randomi?ed trial" OR "Regression adjustment estimate*" OR "Regression discontin*" OR "Step* wedge*" OR "Systematic review*" OR "Systematic synthesis" OR "Treatment condition*" OR "Treatment group" OR "Wait list" OR Blinded OR Doubleblind* OR Experiment* OR Metaanal* OR Meta-anal* OR Quasiexperiment* OR Randomi?ed OR RCT OR Trial OR Waitlist OR Wait-list) Limiters: scholarly (peer reviewed) journals; Language: English; Country: United States, Europe, Ireland, Great Britain, Australia
5	S1 AND S2 AND S3 AND S4

Appendix 6: Search Strategy: School Readiness Rapid Review

Database	PsycINFO	SOCIndex	APA PsycArticles	Psychology and Behavioral Sciences Collection	CINAHL	Business Source Complete	Health Business Elite	Health Source: Nursing/ Academic Edition	ERIC
Searched	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Search date	01.06.2021	01.06.2021	01.06.2021	01.06.2021	01.06.2021	01.06.2021	01.06.2021	01.06.2021	01.06.2021
Search string	See Appendix 5								
Documented changes	NA	NA	NA	NA	NA	NA	NA	NA	NA
Citations	180	21	36	25	52	15	1	1	148
Exported to reference management library	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote
Exported to specialised systematic review management system	No	No	No	No	No	No	No	No	No

Revised Search

Database	PsycINFO	SOCIndex	APA PsycArticles	Psychology and Behavioral Sciences Collection	CINAHL	Health Source: Nursing/ Academic Edition	Education Research Complete
Searched	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Search date	07.07.2021	07.07.2021	07.07.2021	07.07.2021	07.07.2021	07.07.2021	07.07.2021
Search string	See Appendix 5						
Documented changes	NA	NA	NA	NA	NA	NA	NA
Citations	277	62	18	146	145	129	462
Exported to reference management library	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote	EndNote
Exported to specialised systematic review management system	No	No	No	No	No	No	No

Appendix 7: Outcome Domains, Client Outcomes, and Measures: Harm Reduction Rapid Review

Outcome Domain	Client Outcome	Measure
Child abuse and neglect	Child abuse and neglect	• Post-contact recidivism reports • Home visits (observation) and inpatient admissions to hospital • Child protection report (substantiated or unsubstantiated) made to statutory child protection department • Parent report of contact with child, youth, and family services • Official re-reports (regardless of substantiation)
	Child abuse potential	• Child Abuse Potential Inventory (CAPI)
	Child abuse reports: Substantiated	• Substantiated referral to child welfare • Substantiated re-referral to child welfare • State agency data
	Child abuse reports: Unsubstantiated	• Child welfare records
	Child protection services reports	• State agency data
	Child welfare involvement / contact with child protection services	• Number of substantiated maltreatment reports and out-of-home placement episodes • Child protective services contact • Re-referral to child welfare
	Educational neglect	• Questionnaire for evaluating maltreatment and neglect
	Lack of supervision	• Questionnaire for evaluating maltreatment and neglect
	Minor physical aggression	• Self-report
	Neglect	• Conflict Tactics Scale-Parent Child version (CTS-PC)
	Neglectful behaviour	• Conflict tactics scale-Parent Child version (CTS-PC): Neglectful Behavior subscale
	Out-of-home placement	• Child placed out-of-home • CWS-initiated removals
	Protective factors for child maltreatment	• Protective factors survey
	Psychological aggression	• Conflict Tactics Scale-Parent Child version (CTS-PC): Psychological Aggression subscale
	Psychological and physical abuse	• Questionnaire for evaluating maltreatment and neglect
	Physical abuse	• Self-report and reported hospital visits or stays
	Physical assault	• Conflict Tactics Scale-Parent Child version (CTS-PC): Physical Assault subscale
	Physical neglect	• Questionnaire for evaluating maltreatment and neglect
	Risk of child maltreatment	• Edinburgh Postnatal Depression Scale (EPDS) • Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

Outcome Domain	Client Outcome	Measure
		• Interpersonal Violence – Conflict Tactics Scale II • HOME scale plus the Supplement to the Home for Impoverished Families (SHIFs)
	Social support	• Social Support Questionnaire
	Violence directed at child	• A 7-item violence score
	Healthcare decisions	• Sick and injured child checklist
	Hospital outpatient visits	• Frequency and type of outpatient clinic visits to child and youth clinic or emergency department
	Child visits to hospital ER	• Medical records – hospital attendances for accidents/injuries/poisoning
Child health	Immunisations	• Completeness of child immunisations
	Medical chart documentation	• Child's medical chart
	Child injuries and ingestion	• Paediatric and hospital records
	Hazards in the home	• Interviews with mothers and observation checklists
	Safety	• Interview data on safety practices (e.g., wearing a helmet when cycling)
Child safety	Safe home environment	• Royal Children's Hospital Safety Centre and Kidsafe checklists • Home accident prevention inventory
	Consistent discipline	• Parenting questionnaire (adapted for the study)
	Corporal/physical punishment/discipline	• Parenting questionnaire (adapted for the study) • Report by parent of instances of corporal punishment in the last month • Conflict Tactics Scale-Parent Child version (CTS-PC): Total Corporal Punishment subscale • Conflict Tactics Scale-Parent Child version (CTS-PC) • Maternal discipline strategies were observed during two tasks: a 4-minute "don't-touch" task and a clean-up task. • Observation of two tasks: 4 minute "don't touch" task and a clean-up task
	Corporal punishment attitudes	• Adult Adolescent Parenting Inventory 2: Corporal Punishment subscale
Discipline/punishment	Dysfunctional discipline strategies	• Parenting Scale (PS)
	Harsh punishment/discipline	• HOME inventory • Parent Behaviour Checklist - short form (PBC): Harsh Discipline subscale • Self-reported Parent Practices Interview (PPI) Parent-rated questionnaire: Harsh Discipline subscale • Parent Practices Interview (PPI) Parent-rated questionnaire: Harsh and Inconsistent Discipline subscales • Mother report: Punitive Parenting Behaviors Scale (four items)

Outcome Domain	Client Outcome	Measure
	Non-violent discipline	• Conflict Tactic Scale-Parent Child version (CTS-PC): Non-violent Discipline subscale
	Positive discipline	• 10 minute "don't" task • Emotional Availability scales
	Sensitive discipline	• Home visit (observation) and laboratory questionnaires and observations
	Domestic violence	• Time until report made to welfare or other services of domestic violence • Conflict tactics scale (CTS): Violence subscale
	Acceptance of child's autonomy	• Adult Adolescent Parenting Inventory 2: Power and independence subscale
	Attitudes towards sensitivity	• Home visit (observation) and laboratory questionnaires and observations
	Dyadic constriction	• Coding of interactive behavior (CIB)
Domestic violence	Dyadic reciprocity	• Coding of Interactive Behavior (CIB) • HOME inventory: Child spanking question • Dyadic Parent-child Interaction coding system • Self-reported parent-child relationship
Parenting	Family conflict	• Parenting Stress Index-short form (PSI-SF): Family Conflict subscale
	Family functioning	• Family Environment Scale: Relation dimension
	Harsh parenting	• Self-report • Counts of harsh parenting actions/strategies by video monitoring • Conflict Tactic Scales – Parent Child version (CTS-PC)
	Harsh and neglectful parenting	• Conflict Tactic Scales – Parent Child version (CTS-PC)
	Hostile parenting	• Longitudinal study of Australian children (5 items)
	Maternal hostility	• Coding of interactive behavior (CIB)
	Maternal non-intrusiveness	• Emotional Availability scales: Non-intrusiveness and positive parenting subscales
	Maternal supportive presence	• Coding of Interactive Behavior (CIB)
	Maternal sensitivity	• Emotional Availability scales: sensitivity subscale • 10-minute "don't" task
	Neglectful parenting	• Mother-child Neglect Scale (MCNS)
	Nurturing	• Parent Behaviour Checklist - short form (PBC)
	Parent empathy	• Adult Adolescent Parenting Inventory 2: Empathy subscale
	Parenting behaviours	• Adult Adolescent Parenting Inventory subscales: Appropriateness of developmental expectations, Empathy towards child's needs, Belief in use of corporal punishment, Reversing parent-child roles

Outcome Domain	Client Outcome	Measure
	Parenting competence	• Parenting Sense of Competency Scale (PSOS)
	Parenting efficacy	• Toddler care questionnaire
	Parenting practices	• Effective practices test • Parenting Practices interview • Involve interview • Parent perceptions of parent efficacy • Healthy Families Parenting Index (HFPI) • Home environment: use of regular routines and reduced chaotic household • Self-report on the time spent reading to the child on a weekly basis
	Parental sensitivity	• Home visit (observation) and laboratory questionnaires and observations
	Parenting skills	• Child Planned Activities Training checklist (cPAT checklist)
	Parental stress	• Parenting Stress Inventory - short form (PSI-SF) • Parental Stress Index scale • Parent characteristics (parent stress, child abuse potential, depression, verbalisations) • Parenting Stress Index-short form (PSI-SF): Parental Distress subscale • Alabama Parenting Questionnaire • Being a Parent Scale • Centre for Epidemiolohic Studies Depression scale • Family Functioning Scale
	Parental warmth	• Observed parent behaviour was assessed from the free-play and clean-up sessions using the • Dyadic Parent-child Interactive Coding System-revised • Longitudinal study of Australian children (6 items)Parenting stress inventory-short form • Parenting Daily Hassles Scale (PDHS) • Parental Stress Index Scale • Parent characteristics (parent stress, child abuse potential, depression, verbalisations) • Parenting Stress Index-short form (PSI-SF): Parental distress subscale • Alabama Parenting questionnaire • Being a Parent Scale • Centre for Epidemiolohic Studies Depression scale • Family Functioning Scale
	Positive communication	• Dyadic Parent-child Interaction Coding System III
	Positive parenting	• Child Rearing Practices report • Adult- Adolescent Parenting Inventory (AAPI)

Outcome Domain	Client Outcome	Measure
		• Parent practices interview: Positive parenting subscale • Parenting Young Children Scale

Appendix 8: Program Ratings and Direction of Effect: Harm Reduction Interventions

Program Rating and Direction of Effect: Home Visiting Programs

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
Nurse-Family Partnership	Eckenrode et al. (2017)	Child abuse and neglect	Positive	Child abuse and neglect	Supported research evidence	Supported research evidence	Positive
	Eckenrode et al. (2020)	Child abuse and neglect	Positive				
	Olds et al. (1994)	Child abuse and neglect	Non-significant				
	Olds et al. (1999)	Child abuse and neglect	Positive				
	Eckenrode et al. (2020)	Domestic violence	Non-significant	Domestic violence	Evidence fails to demonstrate effect		
	Olds et al. (1994)	Child injuries and ingestion	Positive	Child safety	Supported research evidence		
	Olds et al. (1994)	Hazards in the home	Positive				
	Olds et al. (1999)	Child injuries and ingestion	Positive				
	Olds et al. (1994)	Child visits to hospital ER	Positive	Child health	Promising research evidence		
	Olds et al. (1994)	Harsh punishment/discipline	Negative	Discipline/ punishment	Inconclusive[1]		
Australian Nurse-Family Partnership	Segal et al. (2018)	Child abuse and neglect	Positive	Child abuse and neglect	Promising research evidence	Promising research evidence	Positive
	Segal et al. (2018)	Child abuse reports: Substantiated	Positive				
	Segal et al. (2018)	Out-of-home placement	Positive				
Healthy Families America	DuMont et al. (2008)	Physical abuse	Positive	Child abuse and neglect	Mixed research evidence (with		
	DuMont et al. (2008)	Minor physical aggression	Positive				
	DuMont et al. (2008)	Child abuse reports: Substantiated	Non-significant				
	LeCroy and Lopez (2020)	Violence directed at child	Positive				

[1] Although women who participated in the Nurse-Family Partnership program were observed to punish their children more severely than the control group at the 46-month assessment, this was not necessarily associated with adverse effects in the Olds (1994) study. Olds suggests this outcome should be interpreted in the context of the life course development of women involved in the program. The review has therefore treated the 'harsh punishment/discipline' client outcome as inconclusive and excluded it from the overall program rating.

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
	Green et al. (2017)	Child abuse reports: Unsubstantiated	Negative		adverse effects)	Mixed research evidence (with adverse effects)	Mixed
	Green et al. (2017)	Child abuse reports: Substantiated	Non-significant				
	DuMont et al. (2008)	Harsh parenting	Positive	Parenting	Supported research evidence		
	Rodriguez et al. (2010)	Harsh parenting	Positive				
	LeCroy and Lopez (2020)	Parenting practices	Positive				
	LeCroy and Lopez (2020)	Safety	Positive	Child safety	Promising research evidence		
SafeCare	Gershater-Molko et al. (2002)	Child abuse and neglect	Positive	Child abuse and neglect	Mixed research evidence (with no adverse effects)	Promising research evidence	Positive
	Whitaker et al. (2020)	Protective factors for child maltreatment	Non-significant				
	Whitaker et al. (2020)	Positive parenting	Positive	Parenting	Promising research evidence		
	Whitaker et al. (2020)	Parental stress	Positive				
	Whitaker et al. (2020)	Neglectful parenting	Positive				
SafeCare+	Silovsky (2011)	Child abuse potential	Positive	Child abuse and neglect	Promising research evidence	Promising research evidence	Positive
	Silovsky (2011)	Domestic violence	Positive	Domestic violence			
	Silovsky (2011)	Harsh and neglectful parenting	Positive	Parenting			
SafeCare Dad to Kids Program (Dad2K)	Self-Brown et al. (2017)	Psychological aggression	Non-significant	Child abuse and neglect	Evidence fails to demonstrate effect	Mixed research evidence (with no adverse effects)	Mixed
	Self-Brown et al. (2017)	Neglectful behaviour	Non-significant				
	Self-Brown et al. (2017)	Corporal/physical punishment/discipline	Non-significant	Discipline/ Punishment	Evidence fails to demonstrate effect		
	Self-Brown et al. (2017)	Non-violent discipline	Non-significant				
	Self-Brown et al. (2017)	Parenting skills	Positive	Parenting	Promising research evidence		

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
Early Start	Fergusson et al. (2005)	Child visits to hospital ER	Positive	Child health	Promising research evidence	Mixed research evidence (with no adverse effects)	Mixed
		Positive parenting	Positive	Parenting	Promising research evidence		
		Physical assault	Positive	Child abuse and neglect	Mixed research evidence (with no adverse effects)		
		Child abuse and neglect	Non-significant				
Right@Home	Goldfeld et al. (2019)	Hostile parenting	Positive	Parenting	Promising research evidence	Promising research evidence	Positive
		Parental warmth	Positive				
		Safe home environment	Positive	Child safety	Promising research evidence		
Parents as Teachers	Jonson-Reid et al. (2018)	Child abuse and neglect	Positive	Child abuse and neglect	Promising research evidence	Promising research evidence	Positive
Pride in Parenting	Katz et al. (2011)	Parenting behaviours	Positive	Parenting	Promising research evidence	Promising research evidence	Positive
Hamilton Nurse Home Visiting Program	MacMillan et al. (2005)	Child abuse and neglect	Non-significant	Child abuse and neglect	Evidence fails to demonstrate effect	Mixed research evidence (with adverse effects)	Mixed
		Physical abuse	Negative		Evidence demonstrates adverse effects		
Healthy Steps for Young Children	Minkovitz et al. (2007)	Positive parenting	Positive	Parenting	Promising research evidence	Promising research evidence	Positive
Parents as Teachers + SafeCare at Home	Guastaferro et al. (2018)	Safe home environment	Positive	Child safety	Promising research evidence	Mixed research evidence (with adverse effects)	Mixed
		Child abuse potential	Negative	Child abuse and neglect	Evidence demonstrates adverse effects		
		Physical assault	Non-significant	Child abuse and neglect	Evidence fails to demonstrate effect		

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
		Psychological aggression	Negative	Child abuse and neglect	Evidence demonstrates adverse effects		
		Healthcare decisions	Positive	Child health	Promising research evidence		
		Non-violent discipline	Positive	Discipline and punishment	Promising research evidence		
Promoting First Relationships	Oxford et al. (2016)	Child abuse reports: Unsubstantiated	Non-significant	Child abuse and neglect	Mixed research evidence (with no adverse effects)	Mixed research evidence (with no adverse effects)	Mixed
		Out-of-home placement	Positive				
Johns Hopkins Children and Youth Program	Hardy and Streett (1989)	Hospital outpatient visits	Positive	Child health	Promising research evidence	Promising research evidence	Positive
		Immunisations	Positive				
		Child abuse and neglect	Positive	Child abuse and neglect			
e-Parenting Program	Ondersma et al. (2017)	Harsh parenting	Non-significant	Parenting	Evidence fails to demonstrate effect	Evidence fails to demonstrate effect	No effect
		Risk of child maltreatment	Non-significant	Child abuse and neglect			

Program Rating and Direction of Effect: Programs that Give Centrality to Early Childhood Education Services

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
HeadStart	Green et al. (2020)	Child welfare involvement / contact with child protection services	Non-significant	Child abuse and neglect	Mixed research evidence (with no adverse	Promising research evidence	Positive
	Zhai et al. (2013)	Physical assault	Positive				
	Zhai et al. (2013)	Neglect	Positive				
	Zhai et al. (2013)	Child welfare involvement / contact with child protection services	Positive				
	Green et al. (2020)	Parental stress	Positive	Parenting	Supported research evidence		
	Green et al. (2020)	Family conflict	Positive				
	Green et al. (2020)	Dyadic reciprocity	Positive				
	Zhai et al. (2013)	Corporal/physical punishment/discipline	Positive	Discipline/punishment	Promising research evidence		
Family Support Program	Calheiros et al. (2017)	Physical neglect	Positive	Child abuse and neglect	Mixed research evidence (with no adverse effects)	Mixed research evidence (with no adverse effects)	Mixed
		Educational neglect	Non-significant				
		Psychological and physical abuse	Positive				
		Lack of supervision	Positive				
ParentCorps	Dawson-McClure et al. (2015)	Parenting practices	Positive	Parenting	Promising research evidence	Promising research evidence	Positive
Relief Nursery Program	Eddy et al. (2020)	Parental stress	Non-significant	Parenting	Evidence fails to demonstrate effect	Mixed research evidence (with no adverse effects)	Mixed
		Child abuse potential	Non-significant	Child abuse and neglect	Mixed research evidence (with no adverse effects)		
		Social support	Positive				
Chicago Parent Program	Gross et al. (2009)	Corporal/physical punishment/discipline	Positive	Discipline/punishment	Promising research evidence	Promising research evidence	Positive
		Consistent discipline	Positive				
		Parenting efficacy	Positive	Parenting			
		Parental warmth	Positive				

Program Rating and Direction of Effect: Therapeutic Parent-Child Interaction Programs

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
Parent-Child Interaction Therapy	Leung et al. (2009)	Dyadic reciprocity	Positive	Parenting	Supported research evidence	Supported research evidence	Positive
	Thomas and Zimmer-Gembeck (2012)	Positive communication	Positive				
	Thomas and Zimmer-Gembeck (2012)	Parental stress	Positive				
	Leung et al. (2009)	Parental stress	Positive				
	Leung et al. (2009)	Corporal/physical punishment/discipline	Positive	Discipline/punishment	Promising research evidence		
Video-Feedback to Promote Positive Parenting and Sensitive Discipline	Yagmur et al. (2014)	Corporal/physical punishment/discipline	Non-significant	Discipline/punishment	Mixed research evidence (with no adverse effects)	Mixed research evidence (with adverse effects)	Mixed
	Stolk et al. (2008)	Positive discipline	Positive				
	Negrão et al. (2014)	Maternal non-intrusiveness	Positive	Parenting	Mixed research evidence (with adverse effects)		
	Negrão et al. (2014)	Family functioning	Positive				
	Yagmur et al. (2014)	Maternal sensitivity	Positive				
		Maternal non-intrusiveness	Positive				
	Stolk et al. (2008)	Maternal sensitivity	Negative				
Video-Feedback to Promote Positive Parenting and Sensitive Discipline in Foster Care	Schoemaker et al. (2020)	Sensitive discipline	Non-significant	Discipline/punishment	Evidence fails to demonstrate effect	Evidence fails to demonstrate effect	No effect
	Schoemaker et al. (2020)	Parental sensitivity	Non-significant	Parenting			
		Attitudes toward sensitivity	Non-significant				
Self-Directed Triple P	Markie-Dadds and Sanders (2004)	Dysfunctional discipline strategies	Positive	Discipline/ punishment	Promising research evidence	Promising research evidence	Positive
		Parenting competence	Positive	Parenting	Promising research evidence		

Program Rating and Direction of Effect: Programs Delivered in Clinical Settings

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
The Incredible Years Shortened Basic Version	Reedtz et al. (2011)	Harsh discipline/punishment	Positive	Discipline/punishment	Promising research evidence	Promising research evidence	Positive
	Reedtz et al. (2011)	Positive parenting	Positive	Parenting			
The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits	Karjalainen et al. (2019)	Harsh discipline/punishment	Positive	Discipline/punishment	Promising research evidence	Promising research evidence	Positive
Safe Environment for Every Kid	Dubowitz et al. (2009)	Child protection services reports	Positive	Child abuse and neglect	Promising research evidence	Promising research evidence	Positive
		Medical chart documentation	Positive	Child health			
		Corporal/physical punishment/discipline	Positive	Discipline/punishment			
Parent Training Program	Li et al. (2013)	Harsh parenting	Positive	Parenting	Mixed research evidence (with no adverse effects)	Mixed research evidence (with no adverse effects)	Mixed
		Parental stress	Non-significant				
		Dyadic reciprocity	Positive				
Child-Adult Relationships Enhancement in Primary Care	Schilling et al. (2017)	Corporal punishment attitudes	Positive	Discipline/punishment	Promising research evidence	Promising research evidence	Positive
		Parent empathy	Positive	Parenting			
		Acceptance of child's autonomy	Positive				
Group Attachment-Based Intervention	Steele et al. (2019)	Maternal hostility	Positive	Parenting	Promising research evidence	Promising research evidence	Positive
		Dyadic constriction	Positive				
		Dyadic reciprocity	Positive				
		Maternal supportive presence	Positive				
Adults and Children Together Against Violence: Parents Raising Safe Kids Program	Portwood et al. (2011)	Harsh punishment/discipline	Positive	Discipline/punishment	Promising research evidence	Mixed research evidence (with adverse effects)	Mixed
		Parental stress	Negative	Parenting	Mixed research evidence (with adverse effects)		
		Nurturing	Positive				

Program Rating and Direction of Effect: Family Therapy Programs

Family Group Conferencing	Hollinshead et al. (2017)	Child welfare involvement / contact with child protection services	Non-significant	Child abuse and neglect	Evidence fails to demonstrate effect	Evidence fails to demonstrate effect	No effect
		Child abuse reports: Substantiated	Non-significant				
		Out-of-home placement	Non-significant				
Together We Can	Adler-Baeder et al. (2018)	Harsh punishment/discipline	Non-significant	Discipline/punishment	Evidence fails to demonstrate effect	Evidence fails to demonstrate effect	No effect

Appendix 9: Evidence-Informed Program Summaries: Harm Reduction Interventions

Home Visiting Programs

Evidence type	Evidence-informed program
Name of the program	Nurse-Family Partnership
Brief description of program for search page	The Nurse-Family Partnership (NFP) is a program of home visiting for first-time mothers. The program was designed to address risk factors for child maltreatment.
Outcomes	• Child abuse and neglect • Domestic violence • Child safety • Child health • Discipline/punishment
Strength of evidence	Supported research evidence
Effectiveness	Positive
About the program	The Nurse-Family Partnership (NFP) is a program of home visiting for first-time mothers. The program was designed to address risk factors for child maltreatment. The goals of the program are to improve pregnancy outcomes, to promote children's health and development, and to strengthen families' economic self-sufficiency. During home visits, the nurses promote three aspects of maternal functioning: health-related behaviours during pregnancy and the early years of the child's life, the care parents provide to their children, and maternal life-course development (such as family planning, educational achievement, and participation in the workforce).
Who does it work for?	The program is designed for families experiencing vulnerability , for example, young mothers, single mothers, and families of low socioeconomic status. The original program was developed by David Olds some forty years ago, based on his work in a semi-rural USA community with high rates of child abuse and neglect. Eckenrode et al. (2017, 2000) and Olds et al. (1994) report on the original RCT with a final sample of 324 mothers and their infants. Of these mothers, 61% were from low socioeconomic backgrounds, 47% were under 19 years old at registration, 11% were African American, and 62% were unmarried. Olds et al. (1999) reports on this RCT, and an additional RCT with two study groups, with final samples comprised of 324 and 671 mothers and their infants, where 92% of mothers were African American, 85% had incomes at or below the poverty line, and 98% were unmarried. The program has been adapted for Aboriginal communities in Central Australia. The adapted program, termed Australian Nurse-Family Partnership, has been evaluated (Segal et al. 2018). See summary below.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Hazards in the home, Child visits to hospital ER, and Child injuries and ingestion**: Olds et al. (1994, 1999) found a positive effect on child safety as measured by hazards observed in the home, and child injury in hospital records. Children in intervention group had fewer health care encounters in which injuries and ingestions were detected than did children in the comparison group (0.43 versus 0.56, *p* = .05) (Olds et al. 1999) **Child abuse and neglect**: The NFP program had a positive effect on abuse and neglect perpetrated by mothers. Although one study found that there was no significant difference in allegations of child abuse and neglect made to child welfare (Olds et al. 1994), a later study found that there were significantly fewer child maltreatment reports

	involving the mother as perpetrator for families receiving home visitations during pregnancy and infancy than for the control group (Olds et al. 1999). This effect was observed up to 15 years later (Eckenrode et. al. 2017, 2000). NO EFFECT **Domestic violence:** A follow-up study of the Olds et al. (1994) sample 15 years later found no significant effect of the NFP program on levels of domestic violence (Eckenrode et al. 2000). NEGATIVE OUTCOMES **Harsh punishment/discipline:** Olds et al. (1994) reports that at the 46-month assessment, mothers who participated in the NFP program were more involved with and observed to punish their children more severely than mothers in the control group. This effect was particularly strong for low income, older, unmarried women who joined the workforce more rapidly. This negative outcome was not necessarily associated with adverse effects. Among families in the control group, higher levels of punishment were associated with more injuries and ingestions, but among families in the intervention group, higher levels of punishment were associated with fewer injuries and ingestions. Olds (1994) states that the effects should be interpreted in the context of the program influence on the life course development of at-risk women. Intervention group mothers were more likely to participate in the work force and to delay subsequent pregnancies than control group mothers, and it is reasonable that they would expect at least comparable levels of eventual participation in the work force by their children. It is suggested that the higher rates of involvement and punishment and improved safety of nurse-visited households are reflections of the intervention group mothers' greater belief that their children must be disciplined and protected for them to succeed in school, work, and mainstream society. For these reasons, the review has treated this client outcome as inconclusive and excluded it from the program rating.
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Supported research evidence: • At least two high-quality RCT/QED studies report statistically significant positive effects for at least one outcome, AND • Fewer RCT studies of similar size and quality show no observed effects than show statistically significant positive effects for the same outcome(s), AND • No RCT studies show statistically significant adverse effects
How is it implemented?	Weekly visits begin while the mother is pregnant and continue once every week during pregnancy and until the baby is 6 weeks old, then less frequently until the child is two years old. Visits are made by a qualified nurse. Sometimes mothers are offered transport to prenatal check-ups and child health and development check-ups at health clinics.
How much does it cost?	Information not available
What else should I consider?	There is a large, long-term body of evidence demonstrating positive effects of the Nurse-Family Partnership program on prenatal health behaviours, parental care of the child, child abuse and neglect, child health and development, maternal life-course, and criminal involvement of the mothers and children. The program has been shown to work best and have the largest impact for low income and higher risk groups.

	The program has also been adapted for Aboriginal families in Central Australia as the Australian Nurse-Family Partnership Program (see program summary below).
Where does the evidence come from?	• One RCT conducted in the USA with a final sample of 324 mothers and their infants (Olds et al. 1994) • One RCT conducted in the USA with 2 study groups, comprised of 324 and 671 mother and infant dyads (Olds et al. 1999) • One RCT conducted in the USA with a final sample of 400 mothers and their infants (Eckenrode et al. 2017, Eckenrode et al. 2000)
Further resources	• https://www.nursefamilypartnership.org • Eckenrode, J., et al. (2017). "The Prevention of Child Maltreatment Through the Nurse Family Partnership Program: Mediating Effects in a Long-Term Follow-Up Study." Child maltreatment 22(2): 92-99. • Eckenrode, J., et al. (2000). "Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence." JAMA: Journal of the American Medical Association 284(11): 1385-1391. • Olds, D. L., et al. (1994). "Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life?" Pediatrics 93(1): 89-98. • Olds, D. L., et al. (1999). "Prenatal and infancy home visitation by nurses: recent findings." Future of Children 9(1): 44-65.

Evidence type	Evidence-informed program
Name of the program	Australian Nurse-Family Partnership
Brief description of program for search page	The Australian Nurse-Family Partnership Program (ANFPP) is a program of home visiting for first-time mothers. The program is an adaptation of the Nurse-Family Partnership for Australian Aboriginal families and is designed to address risk factors for child maltreatment using a culturally safe model.
Outcomes	• Child abuse and neglect
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Australian Nurse-Family Partnership Program is a culturally safe adaptation of the Nurse-Family Partnership program for Aboriginal families. It has been implemented in central Australia where it was delivered by an Aboriginal community-controlled health organisation. It involves a program of nurse home visiting for mothers. The nurses promote three aspects of maternal functioning: health-related behaviours during pregnancy and the early years of the child's life, the care parents provide to their children, and maternal life-course development (such as family planning, educational achievement, and participation in the workforce). The goals of the program are to improve pregnancy outcomes, to promote children's health and development, and to strengthen families' economic self-sufficiency. The main adaptation was to include Aboriginal community workers as part of the home visiting team. The program also had an open referral pathway, and was not restricted to first-time mothers.
Who does it work for?	The program is designed for families experiencing vulnerability , for example, young mothers, single mothers, and families of low socioeconomic status. The original program was developed by David Olds some forty years ago, based on his work in a semi-rural USA community with high rates of child abuse and neglect. Several RCTs have shown that the original program is effective with young mothers unmarried mothers, African American mothers, and mothers from

	low socioeconomic backgrounds (Eckenrode et al. 2017, 2000, Olds et al. 1994, 1999). The ANFPP has been evaluated (Segal et al. 2018). A study was conducted in Central Australia with a sample of 854 mothers. There were 291 mothers in the intervention group and 563 in the control group. The mean age of control group mothers was 25.6 years, and the mean age of intervention group mothers was 23.1 years. 100% of the children were Aboriginal. Participants from the most disadvantaged quintile of the whole population made up 35.2% of the control group, and 32.5% of the intervention group. Mothers in employment comprised 19.7% of the control group and 20% of the intervention group. In the control group, 15.8% had had more than one house move per year, and this figure was 20.6% in the intervention group. The program was implemented by a large Aboriginal community-controlled health organisation in Central Australia. Aboriginal home visitors were included in the team. The study sample were pregnant women who met the following inclusion criteria: location in the town of Alice Springs between 10 and 22 weeks gestation, the expectant mother (or father) was Aboriginal, and the mother had not previously participated in the ANFPP.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child abuse and neglect, Child abuse reports: Substantiated**: The ANFPP had a positive effect on child abuse, neglect and maltreatment reports. For children of mothers under 20 years of age, and for children of first-time mothers, the rates of a child protection report made to the statutory child protection department, or an investigation or substantiation of such a report, were all substantially and statistically significantly lower in the ANFPP group than in the control group. This was especially the case for young mothers or first-time mothers (Segal et al. 2018). There was no significant result in this outcome for other demographics. **Out-of-home placement:** The mean annualised adjusted rate of days in out-of-home was lower for children in the ANFPP intervention group than those in the control group. This was statistically significant for children of mothers under 20 years of age, and for first time mothers. There was no significant result in this outcome for other demographics (Segal et al. 2018). NO EFFECT **None** NEGATIVE OUTCOMES **None**
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The ANFPP was delivered through home visiting by community workers. Aboriginal community workers were included as part of the home visiting team. No information was given on the number or duration of home visits, nor over what period they occurred. The content of the home visit was not specified.
How much does it cost?	Information not available

What else should I consider?	Information not available
Where does the evidence come from?	• One QED non-randomised design study conducted in Australia with a sample of 854 mothers, including 563 in the control group, and 291 who received the intervention (Segal et al. 2018)
Further resources	• https://www.anfpp.com.au • Segal, L., Nguyen, H., Gent, D., Hampton, C., and Boffa, J. (2018). 'Child protection outcomes of the Australian Nurse Family Partnership Program for Aboriginal infants and their mothers in Central Australia', *PloS One*, *13*, e0208764.

Evidence type	Evidence-informed program
Name of the program	Healthy Families America
Brief description of program for search page	Healthy Families America is a home visiting program that is widely implemented across many jurisdictions in the USA. The home visitor helps parents with their personal issues and parenting needs, reviews the child's developmental progress, ensures safety in the home, and supports successful adaptation to parenthood.
Outcomes	• Child abuse and neglect • Parenting • Child safety
Strength of evidence	Mixed research evidence (with adverse effects)
Effectiveness	Mixed
About the program	The aims of the Healthy Families America program are to: reduce child maltreatment; improve parent-child interactions; improve children's social and emotional wellbeing; increase school readiness; promote child physical health and development; promote positive parenting; promote family self-sufficiency; increase access to primary care medical services and community services; and decrease childhood injuries and emergency department use. The content of the home visits is intended to be individualised and culturally appropriate but based on approved curricula. The program treatment revolves around four primary areas: 1. Promoting positive child development by using child development activities with families, and promoting expectations appropriate to a child's age/development. 2. Facilitating child health through child health and development check-ups and use of health care and community resources. 3. Improving the parent-child relationship by promoting parent-child attachment and positive parent-child interactions. 4. Enhancing maternal life course outcomes by promoting positive mental health, goal setting and problem solving, and providing referrals for assistance with substance abuse, mental illness, and interpersonal violence and continuing education, training, and employment.
Who does it work for?	The program is targeted at families at risk, using indicators such as education level, single parenthood, employment status, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and/or drug abuse. An RCT was conducted in Arizona, US, with a final sample size of 165, where the average age of the mother was 26 years old, two thirds of the sample were Hispanic American, 42% had not graduated from high school, and 13.2% had previous engagement with child protection services (LeCroy et al. 2020). In New York, an RCT was conducted with a sample of 1,173 families where the average age of the mother in the original sample was 22.5 years old, 34% of the sample were white, 45% African American and

	18% Latina, 29.2% were welfare recipients, and 20.2% had prior child abuse or neglect reports. The final sample at year 2 was 971 (DuMont et al. 2008). The three-year follow-up of this RCT was conducted by Rodriguez et al. (2010) with 677 families and a final sample size of 522. In Oregon, an RCT was conducted with a sample of 2,727 first time mothers, where 81% were unmarried, 33.2% had an education level less than high school diploma, and 79.9% were living with financial stress (Green et al. 2017). This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Minor physical aggression, Physical abuse, Violence directed at child**: Studies found that there was a statistically significant reduction in self-reported child abuse (DuMont et al. 2008, LeCroy et al. 2020), and reduced likelihood of psychological aggression and minor physical aggression (DuMont et al. 2008). **Harsh parenting, Parenting practices**: Studies demonstrated a reduction in harsh parenting (DuMont et al. 2008), and an improvement in parenting practices (Rodriguez et al. 2010, LeCroy et al. 2020). **Safety**: LeCroy et al. (2020) found an improvement in child safety, through improved mobilisation of resources at 6-month and 12-month follow-up assessments, and improved safety practices in the home at the 6 month follow-up assessment. However, at the 12-month assessment, there were no differences in safety practices. NO EFFECT **Abuse and neglect, Child abuse reports: Substantiated**: Green et al. (2017) found no effect on child abuse and maltreatment, measured through substantiated child abuse reports. NEGATIVE OUTCOMES **Child abuse reports**: **Unsubstantiated:** Green et al. (2017) found a small increase in unsubstantiated reports, which the authors argue could be a surveillance effect from being in the Healthy Families America program.
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with adverse effects): • At least one high-quality RCT/QED study reports statistically significant adverse effects for at least one outcome, AND • An equal number or more RCT/QED studies show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality RCT/QED study shows statistically significant positive effects for at least one outcome
How is it implemented?	Home visits are scheduled weekly for newborns during the first six months and then taper off as the family makes progress in the program, up until the child is three. Sometimes there are bi-weekly visits during pregnancy.
How much does it cost?	Information not available
What else should I consider?	The home visitor is a specially trained paraprofessional.
Where does the evidence come from?	Several RCTs in the USA have demonstrated promising research evidence

	• One RCT with 245 families and a final sample size of 165 (LeCroy & Lopez 2020) • One RCT with 1,173 families and a final sample size of 971 (DuMont et al. 2008). • The three-year follow-up of the RCT above (DuMont et al. 2008) with 677 families and final sample size of 522 (Rodriguez et al. 2010) • One RCT with 2,727 families. Of these families, 1,438 were assigned to the Healthy Families America program, but only 636 of these received a home visit (Green et al. 2017)
Further resources	• http://www. healthyfamiliesamerica.org • 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, vol. 32, no. 3, pp. 295-315. • Green, BL et al. (2017). "Using administrative data to evaluate the effectiveness of the Healthy Families Oregon home visiting program: 2-year impacts on child maltreatment and service utilization." Children and Youth Services Review 75: 77-86. • LeCroy, C. W. and D. Lopez (2020). "A Randomized Controlled Trial of Healthy Families: 6-Month and 1-Year Follow-Up." Prevention Science 21(1): 25-35. • Rodriguez ML, Dumont K, Mitchell-Herzfeld SD, Walden NJ, Greene R. Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. Child Abuse Negl. 2010 Oct;34(10):711-23. doi: 10.1016/j.chiabu.2010.03.004. Epub 2010 Sep 17. PMID: 20850872.

Evidence type	Evidence-informed program
Name of the program	Early Start
Brief description of program for search page	Early Start is a home visiting program, founded in the 1990s in New Zealand by a consortium of researchers, health professionals, service providers and community representatives. The program applies a social learning model approach to home visiting.
Outcomes	• Child health • Parenting • Child abuse and neglect
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	The critical elements of the Early Start model include: • Assessment of family needs, issues, challenges, strengths, and resources • Development of a positive partnership between the family support worker and client • Collaborative problem solving to devise solutions to family challenges • The provision of support, mentoring, and advice to assist client families to mobilise their strengths and resources • Involvement with the family throughout the child's preschool years. The program goals are: improvements in child health; reduction of child abuse; improvements in parenting skills; improved parent physical and mental health; family economic and material wellbeing; and stable and positive intimate partnerships. The delivery of services is based on several common principles: • Understanding of the client's individual and cultural perspective

	• Active involvement of clients in the service by sharing ideas and experiences, and engaging in problem solving • Assisting clients to seek and generate their own solutions • Providing support and assistance for clients to implement their solutions • Teaching, mentoring, and providing the client with alternative strategies and solutions • Acting as an interpreter for the client in dealing with new material, ideas, or suggestions.
Who does it work for?	The program is designed for families of children who have been identified as at risk, for example because of the age of parents, parental social support, unplanned pregnancy, parental substance use, the family financial situation, family violence, or where there were serious concerns about the ability of the family to care for the child. In an RCT in New Zealand with 443 families, 27% of parents in the intervention group were Maori, and 24.8% of mothers and 30.7% of fathers in the control group were Maori (Fergusson et al. 2005). In the intervention group, 90.1% of families were welfare dependent; in the control group, 88.4% of families were welfare dependent. The program has not been evaluated in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child visits to hospital ER, Positive parenting, Physical assault**: Fergusson et al. (2005) provided evidence that the program has a positive effect on child safety through a reduction in child visits to hospital Emergency Rooms. They also demonstrated a positive effect on parenting that was not reliant on punishment. NO EFFECT **Child abuse and neglect**: The same study failed to demonstrate an effect on the reduction of harm as measured by rates of contact with child welfare agencies. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is delivered to families of preschool aged children and has a duration of 36 months. The program involves home visits by family support workers with nursing or social work qualifications who have also attended a five-week training program specific to Early Start. Each family support worker supports 10 to 20 families. The program of home visitation is tailored to meet individual family needs. An initial needs assessment is conducted through four weekly visits, to determine the subsequent level of intervention. The study did not provide information on the contents of each level of intervention
How much does it cost?	Information not available
What else should I consider?	Information not available

Where does the evidence come from?	The study was an RCT with original sample size of 443 families, final sample size of 391 families, of whom 220 received the intervention (Fergusson et al., 2005).
Further resources	• https://www.earlystart.co.nz/what-we-do/ • Fergusson, D. M., et al. (2005). "Randomized trial of the Early Start program of home visitation." Pediatrics 116(6): e803-809.

Evidence type	Evidence-informed program
Name of the program	Right@Home
Brief description of program for search page	Right@Home is an Australian nurse home visiting program based on the core framework and training of the Maternal Early Childhood Sustained Home-Visiting (MECSH) program.
Outcomes	• Child safety • Positive parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Right@Home program aims to improve parent care and responsivity, and the home learning environment. The program is structured around the core MECSH framework and training (Kemp et al. 2011), bolstered by five evidence-based strategies for content (sleep, safety, nutrition, regulation, and bonding and/or relationship) and two evidence-based strategies for the delivery process (video feedback and motivational interviewing strategies).
Who does it work for?	The program is designed for families of infants who have been identified as at risk, based on a broad range of psychosocial and socioeconomic risk factors, identified by an assessment. Right@Home is an Australian program, evaluated in Australia. In an RCT study of 722 mothers (596 in final sample) and their infants, 41.4% of mothers lived in an area with the lowest decile of locational disadvantage in the country, 41.3% were living on welfare payments, 24.4% did not complete high school, and 8.6% spoke a language other than English at home (Goldfeld et al. 2019). The study did not report on the Indigenous status of the sample.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Hostile parenting, Parental warmth, Safe home environment:** The program had a positive effect on hostile parenting, warm parenting, and child safety, through the provision of a safe home environment (Goldfeld et al. 2019). Improvements were shown in specific outcomes such as regular bedtimes for children, improved parental involvement in children's learning, and a greater variety of social interactions and stimulation. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program comprises 25 nurse home visits, from pregnancy through to when the child is 2 years old. Visits become less frequent over time.

How much does it cost?	Information not available
What else should I consider?	Right@Home is delivered by a multidisciplinary team of nurses and social workers.
Where does the evidence come from?	One RCT with 722 women; 306 of the 363 women in the intervention group provided data when the child was 2 years old, compared with 290 of 359 women in the control group (Goldfeld et al. 2019).
Further resources	• https://www.aracy.org.au/the-nest-in-action/righthome • Goldfeld, S., et al. (2019). "Nurse Home Visiting for Families Experiencing Adversity: A Randomized Trial." Pediatrics 143(1): 1-12. • Kemp L, Harris E, McMahon C, et al. (2011) Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. Arch Dis Child ; 96:533-540.

Evidence type	Evidence-informed program
Name of the program	Parents as Teachers
Brief description of program for search page	Parents as Teachers is a longstanding and widespread home visiting program in North America and Europe, particularly in the USA and the UK. Parents as Teachers promotes the optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
Outcomes	• Child abuse and neglect
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Parents as Teachers program a comprehensive home-visiting, parent education model. It is delivered by parents trained as Teachers Affilitates to families with children from the prenatal period to kindergarten. The model has four dynamic components: • Personal Visits • Group Connections • Resource Network • Child Screening The program has four primary goals: 1. Increase parent knowledge of early childhood development and improve parent practices 2. Provide early detection of developmental delays and health issues 3. Prevent child abuse and neglect 4. Increase children's school readiness and success
Who does it work for?	This program is not specifically designed for reduction of harm. However, one RCT in the USA examined the impact of the program on reducing recurrent maltreatment (Jonson-Reid et al. 2018). The study used baseline data from a final sample of 122 families, all of whom had prior contact with child welfare services. The mean age of the parents was 26 years, 40% had not completed high school, and 69% were African American. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child abuse and neglect**: The study demonstrated a statistically significant reduction in reports to child protection services among children whose families had no child protection services history prior to the report that led them to be referred to the program. The treatment group had fewer re-reports compared to the control group in this demographic. However, there was no statistically significant between-group difference in the proportion of children with re-reports to child protection services during the 18-month follow-up window.

	NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is delivered through home visits. The program runs for up to 3 years if a child is enrolled at birth. Curriculum elements are provided at the discretion of the home visitor to allow flexibility.
How much does it cost?	Information not available
What else should I consider?	The program is delivered by a paraprofessional parent educator and has a child development and parenting curriculum. It has a focus on younger children, and although it is commonly described as being for children from birth to kindergarten, there is limited material for children aged 3 to 5 years. The Parents as Teachers program has been adapted in Australia and New Zealand as 'Parents as First Teachers'. The Australian 'Parents as First Teachers' has a version for children aged 0-18 months and a version for children aged 18 months to 3 years. The program utilises a groupwork delivery model. It has been delivered to Aboriginal and Torres Strait Islander families in remote communities in the Northern Territory.
Where does the evidence come from?	One RCT with an original sample of 167 families, final sample of 122 families (Jonson-Reid et al. 2018). There were 65 caregivers in the intervention group who provided baseline data, and 34 remained after 18 months. In the control group, 57 caregivers provided baseline data, and 29 remained after 18 months.
Further resources	• https://parentsasteachers.org • https://apps.aifs.gov.au/ipppregister/projects/families-as-first-teachers-nt-faft-indigenous-parenting-support-services-program • Jonson-Reid, M., et al. (2018). "A Randomized Trial of Home Visitation for CPS-Involved Families: The Moderating Impact of Maternal Depression and CPS History." Child maltreatment 23(3): 281-293.

Evidence type	Evidence-informed program
Name of the program	Pride in Parenting
Brief description of program for search page	The Pride in Parenting program is a community-based intervention targeting African American mothers who have not accessed adequate prenatal care.
Outcomes	• Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Pride in Parenting program is a community-based intervention targeting African American mothers who have not accessed adequate prenatal care. The main objectives are to improve mothers' use of maternal and child health and social services resources, identify and maintain existing community systems, develop effective coping strategies, establish family routines and personal goals, and improve responsiveness to the child's needs.

	The curriculum is designed to improve knowledge, influence attitudes and promote life skills that would assist low-income mothers in offering a more optimal health and developmental environment for their infants. The program uses an ecological intervention model focused on parenting, infant health, individual coping skills, and recruitment and maintenance of social support systems. Topics for home visits include newborn care, women's health needs, healthy relationships, family planning, immunisations, health visits, safety in the home, budgeting, developing social support, involvement of fathers, managing child behaviour, drug use and smoking.
Who does it work for?	The program is targeted at African American mothers who have not accessed adequate prenatal care. An RCT conducted in the USA had a final sample of 286 mothers predominantly at risk, unmarried, 98.6% African American, living in the inner-city, with 10.8% educated above high school level, and 60.1% below the poverty level (Katz et al. 2011). This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Parenting behaviours**: Participants receiving a high level of the intervention showed a statistically significant reduction in parentification behaviour (the mother's tendency to reverse parent-child roles in expecting her child to look after her) (Katz et al. 2011). NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program combines home visiting and group-based interventions in the form of playgroups. Participants receive visits from the home visitor for 1 year. Visits occur weekly from birth to 4 months, and biweekly from 5 to 12 months. In addition, mothers are offered biweekly parent-infant playgroups and parent discussion groups beginning at 5 months and continuing until the infant is 12 months old. The group session format is a 45-minute parent/infant playgroup focused on developmental issues, followed by a 45-minute parent group discussion.
How much does it cost?	Information not available
What else should I consider?	The program uses paraprofessional home visitors who participate in a 45-day intensive training on issues to be covered and the specific content for each visit.
Where does the evidence come from?	One RCT with final sample of 286 mothers in the USA. Outcomes were measured for 146 women in the intervention group and 140 in the control group (Katz et al. 2011).
Further resources	• Katz, K., et al. (2011). "Effectiveness of a Combined Home Visiting and Group Intervention for Low Income African American

	Mothers: The Pride in Parenting Program." Maternal and Child Health Journal 15(S1): 75-84.

Evidence type	Evidence-informed program
Name of the program	Healthy Steps for Young Children
Brief description of program for search page	Healthy Steps for Young Children is a widespread and well-established intervention in the USA, first piloted in 1995. The model introduces a child development expert trained in the Healthy Steps approach into the pediatric primary care practice for an integrated approach to the child.
Outcomes	• Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	Healthy Steps for Young Children is a universal, practice-based intervention that enhances the delivery of behavioural and developmental services and relies on partnerships between developmental specialists and families.
Who does it work for?	The intervention is a universal program designed for children aged from newborn to 3 years old. In a 2007 study of Healthy Steps for Young Children by Minkovitz and colleagues, the study cohort was 65% white, 21% Black, with 4.5% described as 'Asian/Native American'. The study excluded families with babies who were too ill to join the program at 4 weeks, mothers did not speak English or Spanish, families intending to move away within 6 months, and families planning to place the baby for adoption or foster care. In the sample, 25% of families were classified as low income; 36% as middle income; and 39% as high income. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Positive parenting**: A smaller percentage of families in the intervention group used severe discipline (e.g. striking their child) (10.1%), compared with families in the control group (14.1%). A greater proportion of families in the intervention group negotiated with their child (59.8%) compared with families in the control group (56.3%). A greater proportion of families in the intervention group tended to ignore misbehaviours (10.3%) compared with families in the control group (8.5%) (Minkovitz et al. 2007). NO EFFECT None. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The core program components include contact with developmental specialists and seven services: • Enhanced well-childcare • Up to six home visits in the first 3 years • A telephone line for non-emergency developmental concerns • Developmental assessments

	• Written materials • Parent groups • Linkages to community resources
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	These findings are from a national evaluation in the USA (Minkovitz, et al. 2007). This study was a prospective randomised controlled trial, with six randomised sites and nine quasi-experimental sites. The study included a follow-up of the children at age 61 to 66 months, finding modest, sustained, positive effects of the program. There were 5,565 families enrolled in the study, including 3,165 families who provided interview data when the child was 5.5 years old.
Further resources	• https://www.healthysteps.org/ • Minkovitz, C. S., et al. (2007). "Healthy Steps for Young Children: sustained results at 5.5 years." Pediatrics 120(3): e658-668.

Evidence type	Evidence-informed program
Name of the program	Parents as Teachers + SafeCare at Home (PATSCH)
Brief description of program for search page	The PATSCH program is a combination of two existing widespread and well-established programs: Parents as Teachers and SafeCare.
Outcomes	• Child safety • Child abuse and neglect • Child health • Discipline/punishment
Strength of evidence	Mixed research evidence (with adverse effects)
Effectiveness	Mixed
About the program	The PATSCH program aims to improve parent-child relationships. PATSCH is a combination of two existing, widespread and well-established programs: Parents as Teachers and SafeCare. SafeCare targets more basic parenting skills than Parents as Teachers. In the PATSCH program, content from the SafeCare curriculum is embedded into the Parents as Teachers approach, delivery methods, and curriculum. Bringing the two models together combines pedagogical approaches of parent education with skills-based learning, theoretical underpinnings of empowerment with social learning theory, and intended outcomes of school readiness with reduction in risk for maltreatment. The PATSCH curriculum covers parent/child interaction, home safety, child health, development-centred parenting, and family wellbeing.
Who does it work for?	The program is targeted at families with a child under four years of age at risk of maltreatment due to factors such as a low-income household, parental low educational attainment, teen parenthood, single parenthood, or non-native English speaking. A cluster randomised trial was conducted in the USA with a sample of 159 families across 23 sites (Guastaferro et al. 2018). The final sample comprised of 93 families. The original sample had a mean parent age of 28 years, and 73% were from 'minority backgrounds'. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Healthcare decisions:** In a comparison of families receiving PATSCH with those receiving only Parents as Teachers (Guastaferro et al. 2018), health care decisions improved over time in the PATSCH group.

	Safe home environment: In a comparison of families receiving PATSCH with those receiving only Parents as Teachers (Guastaferro et al. 2018), the PATSCH group were able to identify more hazards in the home. **Non-violent discipline**: Whilst both the PATSCH group and the group receiving only Parents as Teachers reported an increase in non-violent discipline over time, the change in non-violent discipline was greater for the PATSCH group. Further, parents of minority status were more likely to report lower levels of nonviolent aggression. NO EFFECT **Physical assault**: There were no significant time, treatment, or time by treatment group effects for physical assault. NEGATIVE OUTCOMES **Psychological aggression:** The PATSCH group reported an increase in psychological aggression over time. The Parents As Teachers Alone group reported no change in psychological aggression over time (Guastaferro et al. 2018). **Child abuse potential:** Scores on the 'Brief child abuse potential inventory' tool improved over time in the group receiving only Parents as Teachers, but did not do so in the PATSCH group.
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with adverse effects): • At least one high-quality RCT/QED study reports statistically significant adverse effects for at least one outcome, AND • An equal number or more RCT/QED studies show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality RCT/QED study shows statistically significant positive effects for at least one outcome
How is it implemented?	The program is delivered by trained parent educators through home visiting. There are 12 sessions that are delivered through weekly or biweekly home visits.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One cluster randomised trial across 23 sites with 159 families (Guastaferro et al. 2018). At the 12-month follow-up, 36 families remained in the PATSCH group and 57 in the Parents as Teachers group.
Further resources	• Guastaferro et al. (2018). "Braiding Two Evidence-Based Programs for Families At-Risk: Results of a Cluster Randomized Trial." Journal of Child and Family Studies 27(2): 535-546.

Evidence type	Evidence-informed program
Name of the program	SafeCare
Brief description of program for search page	SafeCare is a structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect.
Outcomes	• Child abuse and neglect • Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive

About the program	SafeCare is a structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect. SafeCare is premised on an eco-behavioural model to address the causes of physical abuse and neglect. This model recognises the need for interventions of differing levels to address maltreatment, and the need to target skills and behaviours in ways that serve to sustain change. This can involve ongoing measurement of observable behaviours, skills modelling, practice and feedback, and training parents to criterion in observable skills. SafeCare is delivered by specifically trained personnel. The program has been tailored to different target groups, for example, fathers and rural families. These modifications introduce considerable variation to the program and limit comparability. To optimise fidelity, training can involve considerable monitoring of the service providers.
Who does it work for?	Two studies of the standard SafeCare model were identified. Both were conducted in the USA. One RCT analysed data from 41 families who had been referred to the program by child welfare services, and 41 matched families who had current substantiated reports of child abuse and neglect and were receiving family preservation services (Gershater-Molko et al. 2002). The study did not report demographic data. The second study was a cluster randomised trial with a sample size of 289 caregivers who were receiving services (Whitaker et al. 2020). Most of the full sample was female (87%), the mean parent age was 29.5 years, and 74.6% were white. Neither of the studies involved First Nations participants. This review did not identify any evidence that the program has been evaluated in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child abuse and neglect:** Gershater-Molko et al. (2002) found that the intervention had a positive effect on child abuse and neglect reports made. The largest difference between the two groups was visible at 36 months after the beginning of the intervention, when 85% of the families who had received the intervention had no reports of child abuse and neglect, compared to 54% of the control group families. **Parental stress:** Whitaker et al. (2020) demonstrated positive and significant improvement for parental stress outcomes for the intervention group. There was positive and significant reduction in dysfunctional interactions, parental distress and improvement in perception of child's temperament and behaviour. **Positive parenting**: Whitaker et al. (2020) found significant effects on positive parenting behaviours for the intervention group, including supporting positive behaviour, proactive parenting, and setting limits. NO EFFECT **Neglectful parenting:** Whitaker et al. (2020) found no significant effect for the intervention in emotional neglect, cognitive neglect and supervisory neglect. **Protective factors for child maltreatment:** Whitaker and colleagues (2020) found no significant effect for the intervention

	group in family functioning, nurturing parenting, and parent knowledge. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	SafeCare involves an 18 to 24-week program comprised of three modules: health training, safety training, and parenting skills. Although each module is typically offered in parents' homes over six sessions, this can vary to reflect a parent's preferred location and their progress. A parent's progress is assessed via direct observation in role-play situations.
How much does it cost?	Information not available
What else should I consider?	The program has been adapted for different target groups, for example fathers and rural families. These modifications introduce considerable variation to the program and limit comparability. See SafeCare+ and SafeCare Dad to Kids Program.
Where does the evidence come from?	Two studies conducted in the USA: • An RCT where 41 families were included in the analysis (Gershater-Molko et al. 2002) • A cluster randomised trial with a sample of 289 caregivers (Whitaker et al. 2020)
Further resources	• https://safecare.publichealth.gsu.edu • Gershater-Molko, RM, Lutzker, JR and Wesch, D 2002, 'Using recidivism data to evaluate project Safecare: Teaching bonding, safety, and health care skills to parents', Child Maltreatment, vol. 7, no. 3, pp. 277-285. • Whitaker, DJ, Self-Brown, S, Hayat, MJ, Osborne, MC, Weeks, EA, Reidy, DE and Lyons, M 2020, 'Effect of the SafeCare© intervention on parenting outcomes among parents in child welfare systems: A cluster randomized trial', Preventive Medicine, vol. 138, no. 106167, pp. 1-8.

Evidence type	Evidence-informed program
Name of the program	SafeCare+
Brief description of program for search page	SafeCare+ is an adaptation of the standard SafeCare training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect.
Outcomes	• Child abuse and neglect • Domestic violence • Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	SafeCare+ is an adaptation of the standard SafeCare structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect. The main adaptation in SafeCare+ is the addition of motivational interviewing and training home visitors on identification and response to imminent child maltreatment and various risk factors.

	SafeCare is premised on an eco-behavioural model to address the causes of physical abuse and neglect. This model recognises the need for interventions of differing levels to address maltreatment, and the need to target skills and behaviours in ways that serve to sustain change. This can involve ongoing measurement of observable behaviours, skills modelling, practice and feedback, and training parents to criterion in observable skills. SafeCare is delivered by specifically trained personnel.
Who does it work for?	One study of SafeCare+ was identified. The program was delivered to families living in rural communities in the USA. The study was a randomised clinical trial with a sample of 105 parents who had an identifiable risk of intimate partner violence, or substance abuse (Silovsky et al. 2011). Of the 48 families allocated to the SafeCare+ group, only 40 received the intervention. Of the 57 families allocated to the control group, 19 received the service as usual intervention. All but one parent in the sample were women, the average age was 27 years, and there was an average of two children per family. In the intervention group, 15% were Black, 15% Native American, 2% Hispanic or Latinx and 68% white; 25% did not complete high school. This review did not identify any evidence that the program has been evaluated in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child abuse potential:** Silovsky et al. (2011) detected a positive, but marginally significant, improvement in the child abuse potential inventory scores of the intervention group. **Domestic violence:** There were no reports made due to domestic violence for the intervention group, compared to seven reports for the control group (Silovsky et al. 2011). **Harsh and neglectful parenting**: Silovsky et al. (2011) found a significant positive program effect in the intervention group, but it was not maintained at the follow-up assessment. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	SafeCare involves an 18 to 24-week program comprised of three modules: health training, safety training, and parenting skills. Although each module is typically offered in parents' homes over six sessions, this can vary to reflect a parent's preferred location and their progress. A parent's progress is assessed via direct observation in role-play situations. SafeCare+ includes the addition of motivational interviewing and training home visitors on identification and response to imminent child maltreatment and various risk factors.
How much does it cost?	Information not available

What else should I consider?	The program has been tailored to different target groups, for example fathers and rural families. These modifications introduce considerable variation to the program and limit comparability.
Where does the evidence come from?	One study conducted in the USA: • A randomised clinical trial with a sample of 105 parents (Silovsky et al. 2011)
Further resources	• https://safecare.publichealth.gsu.edu • Silovsky, JF, Bard, D, Chaffin, M, Hecht, D, Burris, L, Owora, A, Beasley, L, Doughty, D and Lutzker, J 2011, 'Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes', Children and Youth Services Review, vol. 33, pp. 1435-1444.

Evidence type	Evidence-informed program
Name of the program	SafeCare Dad to Kids Program (Dad2K)
Brief description of program for search page	The SafeCare Dad to Kids Program (Dad2K) is an adaptation of the standard SafeCare training program designed specifically for fathers of children aged 0 to 5 years, reported for child abuse and/or neglect.
Outcomes	• Child abuse and neglect • Parenting • Discipline/punishment
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	The SafeCare Dad to Kids Program (Dad2K) is an adaptation of the standard SafeCare structured training program designed specifically for fathers of children aged 0 to 5 years, reported for child abuse and/or neglect. The main adaptations in Dad2K are the introduction of interactive technology via a tablet computer that delivers multimodal learning and modeling of SafeCare target skills through dynamic software-based activities, and the addition (to session 4) of a co-parenting component guided by the "Talking with Mom" workbook created by the National Fatherhood Initiative. SafeCare is premised on an eco-behavioural model to address the causes of physical abuse and neglect. This model recognises the need for interventions of differing levels to address maltreatment, and the need to target skills and behaviours in ways that serve to sustain change. This can involve ongoing measurement of observable behaviours, skills modelling, practice and feedback, and training parents to criterion in observable skills. SafeCare is delivered by specifically trained personnel.
Who does it work for?	One study of SafeCare Dad2K was identified. The program was delivered to fathers in the US. A randomised experimental design study was conducted with a sample of 99 fathers, of whom 93% were Black, 2% Native American and 2% "other" (Self-Brown et al. 2017). Half were unemployed, and 71% reported an annual income below US$25,000. This review did not identify any evidence that the program has been evaluated in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Parenting skills:** Self-Brown et al. (2017) found a statistically significant improvement in parenting skills for the intervention group. NO EFFECT Self-Brown et al. (2017) found a decrease in neglectful behaviours in the intervention group, but this was not statistically significant.

	Corporal/physical punishment/discipline: Self-Brown et al. (2017) found a reduction in the use of corporal punishment in the intervention group, but this was not statistically significant. **Non-violent discipline:** Self-Brown et al. (2017) found a decrease in the use of non-violent discipline in the intervention group, but this was not statistically significant. **Psychological aggression**: When the program was tailored for fathers, there was a decrease in psychological aggression in the intervention group, but this was not statistically significant (Self-Brown et al. 2017). NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	• At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	SafeCare involves an 18 to 24-week program comprised of three modules: health training, safety training, and parenting skills. Although each module is typically offered in parents' homes over six sessions, this can vary to reflect a parent's preferred location and their progress. In Safe Care Dad2K, interactive technology is used to deliver multimodal learning and modeling of SafeCare target skills through dynamic software-based activities, and there is an additional co-parenting component guided by the "Talking with Mom" workbook created by the National Fatherhood Initiative. A parent's progress is assessed via direct observation in role-play situations.
How much does it cost?	Information not available
What else should I consider?	The program has been tailored to different target groups, for example fathers and rural families. These modifications introduce considerable variation to the program and limit comparability.
Where does the evidence come from?	One study conducted in the USA: • A randomised experimental design with a pre-test and post-test, with a sample of 99 fathers (Self-Brown et al. 2017)
Further resources	• https://safecare.publichealth.gsu.edu • Self-Brown, S, Osborne, MC, Lai, BS, De Veauuse Brown, N, Glasheen, TL and Adams, MC 2017, 'Initial findings from a feasibility trial examining the SafeCare Dad to Kids Program with marginalized fathers', Journal of Family Violence, vol. 32, no. 8, pp. 751-766.

Evidence type	Evidence-informed program
Name of the program	Promoting First Relationships
Brief description of program for search page	Promoting First Relationships (PFR) is a relationship- and strengths-based home visiting program that aims to help families facing adversity. PFR seeks to increase caregivers' awareness of their children's social and emotional needs, including their need for a sense of safety and security; and to enhance caregivers' understanding of their own needs as parents.
Outcomes	• Child abuse and neglect
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed

About the program	Promoting First Relationships (PFR) is a relationship- and strengths-based home visiting program that aims to help families facing adversity. PFR service providers are trained to focus on the relationship between the parent and child. Providers employ observational skills using video-based feedback with parents. PFR seeks to increase caregivers' awareness of their children's social and emotional needs, including their need for a sense of safety and security, and to enhance caregivers' understanding of their own needs as parents.
Who does it work for?	An RCT with 247 participants (final sample 228) was conducted in the USA (Oxford et al. 2016). The families who participated in the study had been reported to child protection services with allegations of child maltreatment. To participate, families needed to meet the following inclusion criteria: • Be conversant in English • Have housing • Live in Snohomish, southern Skagit or northern King County in Washington State • Have a child aged 10-24 months and • Have an open case with an allegation of maltreatment of any type recorded in the database of the regional child protective service office at least two weeks prior In the study, children were aged 10-24 months, with a mean age of 16.4 months. The sample was made up of Indigenous (1%); Asian (2%); African American (4%); Mixed/other (31%); and White (62%). 79% received food stamps and 31% were employed full or part-time. The proportion of parents that graduated from high school or had a General Education Diploma was 76%, and 47% lived with a spouse or partner. The PFR program was delivered to the intervention group. The control group received up to three occasions of phone-based resource and referral services. This review did not identify any evidence that the program has been evaluated in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Out-of-home placement**: Oxford and colleagues (2016) showed that 13.0% of the children in the control group had been removed from the home at 15 months post baseline, compared to 5.6% of the children in the intervention group. The chances of removal from the birth parent home were 2.5 times greater for children in the control group than for children in the intervention group at any given time. NO EFFECT **Child abuse reports: Unsubstantiated**: The same study failed to demonstrate a significant effect on new maltreatment allegations (Oxford et al. 2016). Whilst between enrolment and one year post intervention there were new allegations for 36 (29.0%) of the children in the intervention group and 42 (31.6%) of the children in the control group, survival models indicated that chances of a new allegation did not differ significantly by condition. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND

	• An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program consists of weekly home visits for ten weeks, by community-based service providers with master's degrees in social work or counselling, who are certified to deliver the program. The parent and child are video-recorded playing together five times during the 10-week PFR program. The PFR provider will then review the video-recorded play session with the parent, typically the week following the date on which the session was recorded. The provider and parent reflect on the recorded interactions, noting what the child is doing in relation to the caregiver's behaviour and what the caregiver is doing in response to the child.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	An RCT with 247 child protective services cases in the USA (Oxford et al. 2018). The sample included 247 cases taken from the Washington State Department of Social and Health Services (DSHS) database in the USA. 228 cases remained at post-program follow-up.
Further resources	• https://pfrprogram.org • Oxford, M.L., Spieker, S.J., Lohr, M.J., and Fleming, C.B. (2016). Promoting First Relationships ®: Randomized trial of a 10-week home visiting program with families referred to child protective services, *Child Maltreatment*, *21*, 267-277.

Evidence type	Evidence-informed program
Name of the program	Johns Hopkins Children and Youth Program
Brief description of program for search page	This is a community-based home visiting program for mothers and their infants. It aims to provide mothers with health and parenting education in the home.
Outcomes	• Child abuse and neglect • Child health
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Johns Hopkins Children and Youth program is a community-based home visiting program for mothers and their infants. It aims to provide mothers with health and parenting education in the home. The program employs paediatricians, nurses, parent education specialists, social workers and support staff. Emphasis is placed on prevention by training health and parenting education specialists and by employing social workers.
Who does it work for?	One RCT study was conducted with a final sample of 263 infants and mothers in the USA (Hardy and Streett, 1989).The study included inner-city Baltimore mothers of newborns living on low incomes. Mothers' mean age ranged from 18 to 33 years, with a mean age of 22.6 years. Infants' age ranged from 3 to 13 months. All mothers were African American, and 78% were single mothers. 23% had no prior children, and the remainder had children who ranged in age from 1-6 years. No evidence that the program has been evaluated in Australia or with First Nations communities was identified in the review.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Hospital outpatient visits**: The study found a significant positive effect on the number and type of outpatient clinic visits. The control group had an overall mean of 16.6 visits to a child and youth clinic, and 4.3 visits to the emergency department, whereas the study group had a mean of 15.5 visits to a child and youth clinic and three visits to

	the emergency department. There was also a reduction in the likelihood of hospital admission, with 20% of children in the control group admitted to hospital, compared to 6% of children in study group. **Child abuse and neglect:** Fewer instances of abuse and neglect were present in the intervention group. Inpatient care was required by eight (6.1%) of the children in the intervention group and 20 (15.2%) of the children in the control group. **Immunisations**: The program was found to have a positive and significant effect on immunisations. In all, 88% of children in the intervention group had received the complete set of immunisations for their age, compared with 69% of children in the control group. Furthermore, in only 6% of children in the intervention group were immunisations delayed for more than 2 months by illness or a missed appointment, and in only 6% were they incomplete at termination of followup, compared with 14% and 17%, respectively, among children in the control group. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is implemented through fortnightly home visits, for 40-60 minutes each. The duration of the program is up to 24 months. It is a community-based service, with community-based home visitors receiving training and direct supervision from the module's educator (Johns Hopkins University) and the social worker. The home visitor provides education on parenting and childcare skills to mothers, covering topics appropriate for the age of the infants visited. Developmental milestones are discussed with anticipatory parenting guidance, and suggestions are made for enhancing child development. A calendar is developed and given to each parent at the first visit, and includes information on child development, seasonal safety tips, clinic hours, and program contact names and telephone numbers. The program educator does not address psychosocial issues, but instead refers the family to a social worker or educator, depending on the nature and severity of observed presentation. The home visitor's role is one of a support person to the parent, rather than a therapist.
How much does it cost?	In 1983-1984, the per-visit, all-inclusive cost of the child and youth program averaged US$53.
What else should I consider?	The available program evidence is based on one study from the 1980s; this study has not been replicated
Where does the evidence come from?	One RCT study with a final sample of 263 mother and infant dyads conducted in the USA (Hardy & Streett, 1989).

Further resources	• Hardy, J.B. and Streett, R., (1989). Family support and parenting education in the home: An effective extension of clinic-based preventive health care services for poor children. The Journal of pediatrics, 115(6), pp.927–931.

Evidence type	Evidence-informed program
Name of the program	Hamilton Nurse Home Visiting Program
Brief description of program for search page	The Hamilton Nurse Home Visiting Program is a Canadian nurse home visiting program delivered to families with children under 13 years old who have been subject to a reported incidence of physical abuse or neglect.
Outcomes	• Child abuse and neglect
Strength of evidence	Mixed research evidence (with adverse effects)
Effectiveness	Mixed
About the program	The Hamilton Nurse Home Visiting Program is a Canadian nurse home visiting program delivered to families with children under 13 years old who have been subject to a reported incidence of physical abuse or neglect. The three main activities in the program are intensive family support, parent education, and linkage with other services. A manual has been developed. The nurses tailor home visits to the individual needs of the family.
Who does it work for?	One RCT study with 163 families was conducted in Hamilton, Ontario, Canada(MacMillan et al. 2005). Families had been referred to the two local child protection agencies during 1995 and 1996. Of these families, 82% received welfare payments, and 35% had finished high school. All were at risk of maltreating their children. Families in the intervention group received the Hamilton Nurse Home Visiting Program and families in the control group received standard child protection services. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES None NO EFFECT **Child abuse and neglect**: The study did not demonstrate an effect on new maltreatment allegations for neglect. While there were fewer incidences of neglect, and physical abuse, reported to child protection services for children in the intervention group, this result was not significant. NEGATIVE OUTCOMES **Physical abuse**: Research evidence based on hospital records showed a significantly higher occurrence of physical abuse or neglect in children in the intervention group.
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with adverse effects): • At least one high-quality RCT/QED study reports statistically significant adverse effects for at least one outcome, AND • An equal number or more RCT/QED studies show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality RCT/QED study shows statistically significant positive effects for at least one outcome
How is it implemented?	In addition to standard child protection services, families receive a visit from a public health worker of 1.5 hours every week for 6 months,

	then every 2 weeks for 6 months, then monthly for a further 12 months.
How much does it cost?	Information not available
What else should I consider?	Nurses who deliver the program have previous experience working with socially disadvantaged families, and with child protection services.
Where does the evidence come from?	One RCT conducted with 163 families in Canada (MacMillan et al. 2005).
Further resources	• MacMillan, H. L., et al. (2005). "Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial." Lancet 365 North American Edition (9473): 1786-1793.

Evidence type	Evidence-informed program
Name of the program	e-Parenting Program
Brief description of program for search page	The e-Parenting Program is a multi-component computerised supplement to be used in home visiting programs such as Healthy Families America.
Outcomes	• Parenting • Child abuse and neglect
Strength of evidence	Evidence fails to demonstrate effect
Effectiveness	No effect
About the program	The e-Parenting Program is a multi-component computerised supplement to be used in home visiting programs such as Healthy Families America. The program aims to reduce child maltreatment and child maltreatment risk factors. The program is based on research that shows that home visitors often lack confidence and expertise in addressing difficult issues with families, such as domestic violence and substance abuse. The software incorporates elements of three evidence-based interventions: motivational interviewing, cognitive retraining, and SafeCare. The content of the e-training modules includes: engagement in home visiting and goals; key maltreatment risk factors (substance use, partner violence, and depression); causes of infant crying and fussiness (facilitating non-pejorative attributions); ways to soothe infant crying and fussiness (building efficacy) as well as shaking prevention; SafeCare infant play/cognitive stimulation; SafeCare home safety and accident prevention; appropriate medical decision-making; and SafeCare booster (choice of content from above). There are 8 x 20 minute computer generated modules. Home visitors introduce each module in line with family needs and the focus of the visit.
Who does it work for?	The program is targeted at parents who are at risk, but not yet engaged with the child protection system. One RCT was conducted with a final sample of 413 families in the USA (Ondersma et al. 2017). The families had all been referred to a healthy families program due to a risk of child maltreatment. The mean age of parents was 23.6 years, 37.5% were African American, 93.2% received benefits and 23.1% did not complete high school. Also, 41.2% had experienced domestic violence, 41.1% had risky alcohol use, 23.2% risky marijuana use, and 20.5% had experienced depression in the previous week. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES None

	NO EFFECT **Risk of child maltreatment:** The study found no evidence to demonstrate a sustained effect on child maltreatment risk factors. There was evidence of a significant improvement over time in self-reported depression, intimate partner violence (victimisation and perpetration), and alcohol and drug abuse, as well as observer-rated home quality. There was a significant reduction in depression scores and self-reported drug use from baseline to the six-month follow-up for the intervention group, but not for the group receiving services as usual (Healthy Families America) or the control group. There was also a significant benefit for the intervention group in depression between 6 and 12 months, compared to the control group. However, the total change in depression from baseline to the 12-month follow-up did not show an advantage for the intervention group. There were no significant differences between the groups in drug use. **Harsh parenting**: There was no significant difference between groups in harsh parenting practices. All groups reported higher levels of harsh parenting over time. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program was found to have no effect on client outcomes.
How strong is the evidence?	Evidence fails to demonstrate effect: • At least one high-quality systematic review with meta-analyses based on RCT/QED studies reports no observed effects for all reported outcomes, OR • At least one high-quality RCT study reports no observed effects for all reported outcomes. • Criteria are not met for mixed research evidence (with or without adverse effects)
How is it implemented?	The program is a supplement to a home visiting programme (such as Healthy Families America). There are eight 20-minute computer generated modules that families can watch during the home visit, on, for instance, a Smartphone, iPad, or laptop. The modules focus on addressing key maltreatment risk factors. All modules need to be completed within six months (before the child is six months old).
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT conducted in the USA with a final sample of 413 families (Ondersma et al. 2017).
Further resources	• Ondersma, S. J., et al. (2017). "Technology to Augment Early Home Visitation for Child Maltreatment Prevention: A Pragmatic Randomized Trial." Child maltreatment 22(4): 334-343.

Programs that Give Centrality to Early Childhood Education Services

Evidence type	Evidence-informed program
Name of the program	HeadStart
Brief description of program for search page	HeadStart is the largest publicly supported childcare program in the USA and is targeted at low-income children and children with disabilities, two groups at high risk for maltreatment. It is a primary prevention program offering services to an at-risk population of low-income families including pregnant women and families with children up to three years of age.
Outcomes	• Child abuse and neglect • Parenting • Discipline/punishment

Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	HeadStart is the largest publicly supported childcare program in the USA and is targeted at low-income children and children with disabilities, two groups at high risk for maltreatment. It is a primary prevention program offering services to an at-risk population of low-income families including pregnant women and families with children up to three years of age. It offers childcare, home visiting or a mix of the two. The goals of the program are to improve parenting, reduce maltreatment (including the use of abusive discipline or neglectful behaviours), and promote parental involvement and parent education. The program seeks to promote healthy child development, and prevent negative child and family outcomes from the prenatal period, including: child health, social, emotional, cognitive and language development, parenting, and parent wellbeing. It also aims to reduce parental stress and opportunities for maltreatment by providing care for children outside the home. In addition, like other childcare programs, HeadStart can serve a monitoring function; parents might be deterred from abusing or neglecting their children because HeadStart staff observe that behaviour and report the family to child protective services.
Who does it work for?	HeadStart is targeted at low-income children and children with disabilities, two groups at high risk for maltreatment. Two studies were carried out in the USA (Green et al. 2020; Zhai et al. 2013). One study had a final sample of 2794 families, of which 35% were Black; 23% were Hispanic; 38% were white; 40% were adolescent mothers (Green et al. 2020). The second study final sample was 2,807 families, comprised of 49% Black children, 20% Hispanic children and 17% white children, with 19% of households below the 50% poverty line, and 27% of mothers who had not completed high school (Zhai et al. 2013). Multiple comparison groups were used in the Zhai et al. (2013) study, including non-Head Start, parental, pre-kindergarten, other center-based, and other non-parental. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Physical assault, Neglect, Child welfare involvement/contact with child protection services, Corporal/physical punishment/discipline**: Zhai et al. (2013) report a statistically significant reduction in spanking, other physical assault, neglect and contact with child protection services. Zhai et al. (2013) also found that HeadStart participants were less likely to experience neglect when compared to other centre-based care and other non-parental care. **Parental stress, Dyadic reciprocity, Family conflict**: Green et al. (2020) found improvements in dysfunctional parenting, including a reduction in spanking. Green et al. (2020) found that compared to control groups, families in HeadStart had less conflict, and parents reported lower levels of parenting distress. Zhai et al. (2013) observed a marginally significant improvement in parental warmth and a reduction in parental harshness for the intervention group.

	NO EFFECT **Child welfare involvement/contact with child protection services:** Green and colleagues (2020) found no observed effect on substantiated maltreatment reports or out-of-home care placement. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program has a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is delivered by trained service providers in either Health Centres or family homes. The delivery and implementation of the program varies widely from site to site due to differences in implementation quality, curriculum choices, staffing structure, community characteristics and other factors. Services provided to individual families are tailored to their individual needs and circumstances. The intervention duration is up to two years.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT with an initial sample size of 3,001 families across 17 HeadStart programs, which reduced to a final sample size of 2,794 (Green et al. 2020). One QED study with an initial sample of 5,000 families across 20 large cities, which reduced to a final sample size of 2,807 (Zhai et al. 2013). Both studies compared intervention groups with control groups.
Further resources	• https://www.acf.hhs.gov/ohs/about/head-start • Green, B. L., et al. (2020). "Pathways to prevention: Early HeadStart outcomes in the first three years lead to long-term reductions in child maltreatment." Children and Youth Services Review 118: N.PAG-N.PAG. • Zhai, F., et al. (2013). "Estimating the effects of HeadStart on parenting and child maltreatment." Children and Youth Services Review 35(7): 1119-1129.

Evidence type	Evidence-informed program
Name of the program	Relief Nursery Program
Brief description of program for search page	The Relief Nursery Program is designed for and targeted at economically vulnerable families, with the aim of reducing child maltreatment.
Outcomes	• Parenting • Child abuse and neglect
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	The Relief Nursery Program is designed for and targeted at economically vulnerable families, with the aim of decreasing instances of child maltreatment. Social support is seen as a key protective factor and is given focus in each of the core components. The program draws on Bronfenbrenner's socioecological model. The program is offered in face-to-face, individual and group settings, over a period of 36 months. It is delivered by family support workers with nursing or social work qualifications.

Who does it work for?	The Relief Nursery Program is designed for and targeted at economically vulnerable families with children aged between 18 months and 4 years. One RCT was conducted in the USA with a sample of 180 caregivers and 180 children who had been identified as being at risk of maltreatment (Eddy et al. 2020). Of these, 83% were white, 42% were Latinx and 15% were multiracial. Of the caregivers, 43% did not finish high school, and over 50% earned less than US$20,000. This review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Social support**: By the 24-month point, intervention group demonstrated a significant increase in Social Support, indicated bv the Social Support Questionnaire (SSQ) Tangible Support and Social Interaction Support subscales (p<0.05; d=0.36) and the SSQ Social Interaction Support subscale e (p<0.05; d=0.34). At wave 5 (2-year point) there was a significant difference on the SSQ Tangible Support subscale e (p<0.05; d =0.34). NO EFFECT **Social support**: No significant differences were found between the intervention and control groups on the Social support outcome measures assessed at the 12-month point. **Parental stress**: There was a small but statistically insignificant effect on parenting efficacy and stress in the intervention group (Eddy et al. 2020). **Child abuse potential**: There was a small but statistically insignificant improvement in child abuse potential in the intervention group (Eddy et al. 2020). NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is comprised of: 1. The Therapeutic Early Childhood Classroom Program (TECCP) run with small groups of children by early childhood trained teachers and volunteers 2. Home visiting, in which early childhood program teachers work to support parenting skills, promote the parent/child relationship, and provide referrals 3. Group-based parent education and support services. Mental health and special education services are integrated into the classroom on an as-needed basis. All children participate in developmental screening. Other services are provided as needed, including respite care, child nutrition, transportation to and from

	services, and individual and family counselling. Staff offer the program in the parents' primary language and food is provided.
How much does it cost?	Information not available.
What else should I consider?	The study found that the program providers had difficulty engaging the families in group-based parenting program components, and experienced low levels of engagement across all program components. Only 60% of families engaged with the program, and these were families who were provided transport. The levels of engagement dropped rapidly over time so that by 24 months into the study, only 11% were still receiving home visits, 12% still had a child in the TECCP, and 8% were receiving both.
Where does the evidence come from?	One RCT conducted in the USA with 180 primary care givers and 180 children (Eddy et al. 2020).
Further resources	• https://www.oregonreliefnurseries.org/programs • Eddy, JM et al. (2020). "Outcomes from a Randomized Controlled Trial of the Relief Nursery Program." Prevention Science 21(1): 36-46.

Evidence type	Evidence-informed program
Name of the program	Chicago Parent Program
Brief description of program for search page	The Chicago Parent Program (CPP) is a parenting program that capitalises on the strengths of the Webster-Stratton Incredible Years model.
Outcomes	• Discipline/punishment • Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Chicago Parent Program (CPP) was developed in collaboration with a parent advisory group of African American and Latinx parents from a range of economic backgrounds. The CPP is grounded in the assumption that parents play a critical role in shaping a child's behaviour and personality both as role models, as social learning theory suggests, and through the quality and consistency of behavioural interaction. The goals of the program are to improve parent self-efficacy, discipline strategies, and parent behaviour during free play and clean-up sessions, and to reduce the frequency of child behaviour problems.
Who does it work for?	An RCT was conducted with a sample of 985 families (final sample size of 292), across seven day-care centres in Chicago, USA (Gross et al. 2009). Study participants had children aged 2 to 4 years old. Just over half of the sample were African American (51.9%), 37% were Latino, and 8.1% were white. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Corporal/physical punishment/discipline, Parenting efficacy, Consistent discipline, Parental warmth**: At the 12-month assessment, parents in the intervention group used less corporal punishment and issued fewer commands with their children than parents in the control group. Additional group differences were observed when dosage was included in the analytic model. Parents who participated in at least 50% of CPP sessions also reported greater improvements in parenting self-efficacy, more consistent discipline, and greater warmth when compared to reports from parents in the control group. NO EFFECT None

	NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program consists of 11 weekly sessions and a post-program booster. The program is delivered in face-to-face, facilitated parent groups. Parents receive weekly homework assignments and handouts summarising important points from each session. The CPP capitalises on the strengths of the Webster-Stratton Incredible Years model as it also employs videotaped vignettes, a group discussion format that corresponds to principles being addressed in each of the vignettes, and a collaborative interpersonal style for guiding the way group leaders engage parents in the intervention.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	An RCT was conducted with an initial sample size of 985 families and a final sample size of 292 parents, across seven day care centres in Chicago, US (Gross et al. 2009).
Further resources	• https://www.chicagoparentprogram.org/ • Gross, D., et al. (2009). “Efficacy of the Chicago parent program with low-income African American and Latino parents of young children.” Prevention Science 10(1): 54-65.

Evidence type	Evidence-informed program
Name of the program	Family Support Program
Brief description of program for search page	The Family Support Program is based on the Comprehensive Child Development Program and follows the principles of cognitive and behavioural parenting interventions based on social learning models.
Outcomes	• Child abuse and neglect
Strength of evidence	Mixed research evidence (with no adverse effects).
Effectiveness	Mixed
About the program	The Family Support Program is based on the Comprehensive Child Development Program and follows the principles of cognitive and behavioural parenting interventions based on social learning models. The intervention component has two different parts: for parents and for children. The program is flexible and can be adapted to meet the individual needs of each family. The program goals are to provide parenting education in child development, health care, nutrition, and parent–child interaction activities; and to improve the cognitive, social and personal development of children.
Who does it work for?	The program is targeted at children aged between 3 and 5, where the child shows signs of social behavioural problems; has difficulties with socio-emotional or cognitive development; or the parents lack parenting skills. One RCT was conducted in Portugal with a sample of 40 families (final sample 36 families), of which 35.9% were African and 2.6% were of mixed ethnicity (Calheiros et al. 2017). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.

What outcomes does it contribute to?	POSITIVE OUTCOMES **Physical neglect, Psychological and physical abuse**, and **Lack of supervision**: Data was collected using the Questionnaire for evaluating Maltreatment and Neglect at pre intervention and post intervention. There was a statistically significant reduction in physical neglect and psychological and physical abuse, with large effect sizes (Cohen's *d* =−0.71, and Cohen's *d* =−1.01), and a statistically significant improvement in supervision, with medium effect size (Cohen's *d* =−0.48). These findings need to be regarded with caution as the study sample size is very small. NO EFFECT **Educational neglect**: There was not a significant finding for educational neglect (development needs, monitoring mental health, school tracking). NEGATIVE OUTCOMES None Although the outcomes were positive, they should be regarded with caution as the study sample size is very small.
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is delivered by a multi-disciplinary team including a social worker, a psychologist, an early childhood educator and two social educators. For the parents the program consists of 20 individualised sessions in the home every two weeks, each lasting 30 - 90 minutes; 15 individual or group sessions in preschool at least once per month; video-modelling; written resources developed by the intervention team. For the children there are 52 sessions (two per week for half an hour each time). Sessions are conducted in groups of 4-6 children guided by an educator within the school system, and take place at the preschool.
How much does it cost?	Information not available
What else should I consider?	Calheiros and colleagues (2017) emphasised the importance of team training and ongoing supervision for staff. Anecdotal evidence of fidelity was collected and suggested that the program was implemented as intended.
Where does the evidence come from?	One RCT conducted in Portugal with a final sample of 36 families (Calheiros et al. 2017).
Further resources	• Calheiros, M. M. et al. (2017). "Evaluation of an Intervention Program for Families with Children at Risk for Maltreatment and Developmental Impairment: A Preliminary Study." Journal of Child and Family Studies 27(5): 1605-1613.

Evidence type	Evidence-informed program
Name of the program	ParentCorps
Brief description of program for search page	ParentCorps is a program from the USA which involves school personnel, including mental health professionals and teachers, facilitating a parenting intervention with parents, and a concurrent group with children.

Outcomes	• Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	ParentCorps is a program from the USA which involves school personnel (mental health professionals and teachers) facilitating a parenting intervention with parents, and a concurrent group with children. ParentCorps takes a behavioural change approach. The program includes core behavioural change strategies that are found in other parenting interventions (e.g., The Incredible Years, Triple P), combined with a culturally informed approach. The intervention aims to strengthen the following three key domains of parenting: positive behaviour support (e.g., reinforcement, proactive strategies), behaviour management (e.g., consistent consequences), and parent involvement in early learning (e.g., reading to children, communicating with teachers).
Who does it work for?	ParentCorps is designed to serve culturally diverse communities. One RCT was conducted with a final sample of 561 children in the intervention group, and 489 in the control group (Dawson-McClure et al. 2015). It involved interviews and questionnaires with the children and parents at the beginning and end of the school year. There were ten participating schools from two school districts in New York City with high levels of socioeconomic disadvantage. The mean age of the children was 4.15 years, the mean age of the caregivers was 33.9 years, 85% of participants were non-Latinx Black, and 60.8% were identified as low income. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities. ParentCorps is not currently available in Australia.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Parenting practices**: The study demonstrated positive intervention effects on parenting practices such as parenting knowledge, positive behaviour support, and teacher-rated parent involvement (Dawson-McClure et al., 2015). NO EFFECT **Child conduct**: No effect was found. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The ParentCorps family program is run over 13 weeks, with a 2-hour sessions each week for parents of children aged 0-5, and concurrent sessions for children held at the school. Face-to-face groups in school settings are provided by trained residents and social workers. These facilitators undertake a professional development program: 5 days in year 1 and 2 days in years 2 – 4, and 6 hours of consultation per year. The teachers who co-lead the family program receive one hour of training a week for 13 weeks. A professional development program for teachers includes large group-based activities to introduce strategies and consultation to facilitate the adoption and tailoring of strategies.

	A number of incentives such as meals and gift cards are used to facilitate extrinsic motivation for families to participate in the program. The program is promoted through flyers and brief informational sessions at school events with parents who completed the program previously. Teachers engage parents in-person and by phone. During the initial parent group session, facilitators work with families to identify barriers to attendance and elicit parents' intrinsic motivation and commitment to attend as consistently as possible. Weekly reminder calls and "We missed you" flyers are also used.
How much does it cost?	Information not available.
What else should I consider?	Information not available.
Where does the evidence come from?	One RCT was conducted in the USA with 1050 children and 831 parents, with analysis based on the final sample of 561 children. The study involved interviews and questionnaires with both children and parents at the beginning and end of the school year (Dawson-McClure et al. 2015).
Further resources	• https://www.weareparentcorps.org/ • Dawson-McClure, S et al. (2015). "A population-level approach to promoting healthy child development and school success in low-income, urban neighborhoods: impact on parenting and child conduct problems." Prevention Science 16(2): 279-290.

Therapeutic Parent-Child Interaction Programs

Evidence type	Evidence-informed program
Name of the program	Parent-Child Interaction Therapy (PCIT)
Brief description of program for search page	Parent-Child Interaction Therapy (PCIT) is an individualised, evidence-based treatment program for preschool children displaying disruptive, oppositional and defiant behaviour.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Supported research evidence
Effectiveness	Positive
About the program	Parent-Child Interaction Therapy (PCIT) is an individualised, evidence-based treatment program for preschool children displaying disruptive, oppositional and defiant behaviour. The intervention is founded in social learning, attachment and behavioural theory, and incorporating play therapy. PCIT was developed for children aged between 3 and 7 years and their parents. The goal is for parents to strengthen the parent-child bond and increase the prosocial behaviour of the child. It also aims to decrease child externalising and internalising symptoms, caregiver stress, depression, abuse potential and negative communication, and to increase observed maternal sensitivity and positive communication.
Who does it work for?	The program is targeted at preschool children displaying disruptive, oppositional and defiant behaviour, and their parents. One QED study was conducted in Hong Kong with a matched comparison group of 130 Chinese Hong Kong parents with children aged 2 - 8 years (final sample 110) (Leung et al. 2009). Around half of the parents were educated to only lower secondary school level. One RCT was conducted in Australia with 151 female caregivers (mean age 33.9 years) and their children (mean age 4.57 years) (Thomas & Zimmer-Gembeck 2012). In this study, 74% of parents were born in Australia, and 1.4% of parents identified as Aboriginal or Torres Strait Islander. Most mothers had completed some high school (81%) and 16.5% had some tertiary education. Participants were referred from child protection authorities (34.2%), government health services

	(19.7%), and education and nongovernment social service organisations (18.4%). Parent self-referrals also were accepted (27.6%), but the pre-assessment interview had to reveal prior parenting interventions, high risk for child maltreatment and significant levels of child behavioural problems.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Parental stress**: Both studies reported significantly lower parenting stress in the intervention group than in the control group (Thomas and Zimmer-Gembeck, 2012; Leung et al. 2009). **Corporal/physical punishment/discipline:** Leung and colleagues (2009) found a reduction in corporal punishment after the intervention, measured by the number of instances of corporal punishment in the last month as reported by the participant. **Dyadic reciprocity:** Leung and colleagues (2009) found a significant improvement in parent-child interaction. There were decreases in the number of questions and criticisms, and increases in the number of descriptions, reflections, instances of praise, and instances of compliance. **Positive communication**: Thomas and Zimmer-Gembeck (2012) found an increase in parental communication in the intervention group, with larger effects observed for PCIT participants compared to waitlist control group for praise, and descriptions and reflections, and medium-to-large effects in decreasing questions, commands, and negative talk. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program has a positive effect on client outcomes.
How strong is the evidence?	Supported research evidence: • At least two high-quality RCT/QED studies report statistically significant positive effects for at least one outcome, AND • Fewer RCT studies of similar size and quality show no observed effects than show statistically significant positive effects for the same outcome(s), AND • No RCT studies show statistically significant adverse effects
How is it implemented?	One-hour long weekly treatment sessions are delivered over a period of 12 weeks. PCIT skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children. While parent–child dyads are observed through a one-way mirror, parents wear a bug-in-the-ear device and are coached to attend to the child's behaviours consistently and predictably. Parents are taught behaviour management strategies that focus on positive reinforcement rather than power assertion to reduce child oppositional and disruptive behaviours. The behaviour management techniques in PCIT are designed to aid children's emotional regulation by providing parents with developmentally appropriate language and skills. The program is delivered in social service and clinical centres by Masters and Doctoral-level psychologists or social workers trained in PCIT.
How much does it cost?	Information not available.
What else should I consider?	Information not available.

Where does the evidence come from?	• One QED study with a matched comparison group of 110 parents with children aged 2-8 years conducted in Hong Kong (Leung et al. 2009) • One RCT with 151 female caregivers and their children conducted in Australia (Thomas and Zimmer-Gembeck, 2012)
Further resources	• http://www.pcit.org/ • Leung, C et al. (2009). "Effectiveness of Parent-Child Interaction Therapy (PCIT) among Chinese families." Research on social work practice 19(3): 304-313. • Thomas, R. and M. J. Zimmer-Gembeck (2012). "Parent–Child Interaction Therapy: An Evidence-Based Treatment for Child Maltreatment." Child maltreatment 17(3): 253-266.

Evidence type	Evidence-informed program
Name of the program	Self-Directed Triple P (Positive Parenting Program)
Brief description of program for search page	Self-Directed Triple P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems is a behavioural family intervention program, derived from the Triple P program.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	Self-Directed Triple P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems is a behavioural family intervention program derived from the Triple P program, which is widely used in Australian states and territories for children at risk of developing conduct problems. Self-Directed Triple P is based on social learning principles and its purpose is to promote positive caring relationships between parents and children. Self-Directed Triple P targets coercive family interactions known to contribute to the development and maintenance of children's disruptive behaviour problems. The program involves teaching parents 17 core child behaviour management strategies. Ten of the strategies are designed to promote children's competence and development (e.g., quality time; talking with children; physical affection; praise; attention; engaging activities; setting a good example; "Ask, Say, Do"; incidental teaching; and behaviour charts) and seven strategies are designed to help parents manage misbehaviour (e.g., setting rules; directed discussion; planned ignoring; clear direct instructions; logical consequences, quiet-time; and time-out). In addition, parents are taught a six-step planned activities routine to enhance the generalisation and maintenance of parenting skills (e.g., plan; decide on rules; select engaging activities; decide on rewards and consequences; hold a follow-up discussion). The program comprises of an initial telephone screening and intake, a parenting text and a workbook. There is no practitioner contact or prompting following the intake. Consistent with Triple P's overall emphasis on parental self-regulation, parents learn to modify their own behaviour through a process of planned, self-directed change to promote parental self-sufficiency.
Who does it work for?	An RCT of the effectiveness of self-directed Triple P was conducted in Australia with a sample of 63 families with a preschool-aged child (Markie-Dadds & Sanders 2006). This reduced to 47 families at program completion. The sample included families who responded to a community outreach campaign. The families were in the mid-range of socioeconomic status. The authors did not report whether there were Aboriginal or Torres Strait Islander, or CALD participants.

What outcomes does it contribute to?	POSITIVE OUTCOMES **Dysfunctional discipline strategies:** Markie-Dadds and Sanders (2006) demonstrated a statistically significant reduction in the over-reactivity subscale scores on the Parenting Scale in the intervention group. **Parenting competence**: At completion of the program, there was a significant reduction in harsh or authoritarian discipline practices and an increase in satisfaction and efficacy in parenting role in the intervention group, as compared to the waitlist control group. (Markie-Dadds & Sanders 2006). NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	Parents complete a ten-unit self-directed program over ten weeks, in both the home and community settings.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT conducted in Australia with a sample of 63 families with a preschool child, with analysis based on final sample of 47 families who completed the program (Markie-Dadds & Sanders, 2006).
Further resources	• https://www.triplep-parenting.net.au/au-uken/triple-p • Markie-Dadds, C., and Sanders, M. R. (2006). Self-Directed Triple P (Positive Parenting Program) for Mothers with Children at-Risk of Developing Conduct Problems. *Behavioural and Cognitive Psychotherapy, 34*(3), 259–275.

Evidence type	Evidence-informed program
Name of the program	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)
Brief description of program for search page	**Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (**VIPP-SD) was developed in the Netherlands to address disruptive behaviour in very young children.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Mixed research evidence (with adverse effects)
Effectiveness	Mixed
About the program	The VIPP-SD is aimed at reducing or preventing emotional problems and externalising behaviours, such as temper tantrums, in preschool children. The program is designed to strengthen maternal skills and sensitive discipline strategies, and increase maternal sensitivity.
Who does it work for?	The program has been trialled and evaluated with a variety of parental cohorts, including multigenerational migrant communities, low-income migrant families, foster families, and families with risk factors for child protection such as negligence regarding child's emotional needs; lack of limit setting; coercive discipline practices; and marital violence.

	Evidence is based on three RCTs with final sample sizes ranging from 43, 76 and 237 families. Two of these studies were carried out in the Netherlands and targeted different families, including first-time parents (Stolk et al. 2008) and second generation Turkish women (Yagmur et al. 2014). The final sample in Stolk et al. (2008) was 237 first-time mothers with children aged 1 to 3 years; the child was living with both parents. The majority of parents in study had a high educational level (one or both parents had a Bachelor's or Master's degree in 64% of the sample). Yagmur and colleagues (2014) had a sample of 86 mother-child dyads (final sample 76); 83.4% mothers had secondary education and above in the intervention group, compared to 79.9% in the control group. The third study (Negrao et al. 2014) was conducted in Portugal, with a sample of 55 Portuguese families (final sample 43). The mean age of children was 29.07 months. 72.1% of mothers and 50% of fathers were unemployed. Most families benefited from welfare assistance (79.1% of families). Family education level was low: 72.1% of mothers and 86.1% of fathers didn't complete 9 school years. All families had a preschool child exhibiting a significantly high level of externalising behaviours. The program has also been adapted for foster care families – see program summary for Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-SD-FC). The adaptation was evaluated in an RCT with a final sample of 55 families in the Netherlands (Schoemaker et al., 2020). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Maternal non-intrusiveness, Maternal sensitivity:** Measured by the Emotional Availability Scale, Yagmur et al. (2014) found positive and significant improvement in maternal sensitivity and reduction in maternal non-intrusiveness. Negrão et al. (2014) also demonstrated a positive significant effect ($p<0.05$), in parenting due to a significant reduction ($p<0.001$) in maternal intrusiveness. **Family functioning**: Negrão et al. (2014) demonstrated a positive significant effect on family functioning indicated by a significant improvement on the Relation dimension of the Family Environment Scale. **Positive discipline**: This outcome was measured through observation of set tasks during home visits and in the laboratory, and via questionnaires. Stolk et al. (2008) demonstrated a significant effect on increasing positive maternal discipline. NO EFFECT **Corporal/physical punishment/discipline**: Yagmur et al. (2014) found no significant effect on maternal physical discipline. Maternal discipline strategies were observed during two tasks: a 4-minute "don't-touch" task and a clean-up task. NEGATIVE OUTCOMES **Maternal sensitivity:** An unexpected negative effect on maternal sensitivity was found by Stolk et al. (2008) among women with two or

	more children: mothers in the control group showed an increase in sensitivity, whereas mothers in the intervention group showed a constant level of sensitivity over time.
Is the program effective?	Overall, the program evidence rating was mixed research evidence, with adverse effects.
How strong is the evidence?	Mixed research evidence (with adverse effects): • At least one high-quality RCT/QED study reports statistically significant adverse effects for at least one outcome, AND • An equal number or more RCT/QED studies show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality RCT/QED study shows statistically significant positive effects for at least one outcome
How is it implemented?	Female interveners and trainers visit families in six home visits over a period of 3-8 months. Interactions between the mother and child are video-taped and used as the basis for subsequent discussion about parenting strategies. Parents are encouraged to show more sensitive responsiveness by learning to notice child signals, interpret them correctly, and respond to them in a timely and appropriate way. In the version delivered to families with a Turkish background, the program was delivered in a culturally appropriate way following a structured pilot phase which elicited feedback from participants. Specifically, changes were made to some of the stimulus materials and activities to ensure that they were meaningful to participants; the program was delivered by women in appropriate languages (Turkish, Dutch, or a mixture of the two; and the duration of each home visit was extended from one hour to 2.5–3 hours to allow for the visitors to engage in conversation before the protocal commenced, following Turkish cultural norms.
How much does it cost?	Information not available
What else should I consider?	Although studies found that the VIPP-SD did not lead to a reduction in harmful discipline towards preschool children (Yagmur et al. 2014) or increased maternal sensitivity (Stolk et al. 2018), three studies did show positive effects on maternal non-intrusiveness (Yagmur et al. (2014; Negrão et al. 2014), maternal sensitivity (Yagmur et al. 2014), family functioning (Negrão et al. 2014) and positive discipline (Stolk et al. 2008). With slight modifications to ensure cultural appropriateness, the program has shown success for Turkish migrant families. It may be a suitable intervention for families with children displaying disruptive behaviours during the preschool period.
Where does the evidence come from?	Four RCT studies were conducted. • In the Netherlands, Stolk et al. (2008) had a sample size of 246 families (final sample 237). • In the Netherlands, Yagmur et al. (2014) had a sample of 86 mother-child dyads (final sample 76). • In Portugal, Negrão et al. (2014) had a sample size of 55 families (final sample 43).
Further resources	• https://www.universiteitleiden.nl/en/vipp • Negrão, M., et al. (2014). "Enhancing positive parent-child interactions and family functioning in a poverty sample: a randomized control trial." Attachment and human development 16(4): 315-328.Schoemaker et al. (2020) • Stolk, M. N., et al. (2008). "Early parenting intervention: family risk and first-time parenting related to intervention effectiveness." Journal of Child and Family Studies 17(1): 55-83. • Yagmur, S., et al. (2014). "Video-feedback intervention increases sensitive parenting in ethnic minority mothers: a randomized

	control trial." Attachment and human development 16(4): 371-386.

Evidence type	Evidence-informed program
Name of the program	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-SD-FC)
Brief description of program for search page	**Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (**VIPP-SD-FC) is an adaptation of a program developed in the Netherlands to address disruptive behaviour in very young children, targeted at foster care families.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Evidence fails to demonstrate effect
Effectiveness	No effect
About the program	The standard VIPP-SD program is aimed at reducing or preventing emotional problems and externalising behaviours, such as temper tantrums, in preschool children. The program is designed to strengthen maternal skills and sensitive discipline strategies, and increase maternal sensitivity. Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care is adaptation of the program designed specifically for foster care families. The main adaptation was the addition of two themes targeted at foster parents: the importance of sensitive responding to missing or subtle behavioral signals to improve attachment security, and the importance of positive physical contact to improve stress regulation.
Who does it work for?	The standard program has been evaluated with a variety of parental cohorts, including multigenerational migrant communities, low-income migrant families and families with risk factors for child protection such as negligence regarding child's emotional needs; lack of limit setting; coercive discipline practices; and marital violence. This adaptation, named Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care, has been developed specifically for foster care families. Evidence is based on one RCT with a sample size of 60 foster families (final sample 55); 83.4% of caregivers in the intervention group and 79.9% of caregivers in the control group had secondary education and above (Schoemaker et al. 2020). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES None NO EFFECT **Parental sensitivity, Sensitive discipline, Attitudes toward sensitivity:** Schoemaker et al. (2020) found no significant effect on parental sensitivity, sensitive discipline and attitudes to sensitivity. NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program was found to have no effect on client outcomes.
How strong is the evidence?	Evidence fails to demonstrate effect: • At least one high-quality systematic review with meta-analyses based on RCT/QED studies reports no observed effects for all reported outcomes, OR

	• At least one high-quality RCT study reports no observed effects for all reported outcomes. • Criteria are not met for mixed research evidence (with or without adverse effects)
How is it implemented?	Female interveners and trainers visit families in six home visits over a period of 3-8 months. Interactions between the mother and child are video-taped and used as the basis for subsequent discussion about parenting strategies. Parents are encouraged to show more sensitive responsiveness by learning to notice child signals, interpret them correctly, and respond to them in a timely and appropriate way. The adaptation for foster parents included two additional themes: the importance of sensitive responding to missing or subtle behavioral signals to improve attachment security, and the importance of positive physical contact to improve stress regulation.
How much does it cost?	Information not available
What else should I consider?	The study failed to demonstrate that the VIPP-SD-FC can be effectively employed to improve parental sensitivity, sensitive discipline, and attitudes toward sensitivity among foster parents. However, the standard Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline program has been shown to have positive effects on maternal non-intrusiveness (Yagmur et al. 2014; Negrão et al. 2014), maternal sensitivity (Yagmur et al. 2014), family functioning (Negrão et al. 2014) and positive discipline (Stolk et al. 2008). VIPP-SD may be a suitable intervention for families with children displaying disruptive behaviours during the preschool period.
Where does the evidence come from?	One RCT study was conducted. • In the Netherlands, Schoemaker et al. (2020) had a sample size of 60 foster families (final sample 55).
Further resources	• https://www.universiteitleiden.nl/en/vipp • Schoemaker, N. K., et al. (2020). "A meta-analytic review of parenting interventions in foster care and adoption." Development and psychopathology 32(3): 1149-1172. • Negrão, M., et al. (2014). "Enhancing positive parent-child interactions and family functioning in a poverty sample: a randomized control trial." Attachment and human development 16(4): 315-328.Schoemaker et al. (2020) • Stolk, M. N., et al. (2008). "Early parenting intervention: family risk and first-time parenting related to intervention effectiveness." Journal of Child and Family Studies 17(1): 55-83. • Yagmur, S., et al. (2014). "Video-feedback intervention increases sensitive parenting in ethnic minority mothers: a randomized control trial." Attachment and human development 16(4): 371-386.

Programs Delivered in Clinical Settings

Evidence type	Evidence-informed program
Name of the program	The Incredible Years Shortened Basic Version
Brief description of program for search page	The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others in the USA. The Incredible Years Shortened Basic Version is a shortened version designed for children aged between 2 and 8 years with disruptive behavioural problems.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Promising research evidence
Effectiveness	Positive

About the program	The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others. The Incredible Years programs aim to teach parents positive disciplinary strategies (e.g., play, praise and rewards). The basic program is a universal program. The Incredible Years Shortened Basic Version is a shortened version designed for children aged between 2 and 8 years with disruptive behavioural problems (Reedtz et al. 2011). The Incredible Years is premised on social learning theory and a relational framework. It aims to address child behavioural issues by modifying parenting practices. Specifically, parents are supported to improve their parenting skills through practice with their child, paralleled by role play; watching video-recorded program information; and collaborative and interactive group discussion. These activities collectively aim to increase positive parenting strategies (e.g., child-directed play, praise, and incentives; consistent strategies for managing child misbehaviour), and decrease negative parenting strategies (e.g., being critical and inconsistent). The goals of the program are to: • Enhance and support parenting skills • Increase knowledge of child development • Improve children's positive behaviour and parent-child interaction
Who does it work for?	One RCT was conducted with 189 families in Norway, who were self-recruited from the general population (Reedtz et al. 2011). Children were aged between 2 and 8 years, with a mean of less than 4 years of age. Sociodemographic status was mixed. 61% of parents worked full-time, 78% were educated to Bachelor degree level or higher, 80% were two-parent families. Children were excluded from the study if their Eyberg child behavior inventory (ECBI) Intensity scores were above the 90th percentile. The studies did not indicate that The Incredible Years had been tested in Australia, nor had the studies explicitly involved participants who identified as indigenous or from a culturally or linguistically diverse background.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Harsh discipline/punishment**: Reedtz et al. (2011) used the self-reported Parent Practices Interview (PPI) parent-rated questionnaire - Harsh Discipline subscale to measure this outcome at baseline, after the intervention, and at the one year follow-up. They reported a reduction in harsh discipline in the intervention group from baseline to post-intervention, and baseline to follow-up ($p<0.01$), with a moderate to large effect size, as compared to the control group. **Positive parenting**: Reedtz et al. (2011) demonstrated a significant positive increase in positive parenting, with moderate to large effect sizes, using the self-reported parent practices interview (PPI) parent-rated questionnaire – positive parenting subscale. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program has a positive effect on client outcomes.

How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The Incredible Years Shortened Basic Version reduces the number of sessions from 12 in the full version, to the first six sessions. The six 2-hour sessions run weekly. These sessions involve face-to-face groups of 10-12 parents. The program is delivered in a public health care centre. Group leaders are trained nurses specialising in public healthcare, with experience in clinical work. Group leaders are trained according to certification procedures established by The Incredible Years program, and receive continuous supervision through observations, role play, and video reviews from a certified trainer and two mentors. Integrity is optimised by facilitators/group leaders completing self-evaluations and checklists after each group meeting to keep records of the activities of each session and to ensure that the key activities and concepts were covered; ensuring group leaders are supervised; video-recording parent sessions, which the group leader and/or their mentor evaluates; and inviting parents to complete evaluations.
How much does it cost?	Information not available
What else should I consider?	The program is delivered by specifically trained and accredited professionals. There are various adaptations targeted at different groups.
Where does the evidence come from?	• An RCT conducted in Norway with a sample of 189 families, self-recruited from the general population (Reedtz et al. 2011)
Further resources	• https://incredibleyears.com • Reedtz, C., Handegård, B.H., and Mørch, W-T, (2011). Promoting positive parenting practices in primary pare: outcomes and mechanisms of change in a randomized controlled risk reduction trial, Scandinavian Journal of Psychology, 52, 131-137.

Evidence type	Evidence-informed program
Name of the program	The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits
Brief description of program for search page	The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others in the USA. The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits is an adaptation of the program involving additional sessions and home visits. It is intended for children aged between 2 and 8 years with disruptive behavioural problems.
Outcomes	• Discipline/punishment
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The Incredible Years is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others. The Incredible Years programs aim to teach parents positive disciplinary strategies (e.g., play, praise and rewards). The basic program is a universal program. The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits is an adaptation of the program involving additional sessions and home visits (Karjalainen, et al. 2019). It is intended for children aged between 2 and 8 years with disruptive behavioural problems.

	The Incredible Years is premised on social learning theory and a relational framework. It aims to address child behavioural issues by modifying parenting practices. Specifically, parents are supported to improve their parenting skills through practice with their child, paralleled by role play; watching video-recorded program information; and collaborative and interactive group discussion. These activities collectively aim to increase positive parenting strategies (e.g., child-directed play, praise, and incentives; consistent strategies for managing child misbehaviour), and decrease negative parenting strategies (e.g., being critical and inconsistent). The goals of the program are to: • Enhance and support parenting skills • Increase knowledge of child development • Improve children's positive behaviour and parent-child interaction
Who does it work for?	One RCT was conducted with families who were currently clients of child protection services or social services in Finland (Karjalainen et al. 2019). The study had an initial sample size of 102 children and 122 parents, and post-intervention data was collected from parents of 98 children. Children were aged between 3 and 7 years old, with a mean of 5.3 years of age. The study sample was 97% Finnish-speaking families. The sociodemographic profile of the sample was mixed, with 14.7% parents describing covering their expenses with their current income as "easy" ; 62.7% as moderate ; and 20.6% as "difficult". Half of mothers and 79.2% of fathers were employed. Amongst the mothers, 17.3% had no professional training, 57.1% had vocational education, and 25.5% had university education. In the father group, 8.3% had no professional training; 70.8%); had vocational education; and 20.8% had university education.Single parents comprised 46.1% of the sample. The study did not indicate that The Incredible Years had been tested in Australia, nor had the studies explicitly involved participants who identified as indigenous or from a culturally or linguistically diverse background.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Harsh discipline/punishment**: Karjalainen et al. (2019) used the self-reported Parent Practices Interview (PPI) parent-rated questionnaire - Harsh Discipline subscale to measure this outcome. They measured this at assessment and 3 months post-intervention. Karjalainen and colleagues (2019) reported a significantreduction in harsh discipline, with a large effect size (Cohen's d=0.83, p<0.001.) NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program has a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits is an adaptation involving extra meetings and home

	visits, including 19–20 weekly parent group meetings, each 2 hours in duration, plus four additional home visits, monthly, with weekly phone calls. Face-to-face groups consist of 10-12 parents. The estimated duration of the program is 6 months. Dosage in this study included extra sessions and home visits added to the usual intervention for this population. The goal of the home visits is to enhance group learning and provide additional vignettes and practices exercises to complete at home on an individual basis.
How much does it cost?	Information not available
What else should I consider?	The program is delivered by specifically trained and accredited professionals. Preference is for the program to be delivered by accredited group leaders. There are various adaptations targeted at different groups. The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits (Karjalainen et al. 2019) operated from local family counselling centres; and was delivered by family counselling services or child protection services workers trained in The Incredible Years program. Group leaders in this study were all trained. The program protocol included completion of process checklists after each session. Group leaders received supervision and consultation. The program was delivered by family counselling services or CPS workers, trained in The Incredible Years program.
Where does the evidence come from?	• An RCT conducted in Finland with a sample of 122 parents and 102 children, and a final sample of parents of 98 children (Karjalainen et al.2019)
Further resources	• https://incredibleyears.com • Karjalainen, P., Kiviruusu, O., Aronen, E.T., and Santalahti, P. (2019). Group-based parenting program to improve parenting and children's behavioral problems in families using special services: A randomized controlled trial in a real-life setting, Children and Youth Services Review, 96, 420-429.

Evidence type	Evidence-informed program
Name of the program	Safe Environment for Every Kid (SEEK)
Brief description of program for search page	Safe Environment for Every Kid (SEEK) was developed by the University of Maryland. The program is delivered face-to-face, as clinic care at a paediatric clinic, over 2 years.
Outcomes	• Child abuse and neglect • Child health • Discipline/punishment
	Promising research evidence
Effectiveness	Positive
About the program	Safe Environment for Every Kid (SEEK) was developed by the University of Maryland. It is a clinical model, delivered in paediatric clinics to families of children aged 0-5 years. The program goal is to significantly reduce maltreatment rates. It involves training medical residents to address targeted risk factors, screening all families with the brief parenting screening questionnaire, providing doctors and parents with resources in the form of handouts, and establishing a resident-social worker team.
Who does it work for?	The target group for the program were socioeconomically disadvantaged primary caregivers of young children in the pre-school years. One study located at a university-based resident continuity clinic in the USA had 729 families in the original sample size, and 558 families in the final sample size (Dubowitz et al. 2009). The mean child age was 6 months for the intervention group , and 8 months for the control group. The mean parent age was 25.3 years. 93% of the intervention group, and 94% of the control group were Black.

	Approximately a third of the sample were employed. The study used participation in the Medical Assistance scheme as an indicator of socioeconomic status: 93% of the intervention group and 92% of the control group received Medical Assistance. In the intervention group, 36% did not complete high school, 36% completed high school, and 28% had at least some college education. In the control group, 42% did not complete high school, 38% completed high school, and 20% had at least some college education. The mean number of children in the home was 2.3, the mean number of adults in the home was 2.2. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Child protection services reports, Medical chart documentation; Corporal/physical punishment/discipline**: Dubowitz and colleagues (2009) demonstrated a positive effect of the program on child abuse and neglect outcomes including child protection reports, medical chart documentation and harsh discipline. There were significantly fewer child protection services reports for families in the intervention group compared to the control group (respectively 13.3% and 19.2%, $p = .03$). The intervention group had fewer items in their medical charts that suggested neglect, including fewer instances of nonadherence to medical care (4.6%) compared to the control group (8.4%), $p = .05$ and delayed immunisations (3.3%) compared to the control group (9.6%), $p = 0.02$. Parents in the intervention group reported fewer instances of severe or very severe physical assault. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The components of the intervention are: 1. Training: Medical residents are trained in targeted risk factors such as maternal depression, alcohol and substance misuse, intimate partner violence, harsh punishment and major stress. 2. Parent and resident resources: Medical residents receive laminated pocket cards with salient information, and a handbook with comprehensive practical information including local resources, and user-friendly parent handouts. 3. Screening tool: The parents complete this tool while waiting for their check-up appointment. 4. The SEEK social worker: A certified social worker works closely with the residents and parents as requested. Early intervention specialists, early childhood teachers, and other service professionals are consulted as needed for advice and referral.
How much does it cost?	Information not available
What else should I consider?	Clinical residents are trained over 2 half-days, with booster sessions every 6 months.

Where does the evidence come from?	A cluster RCT was conducted with an initial sample size of 729 families, and a final sample size of 558 families (Dubowitz et al., 2009).
Further resources	• https://seekwellbeing.org/ • Dubowitz, H., et al. (2009). “Pediatric primary care to help prevent child maltreatment: The safe environment for every kid (SEEK) Model.” Pediatrics 123(3): 858-864.

Evidence type	Evidence-informed program
Name of the program	Parent Training Program
Brief description of program for search page	The Parent Training Program aims to improve the parent–child relationship and decrease parental stress by reducing harsh parenting at the time of transition to primary school.
Outcomes	• Parenting
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	The Parent Training Program aims to improve the parent–child relationship and decrease parental stress by reducing harsh parenting at the time of transition to primary school. Parents are taught to use more active listening skills, engage less in harsh parenting practices, use more praise and encouragement and set reasonable expectations in the rearing of their children. The program builds on Lazarus and Folkman’s framework of cognitive appraisal, stress and coping. It is also guided by the Health Action Process Approach (HAPA) which explains the psychological mechanisms involved in the gap between intention and actual change in health behaviour.
Who does it work for?	One RCT study was conducted in Hong Kong with a sample of 142 Chinese families in a large public housing estate (final sample 120) (Li et al. 2013). 63.9% of intervention group and 48.6% of control group parents were in the 30-39 years age group. Respectively 44.4% of intervention group and 48.5% of control parents had completed upper secondary school. Children were about to transition to primary school. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Harsh parenting, Dyadic reciprocity**: The program study demonstrated a positive effect on parenting, particularly harsh parenting practices and parent-child interaction (Li et al. 2013). Parents in the intervention group engaged in less harsh parenting practices, measured by the Perceived Parental Aggression subscales of Parental Acceptance Rejection Questionnaire. Based on self-reports, the intervention group had significantly better parent-child relationships than the control group, with a moderate effect size (Li et al. 2013). NO EFFECT **Parental stress**: There were no significant findings on the Parental Stress Scale (Li et al. 2013). NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND

	• An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The Parent Training Program commences approximately 1 month before the start of primary school. Two trained social workers run the program with groups of 8 to 12 parents in each group. The program runs for 4 consecutive weeks, with one 2-hour session per week. Each session begins with a review of the skills or concepts discussed in the previous sessions. Three approaches are used to facilitate the learning process: metaphor (using the living plant as a symbol of growth and nurturing); peer learning (encouraging parents to learn from each other through group discussion); role playing; and planning.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT study was conducted in Hong Kong with 142 Chinese families living in a large public housing estate, with a final sample of 120 families (Li et al. 2013).
Further resources	• Li, H.C.W., et al. (2013). "Effectiveness of a parental training programme in enhancing the parent-child relationship and reducing harsh parenting practices and parental stress in preparing children for their transition to primary school: a randomised controlled trial." BMC public health 13(1): 1079-1079.

Evidence type	Evidence-informed program
Name of the program	Child-Adult Relationship Enhancements in Primary Care (PriCARE)
Brief description of program for search page	Child-Adult Relationship Enhancements in Primary Care (PriCARE) is a trauma-informed group training program to teach caregivers techniques to support the social and emotional growth of children.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	Child-Adult Relationship Enhancements in Primary (PriCARE) is a trauma-informed group training program to teach caregivers techniques to support the social and emotional growth of children. The theoretical foundation is derived from attachment and social learning theory. The program is designed as a prevention model for children with behavioural concerns who might be at risk for maltreatment.
Who does it work for?	The program is designed for children with behavioural concerns who might be at risk for maltreatment. One RCT was conducted in the USA with an initial sample size of 410, and a final sample size of 120 (Schilling et al. 2017). Parents were recruited from an urban primary care clinic, and 15% were Hispanic, 43% Black, and 26% white. Children were aged between 2 and 6 years. 54% ofparents were aged between 18 and 29 years, 26% between 30 and 39 years, and 20% were over the age of 40. Income levels were as follows: under US$22,000 (51% of the sample); US$22-33,000 (30%); and over US$33,000 (19%). For education levels, 15% of participants had not finished high school, 34% had a high school diploma; 51% had attended some college. Family violence was reported by 11% of the sample. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Parent empathy, Corporal punishment attitudes, Acceptance of child's autonomy**: As measured by the AAPI Inventory, there were a slight but significant increase in empathy in

	the intervention group, compared to control; corporal punishment attitudes and acceptance of child's autonomy improved slightly in the intervention group. NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	There are 6 weekly one and a half hour sessions. Caregivers attend sessions without their children. This program is delivered in a clinical setting.
How much does it cost?	Information not available
What else should I consider?	Generalisability is limited by 172 families not enrolling, and lack of blinding of caregivers to the study aim.
Where does the evidence come from?	An RCT was conducted in the USA with an initial sample size of 410 families and a final sample size of 120 families (Schilling et al. 2017).
Further resources	• Schilling, S., et al. (2017). "Child-Adult Relationship Enhancement in Primary Care (PriCARE): A Randomized Trial of a Parent Training for Child Behavior Problems." Academic Pediatrics 17(1): 53-60.

Evidence type	Evidence-informed program
Name of the program	Group Attachment-Based Intervention (GABI)
Brief description of program for search page	The program aims to improve the mother-child relationship and prevent abuse for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child.
Outcomes	• Parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The program aims to improve the mother-child relationship and prevent abuse for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child. The program is based on attachment theory (Ainsworth et al. 1978; Bowlby 1982, 1969).
Who does it work for?	The program was designed for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child. One RCT was conducted in the USA with an initial sample of 193 mothers, of which 115 completed the treatment and subsequently 78 provided data for the final analysis (Steele et al. 2019). Of those who provided data at program completion, 43 were in the intervention group and 35 were in the control group. Referrals came from pediatrics, child welfare, and court systems throughout the Bronx, New York. Children were aged 0 - 36 months; 3.8% were White; 32.1% Black; 43.6% Hispanic; and 20.5% biracial. Mothers were from a low socioeconomic background: 63% were unemployed, and 47.4% did not finish or did not attend high school. The study only included biological parents of a 0-36-month-old child with custody of their child. Parents who were unable to provide informed consent due to mental illness or cognitive

	impairment, and those not fluent in English, were excluded from the study. The control group received the Systematic Training for Effective Parenting (STEP) intervention as 'treatment as usual'. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Maternal hostility, Dyadic constriction:** These were measured using the coding of interactive behavior (CIB) tool, through observation of the parent–child relationship. Outcomes were measured at baseline and post-program. Maternal hostility and dyadic constriction are proxy measures of maltreatment risk. Mothers in the intervention group showed significantly less dyadic constriction and less hostility at the end of treatment than those in the control group (Steele et al. 2019). **Maternal supportive presence, Dyadic reciprocity**: These were measured using the coding of interactive behavior (CIB) tool, through observation of the parent–child relationship. Outcomes were measured at baseline and post-program. Mothers in the intervention group showed a significant increase in maternal supportive presence, significantly greater dyadic reciprocity than mothers in the control group (Steele et al. 2019). NO EFFECT None NEGATIVE OUTCOMES None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program is delivered in a multifamily group setting. It consists of 120-minute sessions, three times weekly over 26 weeks. The program operates in a clinical setting with trained clinicians. There is a specified time for parents and children under 3 years of age to interact with one another, a time for parents to interact with other parents while their children experience individual time with their age-mates in the presence of trained clinicians who help them to engage with peers, and finally, a "reunion" where children and parents are together again for a period that signals the end of a session. Video filming and video feedback is an important component. There is a program manual.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT study was conducted in the USA with an initial sample of 193 mothers, and a final sample of 78 mothers (Steele et al. 2019).
Further resources	• Ainsworth, M., Blehar, M.,Waters, E., andWall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum. • Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books. (Original work published 1969) • Steele, H., Murphy, A., Bonuck, K., Meissner, P., and Steele, M. (2019). Randomized control trial report on the effectiveness of

	Group Attachment-Based Intervention (GABI©): Improvements in the parent-child relationship not seen in the control group, *Development and Psychopathology*, *31*, 203-217.

Evidence type	Evidence-informed program
Name of the program	Adults and Children Together Against Violence: Parents Raising Safe Kids Program
Brief description of program for search page	Adults and Children Together Against Violence: Parents Raising Safe Kids Program is a universal approach to prevention, incorporating education aimed at parents and primary caregivers.
Outcomes	• Parenting • Discipline/punishment
Strength of evidence	Mixed research evidence (with adverse effects)
Effectiveness	Mixed
About the program	Adults and Children Together Against Violence: Parents Raising Safe Kids Program was developed by the American Psychological Association, in collaboration with the National Association for the Education of Young Children. Adults and Children Together is a universal approach to prevention, incorporating education aimed at parents and primary caregivers. The overarching goals of the program are to make early violence prevention a central and ongoing part of the community and to educate adults about their important role in creating healthy and safe environments for children.
Who does it work for?	Adults and Children Together Against Violence: Parents Raising Safe Kids Program is a universal approach to violence prevention. However, one study was identified (Portwood et al. 2011) where all families involved had been referred to the Healthy Families America home visiting initiative, which is designed to prevent maltreatment among at-risk families with young children who were not yet part of the child welfare system. In this experimental study, the original sample comprised of 162 participants in the intervention group and 109 in the comparison group; 197 participants provided data the final sample. Intervention group participants had a mean age of 32.9 years, and control group participants had a mean age of 33.7. 70.7% were Hispanic. Families had a relatively low income, with 35.8% of the intervention group sample reporting annual household income below US$20,000. 40.1% of the sample were high school graduates. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES **Harsh punishment/discipline:** Parents who participated in the Adults and Children Together Against Violence: Parents Raising Safe Kids Program program were less likely to engage in harsh verbal and physical discipline, compared to parents who did not participate in the program. This remained true 3 months after the program had finished. However, these positive effects may be limited to parents who completed at least seven of the eight program sessions. **Nurturing:** Parents who participated in the program were more likely to exhibit nurturing behaviours. **NO EFFECT** **None.** **NEGATIVE OUTCOMES** **Parental stress:** Parents who participated in the Adults and Children Together Against Violence: Parents Raising Safe Kids Program reported increased levels of parenting stress over time.

Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with adverse effects): • At least one high-quality RCT/QED study reports statistically significant adverse effects for at least one outcome, AND • An equal number or more RCT/QED studies show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality RCT/QED study shows statistically significant positive effects for at least one outcome
How is it implemented?	The Adults and Children Together Against Violence: Parents Raising Safe Kids Program consists of eight 2-hour group sessions delivered by community service providers. The sessions cover: understanding child behaviour, children and violence, adults dealing with their anger, dealing with children's anger, resolving family conflicts in a positive way, positive discipline, educing the influence of media parents role in raising safe children. The program is designed to be implemented within the existing service delivery infrastructure. That is, pre-existing supports and programs should still be delivered.
How much does it cost?	Information not available
What else should I consider?	The reported positive effects may be limited to parents who completed at least seven of the eight program sessions.
Where does the evidence come from?	An experimental study with randomised assignment was conducted by Portwood et al. (2011) in the USA, with 271 families, comprised of an intervention group of 162 families, and a comparison group of 109 families; final sample 197 participants.
Further resources	• https://www.apa.org/pi/prevent-violence/programs/act • Portwood, S. G., et al. (2011). "An evaluation of the Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids program." Journal of Primary Prevention 32(3/4): 147-160.

Family Therapy

Evidence type	Evidence-informed program
Name of the program	Together We Can
Brief description of program for search page	Together We Can is a relationship and marriage education program. The program aims to develop relationship skills for adults in couple and co-parenting relationships.
Outcomes	• Discipline/punishment
Strength of evidence	Evidence fails to demonstrate effect
Effectiveness	No effect
About the program	Together We Can involves lectures, discussions, activities, case studies and role plays that promote experiential learning. There is an emphasis on the value of cooperative coparenting and healthy adult relationships in the family. The program is used with both married and unmarried parents, and materials are geared towards lower literacy populations. The program aims to develop relationship skills for adults in couple and co-parenting relationships. The program was developed by Shirer, Adler-Baeder and Contreras (2007).
Who does it work for?	One QED study was conducted in the US with a sample size of 314 children, with data collected on 154 children (Adler-Baeder et al. 2018). Participants were recruited from HeadStart programs in the US, attended by mothers with children. Children were aged 3-5 years. Of the sample, 93.6% were African American. The sample came from a low socioeconomic demographic:57.1% had an annual household income less than US$14,000; and 44.8% of mothers completed high school or less. Of the parents, 21% were married and 20% were not in a couple relationship.

	The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	POSITIVE OUTCOMES None NO EFFECT **Harsh punishment/discipline**: Outcomes were measured on four items in the Mother Report: Punitive Parenting Behaviours scale. Measurements were taken at baseline, post-test, 6 and 12 month follow-up. There was a positive reduction in self-reported punitive parent behaviours, but not a significant effect. Results show a significant decrease over time in punitive parenting in the intervention group and not in the control group. However, although there were significant decreases in punitive parenting for the intervention group, participants did not significantly improve in their parenting compared to nonparticipants.
Is the program effective?	Overall, the program had no effect on client outcomes.
How strong is the evidence?	Evidence fails to demonstrate effect: • At least one high-quality systematic review with meta-analyses based on RCT/QED studies reports no observed effects for all reported outcomes, OR • At least one high-quality RCT study reports no observed effects for all reported outcomes. • Criteria are not met for mixed research evidence (with or without adverse effects)
How is it implemented?	The program consists of a 2-hour session each week for 6 weeks. Sessions are delivered in a groupwork setting at a HeadStart centre. Transportation, childcare and meals are provided.
How much does it cost?	Information not available
What else should I consider?	The control group received written materials on healthy couple relationships and coparenting.
Where does the evidence come from?	A quasi-experimental design study was conducted with a sample of 314 children, with follow-up data collected on 154 children (Adler-Baeder et al. 2018).
Further resources	• https://www.canr.msu.edu/together_we_can • Adler-Baeder, F., Garneau, C., Vaughn, B., McGill, J., Harcourt, K.T., Ketring, S., and Smith, T. (2018). The effects of mother participation in relationship education on coparenting, parenting, and child social competence: Modeling spillover effects for low-income minority preschool children, *Family Process*, *57*, 113-130. • Shirer, K. A., Adler-Baeder, F., and Contreras, D. (2007). Together We Can: Creating a healthy future for family. A 24-lesson for unmarried parents on co-parenting, marriage, father involvement and child support issues. East Lansing, MI: Michigan State University.

Evidence type	Evidence-informed program
Name of the program	Family Group Conferencing
Brief description of program for search page	Family Group Conferencing is an intervention for families receiving in-home child welfare services. It is a family-centred practice that is intended to elevate the voice and the role of participants in the decision-making process and address the power differential between agency staff and families inherent in child welfare practice.
Outcomes	• Child abuse and neglect
Strength of evidence	Evidence fails to demonstrate effect
Effectiveness	No effect
About the program	Family Group Conferencing is an intervention for families receiving in-home child welfare services. It is a family-centred practice that is

	intended to amplify the voice and the role of participants in the decision-making process and address the power differential between agency staff and families inherent in child welfare practice. The program is intended to combat institutional racism. Family Group Conferencing is a process of widening the family and community circle to participate in decision making: the family group lead the development of the initial plan, including the provision of private family time; and follow-up and monitoring activities to support the family's and agency's progress toward achieving the agreed upon goals. The intervention was developed by the New Zealand Government and is based on Maori traditional decision-making processes.
Who does it work for?	One RCT was conducted in the USA with a sample size of 503families (Hollinshead et al. 2017). The families were clients of child protection services or social services and met specific case criteria of being referred to a Family Group Conference under child protection services policy. The mean age of the youngest child in the family was 2.3 years. Families were African American (32.4%); Hispanic (30%); and White (37.6%). The control group received 'business as usual' services which might or might not have included other meeting types, such as a Family Team Meeting (FTM). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	NO EFFECT **Child welfare involvement/contact with child protection services, Child abuse reports: Substantiated, Out-of-home placement**: No significant effect was found regarding new maltreatment allegations; substantiated re-referral to child welfare; or out-of-home placement. Effects were measured from treatment, to between 14- and 32-months post-treatment. African American mothers in the treatment group were more likely to be re-referred than other families.
Is the program effective?	Overall, the program had no effect on client outcomes.
How strong is the evidence?	Evidence fails to demonstrate effect: • At least one high-quality systematic review with meta-analyses based on RCT/QED studies reports no observed effects for all reported outcomes, OR • At least one high-quality RCT study reports no observed effects for all reported outcomes. • Criteria are not met for mixed research evidence (with or without adverse effects)
How is it implemented?	The program is implemented by an independent coordinator who implements the Family Group Conferencing process, including widening the family and community circle to participate in decision-making; organises the family group to lead the development of the initial plan, including the provision of private family time; and engages in follow-up and monitoring activities to support the family's and agency's progress towards achieving the agreed upon goals.
How much does it cost?	Information not available
What else should I consider?	Information not available
Where does the evidence come from?	One RCT study was conducted in the US with a sample size of 503 families (Hollinshead et al. 2017).
Further resources	• Hollinshead, D.M., Corwin, T.W., Maher, E.J., Merkel-Holguin, L., Allan, H., and Fluke, J.D. (2017). Effectiveness of family group

	conferencing in preventing repeat referrals to child protective services and out-of-home placements, *Child Abuse and Neglect*, 69, 285-294. • Nurmatov, B.U., Foster, C., Bezeczky, Z., Owen, J., El-Banna, A., Mann, M., Petrou, S., Kemp, A., Scourfield, J., Forrester, D., & Turley, R. (2020). Impact of shared decision-making family meetings on children's out-of-home care, family empowerment and satisfaction: A systematic review, *What Works for Children's Social Care*, https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_Shared_Decision-making_Family_Meetings_systematic_review_Feb2020.pdf • McGinn, T., Best, P., Wilson, J., et al. (2020) Family group decision-making for children at risk of abuse or neglect: A systematic review. *Campbell Systematic Reviews*; 16:e1088. https://doi.org/10.1002/cl2.1088

Appendix 10: Summaries of Core Components: Harm Reduction Interventions

Evidence type	Core components
Name of the set of core components	Reduction of harm
Brief description of the set	These four core components are common across programs that have been shown to reduce harm amongst vulnerable children 5 years of age and younger.
Outcomes	• Child abuse and neglect • Domestic violence • Safety • Neglect • Harsh punishment/discipline • Physical abuse • Harsh parenting • Positive parenting • Risk of child maltreatment
Name of the set of core components	Reduction of harm
About the set of core components	Four core components are present in programs that reduce harm amongst vulnerable children under 5 years of age. In 2021, an evidence review was conducted to understand what works to prevent child maltreatment. 33 evidence-informed programs were identified. A content analysis identified four commonalities across these programs. These four core components are the common activities across programs that have been shown to reduce harm among vulnerable children under 5 years of age. They make up standardised components of programs that support families where there is a need to reduce harm.
Who does it work for?	These core components are relevant to services working with families and carers of children to reduce harm amongst vulnerable children under 5 years of age.
Core components	**ENGAGEMENT** How services engage with families is crucial to ensuring parents/carers participate and continue with a program until they have achieved their goals. Flexible activities include: • Home visits • Engaging delivery of curriculum material • Overcoming barriers • Practical support for attendance • Flexible curriculum for individuals for cultural appropriateness

The most significant activities that engage families is sustained home visiting and engaging and relevant delivery of learning material. Overcoming barriers to engagement or attendance in a program increases the positive impact of the program. This can be done through practical support to support engagement, and ensuring the program is flexible enough to be tailored to the needs of the family.

BUILDING SUPPORTIVE RELATIONSHIPS AND SOCIAL NETWORKS

Supportive relationships between parents/carers and their infants and children are fundamental to reducing harm to children aged 0 to 5 years of age. The relationship with the service provider and the family is important to achieve this aim. Supportive relationships also enable parents/carers to seek advice and respite from others when needed.

Flexible activities include:

- Building the parent-child relationship
- Building the parent-service provider relationship

The curriculum material of the program includes activities to support parents to build supportive relationships with their children, and interaction between parent and child is often a focus of the delivery sessions. The relationship with the service provider is often built through regular delivery sessions over a long-time frame.

BUILDING PARENTAL CAPACITY

Providing parents/carers education, coaching, and modelling sessions, focusing on topics specific to parenting are vital. This might include practical advice about routines, typical infant and child behaviour, as well as introducing strategies for parents to build their capacity through skills to manage other aspects of their lives.

Flexible activities include:

- A standard curriculum of parenting skills
- Trained service providers
- Life skills

Activities to provide parenting capacity are often delivered using service providers trained in a specific curriculum or program. This can be delivered in several ways, primarily home visiting programs and parenting classes.

CASE MANAGEMENT

Understanding and addressing the needs of families is crucial to improving outcomes. This includes providing material, emotional and practical support to parents/carers. Interventions that aim to reduce harm for children are specifically targeted to at risk families. Universal programs are often not appropriate. Such families often have complex needs where further referrals are required.

Flexible activities include:

- Appropriate referrals
- Recruitment and screening
- Integration with other services and onward referrals

Activities include recruitment processes that are targeted, and pre-screen families to ensure the program is appropriate for their needs, integration of the program with other services, and the ability to make

	onward referrals to other services and agencies. These activities can be delivered with different levels of intensity and for short or long periods of time.
Further resources	See Appendix 11

Appendix 11: Summaries of Flexible Activities: Harm Reduction Interventions

Flexible Activities for Core Component #1: Engagement

Name of the flexible activities	Home visits
Description	The activity of home visits is where a program is substantially delivered through the service provider visiting the family in their home.
How can it be implemented?	During these home visits, the home visitor builds a relationship with the family, and curriculum content is delivered through activities and conversation in these visits. The home visitor also monitors the child in their home environment, and may carry out risk assessments of the home, including observation of hazards, parental behaviour, etc. The number of visits varies by program, as does the time over which the visits occur, from 10 weeks to three years.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families assessed as being likely to benefit from a prevention service • African American mothers who have not accessed adequate prenatal care • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect
What programs conduct this activity?	**Nurse-Family Partnership**: Weekly visits begin while the mother is pregnant and continue each week until the baby is 6 weeks old, then less frequently until the child is 2 years old. **Australian Nurse-Family Partnership Program**: The program is delivered through home visits. Aboriginal community workers acted as cultural brokers and advisors for Program Managers, Nurse Home Visitors and clients. The program also had an open referral pathway, and was not restricted to first-time mothers. **Healthy Families America**: Home visits are scheduled weekly for newborns during the first 6 months and then taper off as the family makes progress in the program, up until the child is three. Sometimes there are bi-weekly visits during pregnancy. **Early Start**: Regular home visits over 36 months for preschool age children. An initial needs assessment was conducted through four weekly visits, to determine the subsequent level of intervention. **Right@Home**: 25 nurse home visits, from pregnancy through to when the child is 2 years old. Visits become less frequent over time.

	Parents as Teachers (PAT): The program is delivered through home visits. The program runs for up to 3 years if a child is enrolled at birth. **Pride in Parenting**: Participants receive visits from the home visitor for 1 year. Visits occur weekly from birth through 4 months and biweekly from 5 to 12 months. **Healthy Steps for Young Children**: Up to 6 home visits in the first three years **Parents as Teachers + SafeCare at Home (PATSCH):** There are 12 sessions that are delivered through weekly or biweekly home visits. **SafeCare**: This is an 18 to 24-week program comprised of three modules; each module is typically offered in parents' homes over six sessions. **SafeCare+**: An 18 to 24-week program comprised of three modules; each module is typically offered in parents' homes over six sessions. SafeCare+ includes the addition of motivational interviewing and training home visitors on identification and response to imminent child maltreatment and various risk factors. **SafeCare Dad2K**: An 18 to 24-week program specifically for fathers, comprised of three modules; each module is typically offered in parents' homes over six sessions. **Hamilton Nurse Home Visiting Program**: Families received a visit of 1.5 hours every week for 6 months, then every 2 weeks for 6 months, then monthly for a further 12 months. **Promoting First Relationships**: Weekly home visits for ten weeks.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	The background, experience and level of training of the home visit staff is important. Home visitors have different levels of training and skills, and might be peer community members, nurses or social workers. Others involved in the programs include: • family support workers with nursing or social work qualifications • trained parent educators • community-based service providers with master's degrees in social work or counselling • community-based home visitors receiving training and direct supervision from the module's educator • public health workers.
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership Program • Healthy Families America • Early Start • Right@Home • Parents as Teachers • Pride in Parenting • Healthy Steps for Young Children • Parents as Teachers + SafeCare at Home (PATSCH) • SafeCare

	• SafeCare+ • SafeCare Dad2K • Hamilton Nurse Home Visiting Program • Promoting First Relationships

Name of the flexible activities	Engaging delivery of curriculum material
Description	Curriculum material delivered in ways that engaged participants through several different ways.
How can it be implemented?	Programs introduced material in different ways, some programs using a mix of delivery modalities. The activities that took place to introduce curriculum material included: • Conversations with home visitors • Activities between children and parents such as play-based activities • Recording video of interactions between children and parents, for review, discussion and coaching • "Bug in the ear" coaching by program staff, live during play between parent and child • Group family sessions • Playgroups • Group role plays • Use of digital media, e.g, Video vignettes for review and group discussion, e-modules for completion by parents • Provision of resources such as calendars, important contacts
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families assessed as being likely to benefit from a prevention service. • African American mothers who have not accessed adequate prenatal care • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Families where the child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development; or the parents lacked parenting skills • Culturally diverse communities. • Multigenerational migrant communities, low-income migrant families, foster families, and families • Low-income Chinese families in Hong Kong • Mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child
What programs conduct this activity?	**Pride in Parenting:** The group session format is a 45-minute parent/infant playgroup focused on developmental issues, followed by a 45-minute parent group discussion. **SafeCare**: ongoing measurement of observable behaviours, direct observation in role-play situations, skill modelling, practice and feedback.

	SafeCare+: ongoing measurement of observable behaviours, direct observation in role-play situations, skill modelling, practice and feedback. SafeCare Dad2K: ongoing measurement of observable behaviours, direct observation in role-play situations, skill modelling, practice and feedback, use of multimodal learning and modeling of SafeCare target skills through dynamic software-based activities. **Promoting First Relationships**: The parent and child are recorded playing together, the provider will then review a recorded play session with the parent. The provider and parent reflect on the recorded interactions, noting what the child is doing in relation to the caregiver's behaviour and what the caregiver is doing in response to the child. **Johns Hopkins Children and Youth Program**: A calendar was developed and given to each parent at the first visit, and included information on child development, seasonal safety tips, clinic hours, and names and telephone numbers. **Chicago Parent Program**: employs videotaped vignettes, a group discussion format that corresponds to principles being addressed in each of the vignettes, and a collaborative interpersonal style for guiding the way group leaders engage parents in the intervention. Parents receive weekly homework assignments and handouts summarizing important points from each session. **Family Support Program**: The program consists of a mix of delivery modalities • Individualised sessions with the parents at home • individual or group sessions in preschool • Video-modelling • Written resources development of the intervention team **ParentCorps**: Face-to-face groups in school settings are provided by trained residents and social workers. The teachers who co-lead the family program receive a professional development program which includes large group-based activities to introduce strategies and consultation to facilitate the adoption and tailoring of strategies. **Parent-Child Interaction Therapy**: PCIT skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children. Parent–child dyads are observed through a one-way mirror and, by using a bug-in-the-ear device, parents are coached to attend to the child's behaviours consistently and predictably. **Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline**: At home visits, interactions between the mother and child are video-recorded and used as the basis for subsequent discussion about parenting strategies **The Incredible Years Shortened Basic Version**: parents improve their parenting skills through practice with their child, paralleled by role play and discussion in groups of parents. **The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits**: parents improve their parenting skills through practice with their child, paralleled by role play and

	discussion in groups of parents. This version of the program involves the addition of home visits. **Parent Training Program**: Three approaches were used to facilitate the learning process: Metaphor (using the living plant as a symbol of growth and nurturing); peer learning (encouraging parents to learn from each other through group discussion); and Role playing and planning. **Group Attachment-based Intervention**: The program is delivered in a multifamily clinical setting with group activities. There is (a) a specified time for parents and children under 3 years of age to interact with one another, (b) a time for parents to interact with other parents while their children experience individual time with their age-mates in the presence of trained clinicians who help them to engage with peers, and finally, and (c) a "reunion" where children and parents are together again for a period that signals the end of a session. Video filming and video feedback is an important component.
What local knowledge is there about this activity?	This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.
What else should I consider?	No further information
Further resources	• Pride in Parenting • SafeCare • SafeCare+ • SafeCare Dad2K • Promoting First Relationships • Johns Hopkins Children and Youth Program • Chicago Parent Program • Family Support Program • ParentCorps • Parent-Child Interaction Therapy • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • Parent Training Program • Group Attachment-based Intervention

Name of the flexible activities	Practical support for attendance
Description	Practical support for families to participate in the program can overcome barriers to attendance and engagement.
How can it be implemented?	These practical support activities were the provision of transport, childcare meals and incentives such as gift voucher raffles.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Universal • Culturally diverse communities

What programs conduct this activity?	**Nurse-Family Partnership:** Sometimes mothers are offered transport to prenatal check-ups and well-child visits at health clinics. **Healthy Steps for Young Children:** a telephone line for non-emergency developmental concerns. **HeadStart:** Provision of childcare is core to program design. **Relief Nursery Program:** Other services are provided as needed, including respite care and transportation to and from services. Food was provided. **ParentCorps:** Meals were provided. Childcare and a creative arts group were provided for children. A gift card raffle was used to maintain parents' motivation to attend the sessions.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Healthy Steps for Young Children • HeadStart • Relief Nursery Program • ParentCorps

Name of the flexible activities	Flexible curriculum for individuals or for cultural appropriateness
Description	Although programs have a standard curriculum / manual, there are opportunities to tailor the curriculum to the needs of individual families, or to tailor the program to the needs of different cultural or target groups.
How can it be implemented?	This flexible activity involves decision-making by program service delivery staff about the most appropriate elements and ways of delivering curriculum content to families in a particular local context, based on individual family needs. This activity ensures that programs are delivered in a culturally appropriate way, through a number of strategies: consultation with cultural or community groups, changes incorporated into the program prior to delivery (e.g., pace and order of content delivery; simplification of materials for low literacy groups); using community members to deliver the program; and delivering the program in families' language.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • African American mothers who have not accessed adequate prenatal care • Aboriginal mothers in Central Australia • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Children who showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • Parents who lacked parenting skills

	• Multigenerational migrant communities, low-income migrant families, foster families
What programs conduct this activity?	**Australian Nurse-Family Partnership Program**: An adaptation of the Nurse-Family Partnership for remote Aboriginal communities. The ANFPP has a culturally appropriate approach. The main adaptation was to include Aboriginal community workers in the home visiting team. They play an essential role, bringing an understanding of the local Aboriginal community and ensuring the program is delivered in a culturally safe way. **Healthy Families America:** The content of the visits is intended to be individualised and culturally appropriate, but based on approved curricula. Content was nonjudgmental, and helped mothers identify their own reasons for participating in home visiting or making change in a key risk factor; sessions elicited and incorporated mothers' preferences, reactions and evaluations of the content. Home visits taper off as the family makes progress in the program. **Early Start:** The delivery of services was based on a common principle of understanding of the client's individual and cultural perspective. The program of home visitation is tailored to meet individual family need, the program should be adapted to clients' needs. An initial needs assessment was conducted through four weekly visits, to determine the subsequent level of intervention. **Parents as Teachers:** Curriculum elements are provided at the discretion of the home visitor to allow flexibility. **Pride in Parenting:** A health educator with expertise in work with low-literate and racial-ethnic minority populations helped create new materials and selected the final materials. Materials were culturally appropriate and relevant to the lives of low-income women. Paraprofessional visitors were drawn from the African American community to effectively influence the mothers' parenting behaviours and attitudes. **Hamilton Nurse Home Visiting Program:** The nurses tailor home visits to the individual needs of the family. **HeadStart:** The delivery and implementation of programs varies widely from site to site due to a number of factors, including community characteristics. Services provided to individual families are tailored to their individual needs and circumstances. **Relief Nursery Program:** On an as needed basis, mental health and special education services are integrated into the classroom. Other services are provided as needed, including respite care, child nutrition, transportation to and from services, and individual and family counselling. Staff offered the program in the parents' primary language. **Chicago Parent Program:** The program was developed in collaboration with a parent advisory group of African American and Latino parents from a range of economic backgrounds. **Family Support Program:** The program is flexible and could be adapted to meet the individual needs of each family. Practitioners for each family were chosen based on the central problem of parents and specific intervention areas.

	Self-directed Triple P: Consistent with Triple P's overall emphasis on parent self-regulation, parents learn to modify their own behaviour through a process of planned, self-directed change to promote parental self-sufficiency. **Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline**: Can be tailored to specific groups (e.g., foster carers) and (e.g., longer home visits in Turkish families' program) as more culturally appropriate. **The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits:** One in a series of group-based programs for parents of children at different ages. Parents are given exercises at home on an individual basis. **The Incredible Years Shortened Basic Version**: One in a series of group-based programs for parents of children at different ages. Parents are given exercises at home on an individual basis.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Healthy Families America • Early Start • Parents as Teachers • Pride in Parenting • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • Chicago Parent Program • Family Support Program • Self-directed Triple P • Video-Feedback to Promote Positive Parenting and Sensitive Discipline • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version

Name of the flexible activities	Overcoming Barriers
Description	Overcoming barriers to engagement or attendance in a program increases the positive impact of the program. This can be done through practical support to attend, and ensure the program is flexible enough to be tailored to the needs of the family.
How can it be implemented?	Programs are designed and delivered with sensitivity to the circumstances of participants, including their cultural and socio-economic identities and considerations. The delivery includes specific approaches to support attendance and engagement.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse

	• African American mothers who have not accessed adequate prenatal care • Aboriginal mothers in Central Australia • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • Parents lacked parenting skills • Multigenerational migrant communities, low-income migrant families, foster families, and families • Universal • Culturally diverse communities
What programs conduct this activity?	**Australian Nurse-Family Partnership:** An adaptation of the Nurse-Family Partnership for remote Aboriginal communities. The main adaptation was to include Aboriginal community workers in the home visiting team. **Healthy Steps for Young Children:** a telephone line for non-emergency developmental concerns. **HeadStart:** Services provided to individual families are tailored to their individual needs and circumstances. **Relief Nursery Program:** Other services are provided as needed, including respite care and transportation to and from services. On an as needed basis, mental health and special education services are integrated into the classroom. Staff offered the program in the parents' primary language. **ParentCorps:** Childcare and meals provided. **Healthy Families America:** Home visiting at an early stage and then phased out as families engage and make progress. **Early Start:** The program of home visitation is tailored to meet individual family need, the program should be adapted to clients' needs. **Parents as Teachers:** Curriculum elements are provided at the discretion of the home visitor to allow flexibility. **Pride in Parenting:** A health educator with expertise in work with low-literate and racial-ethnic minority populations helped create new materials and selected the final materials. Materials were culturally appropriate and relevant to the lives of low-income women. Paraprofessional visitors were drawn from the African American community to effectively influence the mothers' parenting behaviours and attitudes. **Hamilton Nurse Home Visiting Program:** The nurses tailor home visits to the individual needs of the family. **Chicago Parent Program:** The program was developed in collaboration with a parent advisory group of African American and Latino parents from a range of economic backgrounds. **Family Support Program:** The program is flexible and could be adapted to meet the individual needs of each family.

	Video-Feedback to Promote Positive Parenting and Sensitive Discipline: Can be tailored to specific groups and as more culturally appropriate.
What local knowledge is there about this activity?	This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.
What else should I consider?	No further information
Further resources	• Australian Nurse-Family Partnership Program • Healthy Steps for Young Children • HeadStart • Relief Nursery Program • ParentCorps • Healthy Families America • Early Start • Parents as Teachers • Pride in Parenting • Hamilton Nurse Home Visiting Program • Chicago Parent Program • Family Support Program • Video-Feedback to Promote Positive Parenting and Sensitive Discipline

Flexible Activities for Core Component #2: Building Supportive Relationships

Name of the flexible activities	Building the parent-child relationship
Description	Improving the parent-child relationship was foundational to achieving the goal of reduction of harm to children.
How can it be implemented?	The curriculum material that aimed to build parenting skills did this through supporting and building the relationship between parent and child, for example by building skills of maternal sensitivity. Activities between parent and child were incorporated into many of the programs to strengthen this relationship, for example, attendance of parents and children at playgroups, and receiving feedback and coaching using video-recorded parent-child interactions.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Families with a child showing signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • Multigenerational migrant communities, low-income migrant families, foster families, and families • Low-income Chinese families in Hong Kong • Families with children with behavioural concerns who might be at risk for maltreatment
What programs conduct this activity?	**Healthy Families America**: One of the four primary areas of program treatment is improving the parent-child relationship by promoting parent-child attachment and positive parent-child interactions, through home visits. **Parents as Teachers + SafeCare at Home (PATSCH)**: The goals of the program are to improve parent-child relationships, through home visiting by trained parent educators. **Promoting First Relationships**: PFR service providers are trained to observe and assess the qualities of the relationship between the parent and child. **Relief Nursery Program**: Home Visiting in which early childhood program teachers work to promote the parent/child relationship **Parent-Child Interaction Therapy**: A central goal is to strengthen the parent-child bond through clinically base therapy. **Self-directed Triple P:** is based on social learning principles and its purpose is to promote positive caring relationships between parents and children. Self-directed Triple P targets coercive family interactions known to contribute to the development and maintenance of children's disruptive behaviour problems. **Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline**: Parents are encouraged to show more sensitive responsiveness by helping them to notice child signals,

	interpret them correctly, and respond to them promptly and appropriately. **Child-Adult Relationship Enhancements in Primary Care**: The theoretical foundation is derived from attachment and social learning theory.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Healthy Families America • Parents as Teachers + SafeCare at Home (PATSCH) • Promoting First Relationships • Relief Nursery Program • Parent-Child Interaction Therapy • Self-directed Triple P • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline • Child-Adult Relationship Enhancements in Primary Care

Name of the flexible activities	Building the parent-service provider relationship
Description	The success of the programs is often dependent on a trusting relationship between the parent and the service provider.
How can it be implemented?	Activities that build the trust relationship between parent and service provider were often through regular home visiting for an extended period. In some programs, the home visitor was a peer or same cultural background community member who had been trained in the program.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families assessed as being likely to benefit from a prevention service • African American mothers who have not accessed adequate prenatal care • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • Culturally diverse communities
What programs conduct this activity?	**Nurse-Family Partnership**: Trusting relationship built between home visitor and parent. Home visits are continued for two years. **Australian Nurse-Family Partnership Program**: Aboriginal community workers were included as part of the home visiting team. **Healthy Families America**: Relationship built between home visitor and parent. Home visits are continued for three years.

	Early Start: Relationship built between home visitor and parent. Home visits are continued for three years. Each family support worker supports 10 to 20 families. Positive partnerships were developed between the family support worker and client. Program staff are involved with families throughout the child's preschool years **Right@Home**: Relationship built between home visitor and parent. Home visits are continued for two years. **Parents as teachers**: Relationship built between home visitor and parent. Home visits are continued for up to 3 years if a child is enrolled at birth. Families received warm/facilitated referrals to other services. **Pride in parenting**: Home visitors established a supportive, cooperative relationship with mothers, while responding to their individual needs. Trained home visitors of the same racial/ethnic backgrounds as the participants enhance trust and communication during delivery of the intervention **Johns Hopkins Children and Youth Program**: Relationship built between home visitor and parent. Fortnightly home visits are continued for two years. **Hamilton Nurse Home Visiting Program:** Relationship built between home visitor and parent. Home visits are continued for two years. **HeadStart:** Involvement of parents in HeadStart Centres where children received childcare, and a relationship with a home visitor. **Relief Nursery Program**: Social support is seen as a key protective factor and is given focus in each of the core components. Teachers, specialist and parents work together to establish individual goals for each child and find and access needed services. **The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits**: Providers interact with families in a non-shaming way, which builds trust and rapport between providers and parents. **The Incredible Years Shortened Basic Version:** Providers interact with families in a non-shaming way, which builds trust and rapport between providers and parents. **ParentCorps:** School personnel facilitate the parenting intervention and concurrent group for children. **SEEK**: The certified social worker worked closely with the physician and parents as requested.
What local knowledge is there about this activity?	This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership Program • Healthy Families America • Early Start • Right@Home • Parents as Teachers

	• Pride in Parenting • Johns Hopkins Children and Youth Program • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • ParentCorps • Safe Environment for Every Kid

Flexible Activities for Core Component #3: Building Parental Capacity

Name of the flexible activities	Standard curriculum of parenting skills
Description	Building parental capacity through delivery of a standard curriculum was central to the programs. Programs with this core component focus on building parenting skills, including knowledge relating to child safety.
How can it be implemented?	Many of the widespread programs have a core curriculum with a manual. Sometimes a core curriculum is used as a basis for the program, and is delivered in combination with other activities appropriate for the target group. One program (PATSCH) takes two curricula appropriate for the needs of the group, and packages them into one program. Activities to build parenting skills are implemented through the content of the curriculum or intervention that is delivered. Topic areas include: • Promoting positive child development using child development activities with families • Skills of parent-child attachment and positive parent-child interactions • Supporting healthy child sleep patterns • Child nutrition • Supporting child behaviour regulation • Identifying safety hazards in the home
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families assessed as being likely to benefit from a prevention service • African American mothers who have not accessed adequate prenatal care • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • Universal • Child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • The parents lacked parenting skills • Culturally diverse communities • Low-income Chinese families in Hong Kong

	• Families with children with behavioural concerns who might be at risk for maltreatment • for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child
What programs conduct this activity?	**Nurse-Family Partnership:** Standard curriculum is based on the work of Olds and colleagues (1994) and covers three aspects of maternal functioning: health-related behaviours during pregnancy and the early years of the child's life, the care parents provide to their children, and maternal life-course development (such as family planning, educational achievement, and participation in the workforce). **Australian Nurse-Family Partnership Program:** Standard curriculum is based on the work of Olds and colleagues (1994) and covers three aspects of maternal functioning: health-related behaviours during pregnancy and the early years of the child's life, the care parents provide to their children, and maternal life-course development (such as family planning, educational achievement, and participation in the workforce). **Healthy Families America:** The content of the visits is intended to be individualised and culturally appropriate, but based on approved curricula. This includes promoting positive child development using child development activities with families and promoting appropriate age-development expectations; and improving the parent-child relationship by promoting parent-child attachment and positive parent-child interactions. **Right@Home:** The program is structured around the core MECSH framework and training (Kemp et al. 2011), bolstered by 5 evidence-based strategies for content (sleep, safety, nutrition, regulation, and bonding and/or relationship) and 2 for the delivery process (video feedback and motivational interviewing strategies). **Parents as Teachers:** There is a set curriculum, and curriculum elements are provided at the discretion of the home visitor to allow flexibility. **Pride in Parenting:** The focus of the curriculum is to improve knowledge, influence attitudes, and promote life skills. Topics for home visits include newborn care, women's health needs, healthy relationships, family planning, immunisations, health visits, safety in the home, budgeting, developing social support, involvement of fathers, managing child behaviour, drug use and smoking. **Healthy Steps for Young Children:** The program includes written materials that are used in home visits and parenting groups. **Parents as Teachers + SafeCare at Home (PATSCH):** This program brings together the SafeCare and Parents as Teachers curricula. The PATSCH curriculum covers parent/child interaction, home safety, child health, development centred parenting, and family wellbeing. **SafeCare:** SafeCare is a structured training program that targets particular skills and behaviours. **SafeCare+:** SafeCare is a structured training program that target particular skills and behaviours. SafeCare+ includes additional motivational interviewing for parents.

SafeCare Dad2K: SafeCare is a structured training program that target particular skills and behaviours and is designed specifically for fathers.

Promoting First Relationships: Set ten-week program delivered by skilled clinicians.

Johns Hopkins Children and Youth Program: A set of parenting education topics, used by the home visitor with parents.

Hamilton Nurse Home Visiting Program: The nurses cover parent education topics contained in the program manual during the home visits, tailored to the individual needs of the family.

HeadStart: HeadStart programs deliver a parenting education curriculum, adapted in local contexts to contain slight differences.

Relief Nursery Program: The program includes group-based parent education.

Chicago Parent Program: Parent education, based on the The Incredible Years, is delivered in face-to-face, facilitated parent groups. Parents receive weekly homework assignments and handouts summarizing important points from each session.

Family Support Program: The program provides parenting education in child development, health care, nutrition, and parent–child interaction activities. Written resources have been developed.

ParentCorps: The program includes core behavioural change strategies that are found in other parenting interventions (e.g., The Incredible Years, Triple P). The intervention curriculum aims to strengthen the following three key domains of parenting: positive behaviour support (e.g., reinforcement, proactive strategies), behaviour management (e.g., consistent consequences), and parent involvement in early learning (e.g., reading to children, communicating with teachers).

Parent-Child Interaction Therapy: Skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children.

Self-directed Triple P: The program comprises a parenting text and parent workbook, which cover 17 core child management strategies.

Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline: Standardised program to ensure fidelity.

The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits: One in a series of group-based programs for parents of children at different ages, which aim to teach parents positive disciplinary strategies (play, praise, and rewards). Each program has a structured treatment manual.

The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits: One in a series of group-based programs for parents of children at different ages, which aim to teach parents positive disciplinary strategies (play, praise, and rewards). Each program has a structured treatment manual.

	SEEK: Physicians received laminated pocket cards with salient information, and a handbook with comprehensive practical information including local resources, and user-friendly parent handouts. **Parent Training Program:** Curriculum material covers use more active listening skills, engage less in harsh parenting practices, use more praise and encouragement, and set reasonable expectations in the rearing of their children. **Child-Adult Relationship Enhancements in Primary Care:** This is a trauma-informed group training program to teach caregivers techniques to support the social and emotional growth of children. **Group Attachment-based Intervention:** The program is delivered in a multifamily setting with group activities and there is a program manual. **Adults and Children Together Against Violence:** The program incorporates education aimed at parents and primary caregivers. There are 8 two-hour sessions providing research-based content on understanding child behaviour. There is a program manual.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership Program • Healthy Families America • Right@Home • Parents as Teachers • Pride in Parenting • Healthy Steps for Young Children • Parents as Teachers + SafeCare at Home (PATSCH) • SafeCare • SafeCare+ • SafeCare Dad2K • Promoting First Relationships • Johns Hopkins Children and Youth Program • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • Chicago Parent Program • Family Support Program • ParentCorps • Parent-Child Interaction Therapy • Self-directed Triple P • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • Safe Environment for Every Kid • Parent Training Program • Child-Adult Relationship Enhancements in Primary Care • Group Attachment-based Intervention

	• Adults and Children Together Against Violence

Name of the flexible activities	Trained service providers
Description	The knowledge and skills of the service providers are important to develop the capacity of parents.
How can it be implemented?	Service providers who deliver the program as home visitors, facilitators or clinicians are trained in the program, and often have prior professional qualifications, skills, and experience. These include medical clinicians or residents, social or family support workers trained in a particular program. Sometimes the program service provider has lived experience and cultural knowledge, and training in the program.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Families assessed as being likely to benefit from a prevention service • Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect • African American mothers who have not accessed adequate prenatal care • Universal • Child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • The parents lacked parenting skills • Culturally diverse communities • Families with children with behavioural concerns who might be at risk for maltreatment • For mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child
What programs conduct this activity?	**Nurse-Family Partnership:** The home visitor is a qualified nurse. **Australian Nurse-Family Partnership Program**: The home visitor is a qualified nurse. **Early Start:** Family support workers have nursing or social work qualifications and have also attended a five-week training program specific to Early Start. **Right@Home:** The home visitor is a qualified nurse. **Pride in Parenting:** The program uses paraprofessional home visitors who participate in a 45-day intensive training on issues to be covered and the specific content for each visit. **Healthy Steps for Young Children:** The model introduces a child development expert trained in the Healthy Steps approach into the pediatric primary care practice. **PATSCH:** The program is delivered by trained parent educators.

	Promoting First Relationships: The program is delivered by community-based service providers, with master's degrees in social work or counselling, certified to deliver the program. **Johns Hopkins Children and Youth Program:** The program employs paediatricians, nurses, parent education specialists, social workers and support staff. Community based home visitors receiving training and direct supervision from module's educator (Johns Hopkins University) and the social worker. **Hamilton Nurse Home Visiting Program:** Nurses who deliver the program have previous experience working with socially disadvantaged families, and with child protection services. **HeadStart:** The program is provided by trained providers. **Relief Nursery Program:** This program is delivered by appropriately qualified people with ongoing education, training, and individual and group supervision. **Family Support Program:** The program is delivered by a multi-disciplinary team including a social worker, a psychologist, an early childhood educator and two social educators. **ParentCorps:** Face-to-face groups in school settings are provided by trained residents and social workers. These facilitators undertake a Professional Development Program. The teachers who co-lead the family program also receive training. **Parent-Child Interaction Therapy:** The program is delivered by master- and doctoral-level psychologists or social workers trained in PCIT. **The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits:** The program is delivered by professionals specifically trained and accredited. **The Incredible Years Shortened Basic Version:** Group leaders are trained nurses specialising in public healthcare, with experience in clinical work. Group leaders are trained according to certification procedures established by The Incredible Years program, and receive continuous supervision through observations, role play, and video reviews from a certified trainer and two mentors. **SEEK:** The program is delivered by physicians, social workers, early interventionists, early childhood teachers, and other service professionals. The social worker and physician are trained in the use of this program. **Child-Adult Relationship Enhancements in Primary Care:** The program is delivered in a clinical setting by clinicians. **Group attachment-based intervention:** The program operates in a clinical setting with trained clinicians. **Adults and Children Together Against Violence:** The program is designed to be delivered by trained facilitators, who are also professionals who work for organisations and agencies that provide educational, social and/or mental health services to families and children, teachers, or advocates.

What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership • Early Start • Right@Home • Pride in Parenting • Healthy Steps for Young Children • Parents as Teachers + SafeCare at Home (PATSCH) • Promoting First Relationships • Johns Hopkins Children and Youth Program • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • Family Support Program • ParentCorps • Parent-Child Interaction Therapy • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • Safe Environment for Every Kid • Child-Adult Relationship Enhancements in Primary Care • Group Attachment-based Intervention • Adults and Children Together Against Violence

Name of the flexible activities	Life skills
Description	This activity is designed to support the parent by developing their capacity and skills relating to other aspects of their life, through didactic teaching and coaching on topics that are not directly related to parenting.
How can it be implemented?	This activity is implemented through curriculum material on capacity and skills unrelated to parenting behaviours, child relationship and child development. These include: • Promoting positive mental health • Goal setting • Budgeting • Collaborative problem solving to devise solutions to family challenges • Mentoring and advice to assist client families to mobilise their strengths and resources
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • African American mothers who have not accessed adequate prenatal care
What programs conduct this activity?	**Nurse-Family Partnership:** The nurses promote maternal life-course development (such as family planning, educational achievement, and participation in the work force).

	Australian Nurse-Family Partnership Program: The nurses and Aboriginal community workers work with pregnant women to identify strengths and opportunities, develop strategies to achieve goals and build the mothers' capacity to identify solutions to problems. **Healthy Families America:** One primary area of the program is enhancing maternal life course outcomes by promoting positive mental health, goal setting and problem solving, referrals for assistance with substance abuse, mental illness, and interpersonal violence and continuing education, training, and employment. **Early Start:** A critical element of this model is the provision of support, mentoring, and advice to assist client families to mobilise their strengths and resources in order to improve parent physical and mental health; family economic and material wellbeing; and stable and positive intimate partnerships. **Pride in Parenting:** One focus of the curriculum is to promote life skills. Topics for home visits include women's health needs, healthy relationships, family planning, budgeting, developing social support, involvement of fathers, drug use and smoking.
What local knowledge is there about this activity?	This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership Program • Healthy Families America • Early Start • Pride in Parenting

Flexible Activities for Core Component #4: Case Management

Name of the flexible activities	Recruitment and screening
Description	It is important that programs are delivered to the intended participant group, through targeted recruitment and screening practices.
How can it be implemented?	Recruitment and screening activities are by recruiting participants through channels and populations that access the target groups, such as those already involved in child welfare services, or via paediatrics practices. Screening of families that intend to participate in the program is another such activity and can be done through standardised assessment tools. Note that in the studies identified, recruitment and screening were often done for the purposes of the research study, rather than solely to ensure that participants are in target group for the purpose of family engagement.
Who is the target group?	This flexible activity has been implemented to target several different target groups in all programs. See below for details by program. In the studies that were found through this review, the study explained how participants had been recruited for the study, but not necessarily for the intervention.
What programs conduct this activity?	This flexible activity has been implemented to target different groups: **Johns Hopkins Children and Youth Program, Relief Nursery Program, Safe Environment for Every Kid:** First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status. **Nurse-Family Partnership**: Families experiencing vulnerability - young mothers, single mothers, and families of low socioeconomic status. **Australian Nurse-Family Partnership Program**: Aboriginal mothers in Central Australia. **PATSCH, Hamilton Nurse Home Visiting Program, HeadStart, Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline, Adults and Children Together Against Violence:** Families with risk indicators e.g., education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse. **Right@Home:** Families assessed as being likely to benefit from a prevention service. **Pride in Parenting**: African American mothers who have not accessed adequate prenatal care. **Parents as Teachers, SafeCare, Promoting First Relationships:** Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect. **Family Support Program, Parent-Child Interaction Therapy, The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits, The Incredible Years Shortened Basic Version**: Children who showed signs of social behavioural problems; and/or had difficulties with socio-emotional or cognitive development. **Family Support Program:** Parents who lack parenting skills.

	ParentCorps: Culturally diverse communities. **Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline**: Multigenerational migrant communities, low-income migrant families, foster families. **Parent training program**: Low-income Chinese families in Hong Kong. **Child-Adult Relationship Enhancements in Primary Care**: Families with children with behavioural concerns who might be at risk for maltreatment. **Group Attachment-Based Intervention**: Mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Australian Nurse-Family Partnership • Healthy Families America • Early Start • Right@Home • Parents as Teachers • Pride in Parenting • Parents as Teachers + SafeCare at Home (PATSCH) • SafeCare • Promoting First Relationships • Johns Hopkins Children and Youth Program • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • Chicago Parent Program • Family Support Program • ParentCorps • Parent-Child Interaction Therapy • Self-directed Triple P • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • Safe Environment for Every Kid • Parent Training Program • Child-Adult Relationship Enhancements in Primary Care • Group Attachment-based Intervention • Adults and Children Together Against Violence

Name of the flexible activities	Integration with other services and onward referrals
Description	This activity integrates the program within a context of a range of services available to families.
How can it be implemented?	This activity embeds the program in paediatric clinical practice or integrates well-child visits with the GP or paediatrician into the

	program or integrates parenting programs and support with childcare delivery at HeadStart centres.
Who is the target group?	This flexible activity has been implemented with several different target groups. Key characteristics include: • First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status • Aboriginal mothers in Central Australia • Families at risk using indicators such as education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse • Universal • Child showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development • Parents who lack parenting skills • Culturally diverse communities
What programs conduct this activity?	**Nurse-Family Partnership:** Mothers are offered transport to prenatal check-ups and well-child visits at health clinics on a needs basis. **Healthy Families America:** The program facilitates child health through child well visits and use of health care and community resources. **Healthy Steps for Young Children:** The model introduces a child development expert trained in the Healthy Steps approach into the pediatric primary care practice for an integrated approach to the child. Parents are provided with linkages to community resources. **Johns Hopkins Children and Youth Program:** The Johns Hopkins Children and Youth program employs paediatricians, nurses, parent education specialists, social workers and support staff. For psychosocial issues, the home visitor refers the family to the social worker or educator, as indicated by the nature and severity of the problems encountered **Hamilton Nurse Home Visiting Program:** One of the three main activities in the program is linkage with other services. **HeadStart:** HeadStart integrates childcare, health centres and home visiting. **Relief Nursery Program:** On an as needed basis, mental health and special education services are integrated into the classroom. All children participate in developmental screening. Other services are provided as needed, including respite care, child nutrition, transportation to and from services, and individual and family counselling. **Family Support Program:** The program is delivered by a multi-disciplinary team including a social worker, a psychologist, an early childhood educator and two social educators. **ParentCorps:** The program operates in a school setting, with school personnel (mental health professionals and teachers) as the facilitators of a parenting intervention and a concurrent group for children.

	Safe Environment for Every Kid: Embedded in paediatric clinics to families of children aged 0-5 years. Early interventionists, early childhood teachers, and other service professionals were called on as needed to give advice and make referrals.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	• Nurse-Family Partnership • Healthy Families America • Healthy Steps for Young Children • Johns Hopkins Children and Youth Program • Hamilton Nurse Home Visiting Program • HeadStart • Relief Nursery Program • Family Support Program • ParentCorps • Safe Environment for Every Kid

Name of the flexible activities	Appropriate Referrals
Description	Interventions that aim to reduce harm for children are specifically targeted to at-risk families. Universal programs are often not appropriate. Such families often have complex needs where further referrals are required.
How can it be implemented?	Appropriate referral involves identification of suitable families already involved in child welfare services, or attending paediatric practices, and screening with standardised assessment tools. Integration with other services facilitates onward referrals, as required.
Who is the target group?	This flexible activity has been implemented to target several different target groups in all programs. See below for details by program. Note that the studies contained in this review provide the method of recruitment for the study, but not necessarily for the intervention in the field.
What programs conduct this activity?	This flexible activity has been implemented to target different groups: **Johns Hopkins Children and Youth Program, Relief Nursery Program:** First time mothers who are vulnerable in some way, for example young mothers, single mothers, and families of low socioeconomic status. **Safe Environment for Every Kid:** Embedded in paediatric clinics to families of children aged 0-5 years. Early interventionists, early childhood teachers, and other service professionals were called on as needed to give advice and make referrals. **Nurse-Family Partnership**: Families experiencing vulnerability - young mothers, single mothers, and families of low socioeconomic status. **Australian Nurse-Family Partnership**: Aboriginal mothers in Central Australia. **Parents as Teachers + SafeCare at Home (PATSCH):** Families with risk indicators, including education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse.

	Adults and Children Together Against Violence: Families with risk indicators, including education level, single parenthood, employment, history of abuse or neglect, potential for violence, and a history of mental illness, criminality, and drug abuse. **Right@Home:** Families assessed as being likely to benefit from a prevention service. **Pride in Parenting**: African American mothers who have not accessed adequate prenatal care. **Parents as Teachers, SafeCare, Promoting First Relationships:** Families with prior contact with child welfare services, or who have been reported for alleged child abuse or neglect. **Family Support Program, Parent-Child Interaction Therapy, The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits, The Incredible Years Shortened Basic Version**: Children who showed signs of social behavioural problems; had difficulties with socio-emotional or cognitive development. **ParentCorps:** The program operates in a school setting and is designed to serve culturally diverse communities. **Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline**: Multigenerational migrant communities, low-income migrant families, foster families. **Parent Training Program**: Low-income Chinese families in Hong Kong. **Child-Adult Relationship Enhancements in Primary Care**: Families with children with behavioural concerns who might be at risk for maltreatment. **Group Attachment-Based Intervention**: Mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child. **Relief Nursery Program:** On an as needed basis, mental health and special education services are integrated into the classroom. All children participate in developmental screening. Other services are provided as needed, including respite care, child nutrition, transportation to and from services, and individual and family counselling.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	No further information
Further resources	This flexible activity has been implemented to target several different target groups: • Johns Hopkins Children and Youth Program • Relief Nursery Program • Safe Environment for Every Kid • Nurse-Family Partnership • Australian Nurse-Family Partnership

	• Parents as Teachers + SafeCare at Home (PATSCH) • Adults and Children Together Against Violence • Right@Home: • Pride in Parenting • Parents as Teachers • SafeCare • Promoting First Relationships • Family Support Program • Parent-Child Interaction Therapy • The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits • The Incredible Years Shortened Basic Version • ParentCorps • Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline • Parent Training Program • Child-Adult Relationship Enhancements in Primary Care • Group Attachment-Based Intervention • Relief Nursery Program

Appendix 12: School Readiness Outcome Domains, Client Outcomes, and Measures: School Readiness Review

Outcome Domain	Client Outcome	Measure
School readiness	Improvement in conduct behaviour	• Multiple option observation system for experimental studies (MOOSES)
	Reduced classroom disruptiveness	• Teacher and observer ratings
	Reduced oppositional and aggressive behaviour	• Child behaviour checklist: aggression and delinquency subscales
	Classroom engagement	• Multiple option observation system for experimental studies (MOOSES)
	Positive behavioural support	• A latent construct of four observed parenting factors
	Self-regulation	• CBQ inhibitory control scale • HTKS-R • A composite score including inhibitory control; behaviour regulation; and emotional regulation
	Prosocial skills	• Preschool Penn interactive peer play scale
	Social emotional skills development	• Emotion matching task (EMT) + challenging situation task (CST)
	Identification of positive feelings	• Wally problem-solving and feelings test
	Child engagement	• Individualised classroom assessment scoring system (inCLASS)
	Pre-literacy skills	• Dynamic indicators of basic early literacy skills (DIBELS) • Woodcock Johnson tests: letter word identification subscale
	Language development	• Fluharty-2 test • Woodcock Johnson tests: understanding directions and story recall subscales
	Pre-numeracy skills	• Woodcock Johnson Tests: applied problems subtest
	Caregiver cognitive stimulation	• StimQ
	Executive functioning skill development	• Head-toes-knees-shoulders + backward digit span
	Teacher-parent bonding	• INVOL-VE-T
	Emotionally supportive teacher-child interactions	• Pre-K classroom assessment scoring system (CLASS): emotional support domain only
	School adjustment	• Coder observation of classroom adaptation (COCA-R)
Positive parenting	Positive parent-child interactions	• Parent-child Interaction Rating Scale – infant adaption (PCIRS-IA)

Appendix 13: Program Ratings and Direction of Effect: School Readiness Interventions

Program	Study	Client outcome	Direction of effect	Outcome domain	Evidence rating	Program rating	Direction of effect
Roots of Resilience	Lipscomb et al. (2021)	Emotionally supportive teacher-child interactions	Positive	School readiness	Promising research evidence	Mixed research evidence (with no adverse effects)	Mixed
		Child engagement	Positive	School readiness	Promising research evidence		
		Pre-numeracy skills	Positive	School readiness	Promising research evidence		
		Pre-literacy skills	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Self-regulation	Non-significant	School readiness	Evidence fails to demonstrate effect		
Smart Beginnings	Roby et al. (2021)	Caregiver cognitive stimulation	Positive	School readiness	Promising research evidence	Promising research evidence	Positive
		Parent-child interaction	Positive	Positive parenting	Promising research evidence		
Second Step Early Learning	Upshur et al. (2019)	Executive functioning skill development	Positive	School readiness	Promising research evidence	Mixed research evidence (with no adverse effects)	Mixed
		Social-emotional skill development	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Pre-numeracy skills	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Pre-literacy skills	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Language development	Non-significant	School readiness	Evidence fails to demonstrate effect		

The Incredible Years Teacher and Child Training Program	Webster-Stratton et al. (2008)	School adjustment	Positive	School readiness	Promising research evidence	Promising research evidence	Positive
		Improvement in conduct behaviour	Positive	School readiness	Promising research evidence		
		Classroom engagement	Positive	School readiness	Promising research evidence		
		Identification of positive feelings	Positive	School readiness	Promising research evidence		
		Teacher-parent bonding	Positive	School readiness	Promising research evidence		
Family Check-Up	Lunkenheimer et al. (2008)	Self-regulation	Positive	School readiness	Promising research evidence	Mixed research evidence (with no adverse effects)	Mixed
		Language development	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Positive behaviour support	Positive	School readiness	Promising research evidence		
Kids in Transition to School (KITS)	Pears et al. (2012)	Student oppositional and aggressive behaviour	Positive	School readiness	Promising research evidence	Mixed research evidence (with no adverse effects)	Mixed
		Level of disruptiveness in the classroom	Non-significant	School readiness	Evidence fails to demonstrate effect		
	Pears et al. (2013)	Pre-literacy skills	Positive	School readiness	Promising research evidence		
		Prosocial skills	Non-significant	School readiness	Evidence fails to demonstrate effect		
		Self-regulation	Positive	School readiness	Promising research evidence		

Appendix 14: Evidence-Informed Program Summaries: School Readiness Interventions

Evidence type	Evidence-informed program
Name of the program	Roots of Resilience
Brief description of program for search page	Roots of Resilience is an online professional development program for early childhood education (ECE) teachers in home and centre-based programs to strengthen resilience with children impacted by trauma. The program nurtures resilience within ECE programs through professional supports for early childhood teachers.
Outcomes	• School readiness
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	Roots of Resilience impacts on three protective factors, namely: • Emotionally supportive teacher-child interactions • Children's engagement • Children's school readiness skills It focuses on four key actions: • Seeks to strengthen resilience through responsive interactions during everyday moments, encouraging teachers to notice and utilise small moments with children, as well as with parents or other caregivers, to strengthen resilience • Supports early childhood teachers as "gardeners" who tend to children's roots of resilience. It focuses on teachers' strengths, and on their own self-regulation, self-care in support of teachers' own wellbeing, and in turn their responsivity to young children • Builds directly upon teachers' prior knowledge by overlaying a trauma-informed perspective on best practices in ECE established by the National Center on Early Childhood Development, Teaching, and Learning and the Center on the Social and Emotional Foundations for Early Learning • Provides online, relationship-based PD to support providers who often work in isolation and/or cannot attend traditional professional learning opportunities
Who does it work for?	Roots of Resilience coaching was designed specifically for early childhood teachers working with preschool aged children. Teachers do not need to know children's trauma histories to nurture resilience. Rather, the program guides teachers to consider trauma as a potential source of children's behaviours, to be responsive to all children in their care while also honing in on challenges that might be due to trauma, and to nurture their own self-regulation and care to nurture resilience with children. It focuses on self-regulation during serve and return interactions, and explicitly discusses trauma and resilience within six sessions. The roots of resilience coaching sessions emphasise self-regulation by isolating interactions in which: • Children's "serves" show self-regulation (less-regulation or more-regulation) • Teachers exhibit self-regulation when responding to children's challenging behaviours or emotions ("returning children's serves") • Teachers "return children's serves" in specific ways that support children's growing self-regulation A small RCT with 17 classrooms/groups, 23 teachers, and 61 children was conducted in the USA (Lipscomb et al. 2021). On average, the children were 4.16 years of age, ranging from 2.96 to 5.18 years. Teachers reported their highest level of education as: high school graduate (8.7%), some college (17.4%), Associates Degree (21.7%), Bachelor's Degree (30.4%), and graduate degree (17.4%); 4.3% missing. One teacher (4.3%) identified as male; 95.7% identified as female; none identified as non-binary or transgender. Teachers reported their race/ethnicity as 8.7% Latino or Hispanic and 95.7%

	White (91.3% White only). All children's parents identified their primary language as English. Their race/ethnicity (identifying all that applied) was as follows: 1.2% Native American, 4.9% Asian/Pacific Islander, 4.9% African American, 3.3% Latino, 91.8% White; 85% were White only. Parents reported that the majority (63.4%) of children in the current study had experienced at least one adverse childhood experience; that is: • Parental separation or divorce • Parental incarceration • Mental illness of a household member • Domestic violence, physical abuse, verbal abuse, sexual abuse, neglect, substance abuse by someone within the home • Feelings of being unsupported/unloved • Being in foster care • Experiencing harassment or bullying at school • Living with a parent or guardian who died • Being separated from primary caregiver through deportation or immigration • Having a serious medical procedure or life-threatening illness • Seeing or hearing violence in the neighbourhood or school neighbourhood • Often treated badly because of race, sexual orientation, place of birth, disability, or religion The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	**POSITIVE OUTCOMES** **Emotionally supportive teacher-child interactions**: Participation in Roots of Resilience program had a positive impact on the emotional support domain of the Pre-K Classroom Assessment Scoring System (CLASS PreK) relative to the waitlist control group. Children in emotionally supportive classrooms, as measured by the CLASS are more likely to show protective factors that can help mitigate effects of trauma. Children in classrooms with more consistently warm, responsive interactions are more likely to demonstrate a predictable decline of cortisol while at preschool (Hatfield & Williford 2017) and higher literacy and social skills. The Roots of Resilience professional development program aims to nurture these protective interactions. The program guides teachers to practice noticing children's cues and interpreting them with a trauma lens to enhance responsiveness to children's needs. The course and coaching support teachers in "serve and return" interactions. **Child engagement, Pre-numeracy skills:** Participation in Roots of Resilience was associated with moderately sized increases in emotionally supportive teacher child interactions and modestly sized reductions in children's negative engagement and increases in math scores. **NO EFFECT** **Pre-literacy skills, Self-regulation**: No effects on early literacy or self-regulation were detected. **NEGATIVE OUTCOMES** None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND

	• An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The program consists of an online course and complementary online video-based coaching which can be completed independently. The online course includes six modules with a total of 27 learning outcomes. These range from identifying sources of trauma and resilience, to planning and practicing self-care, partnering with families and specialists, and using a trauma-informed perspective to observe behaviour and promote children's self-regulation. The course is facilitated by a masters-level instructor, and uses an interactive, self-paced format. There is a workbook for practice and reflection between modules, and discussion boards to create community and encourage peer-shared reflection about trauma-responsive practice.
How much does it cost?	Information not provided
What else should I consider?	This is the first study to examine impacts of the Roots of Resilience professional development program for early childhood teachers. Further research is required, due to the following limitations: • Teachers reported increased knowledge and application of trauma-responsive practices after participating in the program. However, the impact on teachers and children needs to be systematically assessed. • The study had a small sample with and limited racial and linguistic diversity. The small sample size limits the statistical power of the study, which makes detection of statistically significant effects more difficult for some of the outcomes (e.g., self-regulation and emotional support) • The study did not have a long term follow up. A much longer timeframe is needed to assess whether gains in emotionally supportive interactions and children's outcomes are maintained in kindergarten. The study utilises the CLASS Pre-K. The Emotional Support domain of the CLASS Pre-K is used as a measure of the more supportive interactions. However, it is not designed to measure trauma-responsive practice or to align with the specific needs of an individual child. Additionally, CLASS Pre-K is designed to focus more on the child than the teacher
Where does the evidence come from?	One RCT conducted in the USA with a sample of 23 teachers and 61 children (Lipscomb et al. 2021).
Further resources	• Lipscomb, S.T., Hatfield, B., Goka-Dubose, E., Lewis, H., and Fisher, P.A. 2021. Impacts of Roots of Resilience professional development for early childhood teachers on Young children's protective factors. Early childhood research quarterly, 56, 1-14.

Evidence type	Evidence-informed program
Name of the program	Second Step Early Learning (SSEL)
Brief description of program for search page	SSEL is a commercially available early learning kit targeted within the classroom environment for children (http://www.cfchildren.org/second-step/early-learning).
Outcomes	• School readiness
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	SSEL is a program designed to facilitate the development of social emotional competence and self-regulation, in order to improve school readiness. SSEL uniquely integrates activities and instruction in emotion recognition, empathy, and social problem solving with self-regulation techniques such as self-talk and learning to calm down. SSEL also contains daily 'Brain Builder' games that require starting and stopping activities based on various oral or visual cues. The program

	schedule is a combination of weekly theme curriculum topics, ongoing teacher reinforcement, the Brain Builder games, and information for parents for reinforcement at home. The objectives of the SSEL program for children are to: • Increase short-term/proximal self-regulation and social/emotional competence • Reduce aggression • Improve peer relations • Improve on-task and classroom behaviour Achievement of SSEL objectives is anticipated to contribute to distal/long-term outcomes including improved school readiness, academic success, and engagement in learning. SSEL is not designed as a substitute for literacy, maths or science activities. Rather, it addresses the underlying social and cognitive processes necessary for successful learning, and overall behavioural and academic success.
Who does it work for?	The program targets children aged 4 to 5 years. It can also be used in mixed age classrooms with children aged 3 to 5 years. A classroom randomised control efficacy trial of the SSEL curriculum was conducted in the USA, in preschools with low-income children (Upshur et al. 2019). The study investigated the primary impact of the program on executive functioning skill development and social-emotional skill development, and potential secondary impact on pre-academic skills and classroom quality. A total of 770 children participated. The children's average age was 53.0 months, and they were evenly divided by sex. The sample was diverse, with about one quarter of the children with African American heritage, about two-fifths Anglo American, and two-fifths Hispanic American. A total of 187 teachers in both the intervention and control conditions participated in the study over 4 years. They were mostly female (only three were male); 78% were Anglo American, 14% Hispanic American, and 6% African American. Teachers' average age was 37 years, mean preschool experience was 13 years, and the majority of teachers (55%) had a college degree or higher, with another 32% having an associate's degree, and 13% having only a high school diploma. The study randomly assigned 67 classrooms across 13 sites into the SSEL intervention group or the control usual curricula group. Six sites had HeadStart programs and seven had community preschool programs that enrolled a large proportion of low-income and at-risk children. Both types of preschools participated in each cohort. The study took place over two years. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	SSEL promotes self-regulatory processes in the classroom that will support both individual and group learning. Activities are directed at developing specific academic skills that will improve preschool education and school readiness. **POSITIVE OUTCOMES** **Executive functioning skill development** There was a significant increase on the head-toes-knees-shoulders and the backward digit span tasks in the intervention group. SSEL successfully impacted attention, working memory, inhibition, and on-task behaviour that promote academic learning consistent with the SSEL logic model. **NO EFFECT**

	Social-emotional skill development There were no differences between the intervention and control groups on the Emotion matching task (EMT) or the Challenging situation task (CST). **Pre-numeracy skills, Pre-literacy skills, Language development:** There were no significant differences between the intervention and control groups on preacademic maths, reading or oral language skills, as measured by the Woodcock-Johnson Tests of Achievement scales. **NEGATIVE OUTCOMES** None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	SSEL has scripted, five day-a-week, brief large and small group lessons with 28 weekly themes, along with suggested extension and generalisation activities. • Day 1 of each week introduces the weekly theme using puppets • Day 2 uses the picture on the curriculum card to describe a theme-related situation and how to solve it • Days 3 and 4 are reinforcement days that involve small or large group practice activities • Day 5 involves reading a book that addresses the weekly theme, such as recognising emotions, or playing fairly The SSEL kit contains the following: • Large, colourful weekly lesson cards designed to show children a situation reflecting the weekly theme, with the teacher's script and instructions on the back. • A CD with songs to be played and sung daily, with words that reinforce the weekly theme. • Puppets to be used during the lessons • Posters showing different social-emotional skills • Small cards with children's faces showing different emotions. • Detailed instructions for Brain Builder games, which are played daily. The Brain Builder games are designed to help children practice attention, working memory, and inhibition. • A weekly hand out that can be copied and distributed to parents, covering the weekly theme and activities that could be carried out at home to reinforce the theme. There are five units within the program: • Six lessons covering skills for learning, such as listening, paying attention, using self-talk to remember directions, and asking for help • Six lessons on empathy, such as identifying feelings in self and others, learning how others feel, and demonstrating caring and helpfulness towards others • Six lessons on managing emotions, such as identifying strong emotions and calming down • Seven lessons on friendship skills, such as how to join a group, inviting others to play, fair ways to play, and techniques for calming down and solving problems

	• Three lessons to review skills in preparation for transition to kindergarten Strategies for reinforcing EF skills are given: • Asking children to engage in 'think time' before raising their hand • Asking for the group to show nonverbal agreement (e.g., pat your head) to engage them when one child or the teacher is giving an answer • Using random calling in group activities to bring children back to focus and reinforce those paying attention but sitting quietly Additionally, teachers were encouraged to reinforce specific skills throughout the day by asking children to think ahead about using the skills taught in upcoming activities, and to think back and recall when they or someone else demonstrated a skill; providing ongoing reinforcement when children demonstrate the skills; and offering art, literacy, math, and STEM extension activities that incorporate the learning strategies of the curriculum.
How much does it cost?	Information not provided
What else should I consider?	The study did not collect data on family participation. This is an important area for future study, since the curriculum kits provide extensive materials to engage families. SSEL curriculum has potential for further dissemination due to the reasonable cost of materials, ease of implementation, and modest teacher training and supervision burden to achieve adequate fidelity, which in turn seem to produce meaningful changes in children's EF skills. It is important to go beyond overall group outcomes and interrogate the suitability of the curriculum for cohorts with specific needs.
Where does the evidence come from?	One RCT conducted in the USA with a sample of 770 children in 67 preschool classrooms (Upshur et al. 2019).
Further resources	• http://www.cfchildren.org/second-step/early-learning • Upshur, C.C., Wenz-Gross, M., Rhoads, C., Heyman, M., Yoo, Y., and Sawosik, G. 2019. A Randomized Efficacy Trial of the Second Step Early Learning (SSEL) Curriculum. *Journal of Applied Developmental Psychology*, 62, 145-159.

Evidence type	Evidence-informed program
Name of the program	The Incredible Years Teacher and Child Training Program (IY)
Brief description of program for search page	The Incredible Years Child Training Curriculum ('Dinosaur School') was originally developed to treat clinic-referred children diagnosed with oppositional defiant disorder or early-onset conduct problems.
Outcomes	• School readiness
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	The program was originally a clinic-based treatment model, and was subsequently revised and adapted to be used by teachers as a preschool and early school-based preventive model. The 'Dinosaur School' curriculum is grounded in cognitive social learning theory and research on conduct problems in children, including associated social, emotional, and cognitive deficits. The program was designed to promote children's social competence, emotional self-regulation (e.g., engagement with classroom activities, persistence, problem solving, anger control), and school behaviour (e.g., following teacher directions, cooperation). It uses social learning behaviour change methods such as videotape modelling, role play and practice of targeted skills, and reinforcement for targeted behaviours.

	The program trains teachers in various child engagement strategies, including: • Effective classroom management • Promoting prosocial behaviours and emotional literacy • Prevention or reduction of conduct problems • Increasing parents' involvement in children's education and behaviour planning The program targets four risk and protective factors: • Teacher classroom management skills and classroom environment • Teacher-parent involvement • Child school readiness (social competence, emotional self-regulation, and absence of behaviour problems) • Poverty The IY 'Dinosaur School' is designed to target the first three of these more malleable risk factors and it is hypothesised that the increase of protective factors will prevent problematic behaviour patterns. The fourth area of risk – poverty – is not one that can be easily changed by schools.
Who does it work for?	IY targets children with social, emotional, or behavioural problems. Children living in poverty are at higher-risk of these problems, which is why the intervention targets high-needs and low-income schools where high percentages of students live in poverty. An RCT study was conducted in the USA with a sample of 120 classrooms from Seattle HeadStarts and 14 elementary schools (Webster-Stratton et al. 2008). The study design randomly assigned culturally diverse HeadStart programs and elementary schools serving low-income populations to intervention or control conditions. 120 classrooms from Seattle area HeadStarts and 14 elementary schools were involved in the project. These schools were matched on variables such as size, geographic location, and demographics of the children, and matched pairs were randomly assigned to intervention or control conditions. Parents of all children in the study classrooms were invited to participate in the research project. Of those approached, 86% of HeadStart and 77% of elementary school families signed consent forms indicating their willingness to participate. On average, students were 5.31 of age and 50% were male. The sample was ethnically diverse:18% Latinx, 18% African American, 20% Asian, 27% Caucasian, 8% African, and 9% other minority. Almost a third (31%) of children did not speak English as their first language. Teacher demographic variables were comparable across the intervention and control conditions. No significant differences were found for any of the teacher demographic variables. Teachers were Caucasian (65%), African American (16%), Asian (12%) and other (8%). The majority (95%) were female. Thirty-nine percent of teachers taught in HeadStart (HS), 30% kindergarten, and 31% 1st grade. Teachers' level of education was high school (4%), two years of college (13%), Bachelor's degree (43%), Master's degree (40%). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	**POSITIVE OUTCOMES** **School adjustment, Improvement in conduct behaviour, Classroom engagement, Identification of positive feelings, Teacher-parent bonding**: Students of teachers who received the IY training showed more indicators of school readiness and fewer

	conduct problems than students in control classrooms. Results showed both significant improvement and significant differential improvement in emotional self-regulation, social competence and conduct problems compared with the control students' behaviours. There were also improvements in children's conduct problems at home. These results are based on independent observations as well as parent and teacher reports. When teachers were trained to deliver the IY Dinosaur School curriculum and utilised positive classroom behaviour management strategies, this led to positive and responsive teaching, less harsh or critical discipline, and increased focus on social and emotional teaching, and parent involvement in children's education. Teachers who received the IY training were significantly different from control teachers on four of the five TCI variables: harsh/critical; warm/affectionate; inconsistent/permissive; and social/emotional. Intervention teachers used more specific teaching strategies that addressed social and emotional skills than teachers in control classrooms. The effect sizes were moderate to high, indicating that the curriculum and training had robust effects on changing teachers' classroom management approaches. No evidence was found that the student gender, age, or grade moderated the effects of the intervention on student outcomes. Students who received intervention had more prosocial solutions to problem situations and an increased positive feeling vocabulary compared with control students. Increasing children's social problem-solving knowledge and emotional language is promising because it increases the likelihood that children exposed to this curriculum will be more successful in solving problems with peers **NO EFFECT** None **NEGATIVE OUTCOMES** None
Is the program effective?	The program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	The classroom-based version of the Dinosaur School curriculum uses a format of 30 classroom lessons per year and has preschool and primary grade versions. The content is broken into 7 units: • Learning school rules • How to be successful in school • Emotional literacy, empathy, and perspective taking • Interpersonal problem solving • Anger management • Social skills • Communication skills In the study, teachers followed lesson plans that covered each of these content areas at least 2 times a week. They worked with students in a large group circle for 15-20-minutes, followed by 20 minutes of small group skill practice activities. A certified research staff member co-led

	all the lessons with the teachers to ensure that each classroom received a full dose of intervention. The curriculum involves over 300 small group activities which focus on social emotional skills and cover a wide variety of teaching modalities. The program caters to young children by using life-size puppets, "Dinosaur homework" activities, picture cue cards for non-readers, and games to stimulate group discussion, cooperation, and skill-building. In the classroom, teachers are encouraged to promote the skills taught in circle time lessons throughout the day during less structured settings, such as during choice time, in the lunchroom, or on the playground. Intervention teachers participated in 4 days (28 hours) of training spread out in monthly workshops. The training followed the textbook on how to promote social and emotional competence in young children (Webster-Stratton, 2000). The teacher training program also contained over 100 videotaped vignettes of children demonstrating social skills and conflict management strategies. At each assessment period, children, parents, and teachers completed report measures and children and teachers were observed in the classrooms by independent observers (blind to intervention condition) during structured and unstructured times (e.g., playground). Fidelity was monitored and measured in the following ways: • Teacher training was conducted using a standard protocol and was delivered by certified IY trainers • All training sessions were videotaped and reviewed by the program developer • Detailed manuals were provided for all Dinosaur lessons, complete with activities, role plays, and homework assignments • Protocol checklists were completed by the research co-leader after each session, indicating which lessons, small group activities and vignettes were used • Lessons were observed by certified IY supervisors and standardised process, and content evaluations were completed after each of these observations • IY Dinosaur research co-leaders met for weekly supervision to review protocols and ensure adherence to the curriculum Recruitment of schools and students occurred in each of 4 consecutive years (4 cohorts) to ease project burden in each year. By design, schools that served as control participated as intervention in the next year, and by design, each year a new set of schools were matched and randomly assigned to intervention or control. This procedure was repeated over four consecutive years to fill out the sample.
How much does it cost?	Information not provided
What else should I consider?	This study contributes to a growing body of literature evaluating the instruction in social, emotional, and problem-solving techniques in the classroom, showing promise for improving young children's overall school readiness and reducing conduct problems. Further research is needed to conduct an effectiveness trial where the program is evaluated under 'real world' conditions without the research support and careful monitoring that was offered in the current project. It remains to be seen what level of technical support teachers will need to implement the program effectively on their own after receiving the training. Another limitation of the study is that the study cannot determine whether the child behaviour improvements occurred outside the classroom environment and whether they generalised to the home

	environment. Further research should include parent report of home based behaviour change as well.
Where does the evidence come from?	One RCT conducted in the USA with a sample of 120 classrooms from Seattle HeadStarts and 14 elementary schools (Webster- Stratton et al. 2008).
Further resources	• https://incredibleyears.com/programs/teacher/ • Webster-Stratton, C., Jamila Reid, M., and Stoolmiller, M. 2008. Preventing conduct problems and improving school readiness: evaluation of The Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and Psychiatry*, 49(5), 471-488.

Evidence type	Evidence-informed program
Name of the program	Smart Beginnings
Brief description of program for search page	Smart Beginnings integrates universal (primary) and targeted (secondary) prevention programs, each focused on promoting positive parent-child interactions.
Outcomes	• School readiness • Positive parenting
Strength of evidence	Promising research evidence
Effectiveness	Positive
About the program	Smart Beginnings integrates two interventions: 1) A universal prevention program, the Video Interaction Project (VIP), is delivered in paediatric primary health care to maximise identification, engagement, and retention while minimising costs. VIP's core component is video recording of the parent and child interacting using a provided toy or book, with real-time review to identify and reinforce strengths in the interaction. 2) A targeted prevention program, Family Check-Up, is provided in the home for families meeting risk criteria, based on screening beginning at 6 months. Clinical-level support is tailored to family heterogeneity.
Who does it work for?	This program is designed for low-income families with toddlers at risk for conduct problems. An RCT conducted in the USA had a total final sample of 403 families (Roby et al. 2021) randomly assigned into the intervention and control conditions; 200 families were in NYC and 203 in Pittsburgh. Participants were children and their parents, across a broad range of locations, race and ethnic background (primarily low-income Latinx and Black/African American). There were many between-site differences, with NYC primarily Latinx and Pittsburgh primarily Black/African American participants. Mothers in NYC had higher rates of marriage and cohabitation and were less likely to be high school graduates. No significant differences emerged between the treatment and control groups across baseline variable data. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	**POSITIVE OUTCOMES** **Caregiver cognitive stimulation, Parent-child interaction**: The program positively impacted multiple domains of parent-reported cognitive stimulation, including reading, verbal responsivity, and teaching behaviours; and significantly improved parent-child interaction, including parental support for cognitive development, language quantity, and language quality. These findings replicate previous research on the effect of VIP on cognitive stimulation and parent-child interactions, and widen the generalisability of findings due to the comprehensive set of survey and observational measures and a more demographically diverse sample.

	The impacts are notable given substantial research demonstrating that the above caregiver behaviours mediate the relationship between poverty and school readiness. This has implications for long-term educational trajectories. The results are especially significant given that replication of findings in the behavioural sciences is often challenging. **NO EFFECT** None **NEGATIVE OUTCOMES** None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	Smart Beginnings includes VIP as a universal primary prevention strategy. In the study, the program wasprovided to all families with children randomly assigned to the treatment group at birth, and Family Check-Up was provided to treatment families with identified psychosocial risks beginning at 6 months. In the VIP program, Bachelor's level educated coaches hired for this project delivered fourteen 25-30 minute sessions in paediatric primary care to families with children from birth to 3 years. Coaches received a 3-day training course and ongoing supervision. Every VIP session follows the same format. The coach provides a developmentally appropriate learning material (book, toy) to the parent to engage them in interaction with their child. The coach records a short video of the parent and child interacting with the book or toy, and immediately reviews the video with the parent, identifying and reinforcing strengths in the interaction and encouraging self-reflection. The coach also provides the parent with a copy of the video; a personalised pamphlet with information about age-specific developmental milestones (e.g., making sounds at 6 months); age-specific suggestions for engaging with their child (e.g., imitating infant sounds at 6 months); a developmentally appropriate toy (e.g., hand puppets), and the parent's goals for interacting with their child at home. Family Check-Up is an evidence-based home visiting model that seeks to reduce the development of early disruptive behaviour and motivate parents to engage in services that improve parenting practices. Whereas VIP begins at birth in the Smart Beginnings model, families do not begin receiving Family Check-Up until the infant is 6 months.
How much does it cost?	Information not provided
What else should I consider?	This study had many strengths, including a multimethod assessment across a geographically and racially and ethnically diverse sample. It had the following limitations: • The study did not have sufficient statistical power to show differences across the two sites and populations, resulting in exploratory subgroup analyses • Due to specific race and ethnicity profiles at the different sites, these presented as counfounding variables in the study design. Future studies need to isolate the role of each characteristic in analysis of intervention effects.

	• The study took place during a period of specific stressors for immigrant and other racial and ethnic minority families, ovjectives • including heightened racism and discrimination. Experience of stress in these communities might have impacted enrolment and participation in assessments and could have implications for generalisability • Future studies need to assess whether the observed patterns of change persist longitudinally.
Where does the evidence come from?	One RCT conducted in the USA with a sample of 403 families (Roby et al. 2021).
Further resources	• https://steinhardt.nyu.edu/ihdsc/projects/smart • Roby, E., Miller, E.B., Shaw, D.S., Morris, P., Gill, A., Bogen, D.L., Rosas, J., Canfield, C.F., Hails, K.A., Wippick, H., Honoroff, J., Cates, C.B., Weisleder, A., Chadwick, K.A., Raak, C.D., and Mendelsohn, A.L. 2021. Improving Parent-Child Interactions in Pediatric Health Care: A Two-Site Randomized Controlled Trial. *Pediatrics*, 147(3), 1-12.

Evidence type	Evidence-informed program
Name of the program	Kids in Transition to School (KITS)
Brief description of program for search page	The KITS Program was designed to be a focused, short-term intervention to increase school readiness prior to kindergarten entry and to promote better subsequent school functioning in children in foster care.
Outcomes	• School readiness
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	The KITS program features a 16-week group-based school readiness curriculum for children and groups for caregivers. It has two phases. The school readiness phase (approximately two thirds of the curriculum) occurs in the 2 months before kindergarten entry and includes child playgroups that meet twice weekly and caregiver groups that meet twice monthly. This phase is focused on preparing children for school. The transition or maintenance phase occurs in the first 2 months of kindergarten, during which the children meet once a week for playgroups and the caregivers continue to meet twice monthly. This phase focuses on supporting a positive transition to school. The KITS program is based on the rationale that effective interventions are time-sensitive. The period of transition to school is a critical developmental stage and therefore, an optimal period for intervention. At this critical life stage, children are in the process of reorganising their competencies and might be particularly open to learning. The program does not necessarily follow an academic calendar. However, it is designed to be an intervention during a time that children might fail to gain or even lose critical skills necessary for school success. The KITS program focuses on self-regulatory skills in addition to early literacy and social skills. The program curriculum explicitly teaches, models, and reinforces self-regulation skills. The curriculum has frequent learning opportunities specifically focused on critical early literacy, social, and self-regulatory skills within the classroom context.
Who does it work for?	The KITS program is a short-term intervention to increase school readiness prior to kindergarten entry and to promote better subsequent school functioning in children in foster care. A total of 192 children in foster care and their caregivers participated in a randomised efficacy trial of the KITS program (Pears et al., 2012).

	Participants who were already involved in another treatment protocol closely associated with the KITS intervention were not eligible for inclusion. On average, students were 5.26 years of age and 52% were male. There were no statistically significant differences between ?? and the children's ethnicity (30% Latino, 1% African American, 55% European American, 2% Native American, 2% Pacific Islander, and 10% mixed race). The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	**POSITIVE OUTCOMES** **Pre-literacy skills, Self-regulation**: Pears and colleagues (2013) demonstrated that children in foster care who received the KITS program showed greater gains in both their early literacy and self-regulatory skills across the 8 weeks of the school readiness phase of the intervention just prior to kindergarten entry than did children who received foster care services as usual **Student oppositional and aggressive behaviour:** Pears and colleagues (2012) found a significant intervention effect on children's oppositional and aggressive behaviour with children in the intervention group showing lower levels of oppositional and aggressive behaviours. **NO EFFECT** **Level of disruptiveness in the classroom, Prosocial skills:** Children's level of disruptiveness in the classroom remained unchanged in the treatment group (Pears et al. 2012). The intervention failed to show a significant impact onprosocial skills (Pears et al. 2013). **NEGATIVE OUTCOMES** None
Is the program effective?	Overall, the program had a positive effect on client outcomes.
How strong is the evidence?	Promising research evidence: • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • Fewer RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	Teachers and caregiver group facilitators form the KITS school readiness group. All facilitators complete a standardised training program before the school readiness groups begin. At weekly intervention team meetings, facilitators discuss the progress of individual families within the three school readiness domains, and formulate strategies to address behavioural and literacy needs within the broader curriculum. The KITS intervention consists of two components. 1. The school readiness group A 24-session school readiness group runs for 2 hours twice weekly in the summer, and 2 hours once weekly in the autumn. The intervention covers the 2 months prior to kindergarten entry and the first 2 months of kindergarten. A graduate-level lead teacher and two assistant teachers conduct the school readiness groups with 12-15 children using a manualised set of empirically based instructional and positive behaviour management strategies. The school readiness group focuses on promoting early literacy and social-emotional skills in children. The school readiness group

	sessions have a highly structured, consistent routines with many transitions between activities. The curriculum covers: • Early literacy skills (e.g., letter names, phonological awareness, conventions of print, and comprehension) • Essential social skills (e.g., reciprocal social interaction, social problem-solving, and emotion recognition) • Self-regulatory skills (e.g., handling frustration and disappointment, controlling impulses, following multistep directions, listening, and making appropriate transitions) The curricular objectives are clearly specified for each session by skill domain, and activities are designed to promote these specific skills (i.e., the early literacy activities include a letter of the day (letter naming and letter–sound knowledge), a poem of the week (phonological awareness, concepts about print, and language), and storybook and dramatic activities (understanding of narrative). Prosocial and self-regulatory skills are taught using a blend of: • instruction (e.g., teachers define sharing, provide verbal examples, and ask the children for examples) • role-playing (e.g., teachers model sharing and not sharing in a series of skits and children are asked to differentiate between the two) • activity-based intervention (e.g., children must complete an art project requiring that they share the materials). Teachers give feedback to children and guide their practice of target skills. There are multiple opportunities for using inhibitory control, maintaining attentional focus, and practicing newly acquired social skills across activities. 2. The KITS caregiver group The 8-session caregiver group runs for 2 hours every 2 weeks. It is focused on promoting caregiver involvement in early literacy and schooling. The caregiver group meetings coincide with the school readiness group meeting times. Each group is led by a facilitator and an assistant. The manualised caregiver curriculum focuses on skills relevant to the kindergarten transition. These include helping children to develop their early literacy skills, and promoting child self-regulation using, behaviour management skills consistent with the school readiness group curriculum. The facilitator presents information to caregivers, leads structured group discussion of materials, and addresses questions and concerns. Facilitators reinforce skill acquisition via role-plays and discussion. Caregivers who miss a meeting receive a home visit or a phone call from the facilitator to cover the content and materials for that session. Families receive supplementary materials to support the implementation of new skills. These include weekly school readiness group homework assignments, weekly home-school connection newsletters outlining the school readiness group topics for a given week, and home practice activities. Implementation fidelity for the school readiness groups was determined by trained coders in vivo or via videotape based on systematic coding of the presence or absence of key elements of the curriculum.
How much does it cost?	Information not provided
What else should I consider?	Evidence shows that the KITS program might be an effective way to prevent disruptive classroom behaviours in a group at high risk for

	school difficulties. Delivered at the developmentally critical stage of transition to kindergarten, the KITS program appears to decrease the likelihood that the children will be oppositional and aggressive in their classrooms up to 8 months later. This might reduce the likelihood that these children will engage in disruptive and externalising behaviours as they proceed through primary school, potentially setting the stage for better outcomes throughout school. The results of the study suggest that improving school readiness in children in foster care might improve behaviour across kindergarten. The positive results of this short-term intervention also suggest that targeting critical transition points in the lives of these children and focusing on essential skills for the successful navigation of those transitions might be an efficacious, and cost-effective means of preventive intervention. Some of the limitations identified in the study were: • The study sample was moderate in size compared to other randomised trials of pre-kindergarten interventions. This reflects the challenges in recruiting participants in this population • Although the ethnicity of the sample was reflective of the state in which the participants lived, the proportions of some ethnic groups such as African Americans were not representative of the national average. This reduces the generalisability of findings and therefore the external validity of the study. The measures of overall classroom disruption were not independent of the measures of the oppositional and aggressive behaviour of the focal children, as they focused on all the children in the class including the study child. While positively correlated, the two measures were not singular. Thus, it is likely that while they might have overlapped, the measure of classroom disruptiveness was reflecting the behaviour of students other than the study child.
Where does the evidence come from?	• RCT conducted in the US with a sample of 192 children in foster care and their caregivers (Pears et al. 2012, 2013)
Further resources	• https://kidsintransitiontoschool.org/ • Pears, K.C., Fisher, P.A., Kim, H.K., Bruce, J., Healey, C.V., and Yoerger, K. 2013. Immediate effects of a school readiness intervention for children in foster care. Early Education and Development, 24(6), 771-791. https://doi.org/10.1080/10409289.2013.736037 • Pears, K.C., Kim, H.K., and Fisher, P.A. 2012. Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviours in kindergarten. Children and Youth Services Review, 34(12), 2361-2366. https://doi.org/10.1016/j.childyouth.2012.08.015

Evidence type	Evidence-informed program
Name of the program	Family Check-Up
Brief description of program for search page	The Family Check-Up program was inspired by motivational interviewing theory and was specifically designed to address parents' motivation to change.
Outcomes	• School readiness
Strength of evidence	Mixed research evidence (with no adverse effects)
Effectiveness	Mixed
About the program	Family Check-Up is a brief, motivational intervention that supports parents' existing strengths, as well as their engagement in additional parent training services when needed. The intervention is based on an ecological assessment of the child and the family. Model-driven, ecological intervention strategies that explicitly target parenting practices have been shown to lead to long-term positive outcomes in children and adolescents. The Family Check-Up assessment captures

	a comprehensive picture of the various direct and indirect factors that could impose constraints as well as offer windows of intervention in the family system. A feedback session is tailored to parents' goals and strengths derived from the assessment. Family Check-Up is delivered over three sessions. Therapists adapt and tailor any additional family interventions by providing a flexible menu of change strategies to choose from to achieve their goals. Family Check-Up provides a link between home-based preventive intervention services and treatment programs available to parents in other community and service settings. The program provides at least one annual contact with families, in order to promote skill maintenance and support adaptive changes over the course of key developmental transitions for the child and family.
Who does it work for?	This program is designed for low-income families and their toddlers at risk for conduct problems. An RCT was conducted in the USA with a sample of 731 families (Lunkenheimer et al. 2008). Participants were recruited from Women, Infants, and Children (WIC) Nutrition Programs in the metropolitan areas of Pittsburgh, Pennsylvania and Eugene, Oregon; and within and outside the city of Charlottesville, Virginia. Researchers approached families at WIC sites and invited them to participate if they had a child aged between 2 years and 2 years 11 months. Families were screened to ensure they met the study criteria, including presence of socioeconomic, family, or child risk factors for future behaviour problems. Inclusion risk criteria were grouped by the following three domains: • Child behaviour problems (e.g., conduct problems, high-conflict relationships with adults) • Family problems (e.g., maternal depression, daily parenting challenges, substance use problems, teen parent status) • Sociodemographic risk (e.g., low education achievement and low family income as defined by the WIC criterion) Children in the sample (49% female, 51% male) had a mean age of 29.9 months at the time of assessment at the age of 2. Across sites, the children were reported to belong to the following racial groups: 50.1% European American, 27.9% African American, 13.1% biracial, and 8.9% other races (e.g., Asian American, Native American, Native Hawaiian). At the time of the first assessment, 36.2% of participating parents were married, 31.6% were single, 19.8% were living together, 7.7% were separated, 4% were divorced, and 0.7% were widowed. Of the families assigned to the intervention condition, 77.9% participated in the Family Check-Up and feedback sessions at child age 2, and 65.4% participated at child age 3. The review did not identify any evidence that the program has been evaluated in Australia or with First Nations communities.
What outcomes does it contribute to?	**POSITIVE OUTCOMES** **Self-regulation, Positive behaviour support**: Family Check-Up has shown positive effects for families more likely to have low participation because of their children's risk of behavioural problems. Lunkenheimer and colleagues (2008) found that the program contributes to an increase in positive behaviour support. Furthermore, the study found that positive parenting and children's various school readiness skills interact over time during the early childhood years. The effect size of Family Check-Up on positive parenting practices was small, and the indirect intervention effects on child school readiness

	were modest, however, these effects remain statistically meaningful due to high stability in parenting and child factors over time. **NO EFFECT** **Language development:** The program had no effect on children's language development (Lunkenheimer et al. 2008). **NEGATIVE OUTCOMES** None
Is the program effective?	Overall, the program had a mixed effect on client outcomes.
How strong is the evidence?	Mixed research evidence (with no adverse effects): • At least one high-quality RCT/QED study reports statistically significant positive effects for at least one outcome, AND • An equal number or more RCT/QED studies of similar size and quality show no observed effects than show statistically significant positive effects, AND • No RCT/QED studies show statistically significant adverse effects
How is it implemented?	Parents or caregivers who agreed to participate in the study were scheduled for a two and a half hour home visit. The assessment began by introducing children to an assortment of age-appropriate toys and having them play for 15 minutes while the parents completed questionnaires. After this free play an undergraduate videographer approached the family, and each primary caregiver and child participated in a clean-up task (5 minutes) followed by a delay of gratification task (5 minutes), four teaching tasks (3 minutes each, with the last task completed by the alternate caregiver and child), a second free play (4 minutes), a second clean-up task (4 minutes), the presentation of two inhibition-inducing toys (2 minutes each), and a meal preparation and lunch task (20 minutes). The average cumulative length of the parent–child interaction tasks was 1 hour (60.71 minutes) at age 3 and slightly more than 1 hr (72.13 minutes) at age 4. This home visit assessment protocol was repeated at ages 3 and 4 for both the control and intervention groups. The randomisation sequence was computer generated by a member of the staff who was not involved with recruitment. Randomisation was balanced by gender to ensure an equal number of boys and girls in the control and intervention subsamples. To ensure a double-blind research design, the examiner opened a sealed envelope to reveal the family's group assignment only after the assessment was completed and then shared this information with the family. Examiners carrying out follow-up assessments were not informed of the family's randomly assigned condition. Families randomly assigned to the intervention condition were then scheduled to meet with a parent consultant for two or more sessions, depending on the family's preference. Typically, the three meetings include an initial contact session, an assessment session, and a feedback session. However, to optimise the internal validity of the study (i.e., to prevent differential dropout for intervention and control conditions), the assessments were completed before random assignment results were known to either the research staff or the family. The initial meeting was an assessment conducted with research staff, during which the family engaged in a variety of video-recorded in-home tasks of parent–child interaction and caregivers completed several questionnaires about their own, their child's, and their family's functioning. During this home assessment, staff also completed ratings of parent involvement and supervision. The second

	session was a "get to know you" meeting during which the parent consultant explored parent concerns, focusing on family issues that were currently the most critical to the child's wellbeing. The third meeting involved a feedback session during which the parent consultant used motivational interviewing strategies to summarise the results of the assessment. An essential objective of the feedback session was to explore the parent's willingness to change problematic parenting practices, to support existing parenting strengths, and to identify services appropriate to the family's needs. The parent consultant offered the parent the choice to engage in follow-up sessions that were focused on parenting practices, other family management issues (e.g., co-parenting), and contextual issues (e.g., childcare resources, marital adjustment, housing, and vocational training). Although parent consultants offered appropriate community service referrals according to the particular needs of the family, follow-up sessions most often consisted of ongoing in-person or phone sessions with the parent consultant. Parent consultants were initially trained for 2.5-3 months in a combination of strategies that included didactic instruction, role play, and ongoing video-recorded supervision of intervention activity. Certified lead parent consultants at each site certified new parent consultants before they started work with study families. Certification was achieved by review and assessment of competence and fidelity to program protocol via videotapes of feedback and follow-up intervention sessions. Parent consultants were re-certified yearly as part of their ongoing professional development, and to reduce drift from the intervention model. This followed Forgatch, Patterson, and DeGarmo (2005), who found that direct observations of therapist fidelity to parent management training predicted change in parenting practices and child behaviour. In addition, cross-site case videoconferences were convened weekly to further enhance fidelity. Finally, annual parent consultant meetings were held to update training, discuss possible changes in the intervention model, and address special intervention issues reflected by the needs of families across sites.
How much does it cost?	Information not provided
What else should I consider?	Given the modest, indirect effects of the FCU on children's inhibitory control and language skill, questions arise as to whether the FCU could be revised to be more sensitive to these aspects of child development in early childhood. Parent consultants working with families randomly assigned to the intervention noted anecdotally that many of the caregivers seemed depressed and disengaged from their young child, which could make it challenging for these parents to engage in proactive behaviours that would promote their children's language development and inhibitory control. Although efforts were made in this intervention to promote positive parenting in general, future versions of the Family Check-Up could be refined to specifically target parenting behaviours known to influence children's school readiness competencies, as well as to target maternal depression.
Where does the evidence come from?	RCT conducted in the USA with a sample of 731 families (Lunkenheimer et al. 2008).
Further resources	• https://www.nwpreventionscience.org/ • Lunkenheimer, E.S., Dishion, T.J., Shaw, D.S., Connell, A.M., Gardner, F., Wilson, M.N., and Skuban, E.M. 2008. Collateral Benefits of the Family Check-Up on Early Childhood School Readiness: Indirect Effects of Parents' Positive Behaviour Support. *Developmental Psychology*, 44(6), 1737-1752.

Appendix 15: Summaries of Core Components: School Readiness Interventions

<table>
<tr><td>Evidence type</td><td>Core components</td></tr>
<tr><td>Name of the set of core components</td><td>Improve school readiness</td></tr>
<tr><td>Brief description of the set</td><td>These three core components describe the essential types of activities that need to be delivered to build school readiness in children 6 years of age and younger.</td></tr>
<tr><td>Outcomes</td><td>From the data extraction template and Appendix 12</td></tr>
<tr><td>About the set of core component</td><td>In 2021, an evidence review was conducted to understand what works to support school transition. The review identified seven evidence-informed programs. Content analysis identified three commonalities across these programsThese three core components are the common activities across programs that have been shown to build school readiness in children aged 6 years or younger. They make up standardised program components that would need to be delivered by any program for children where there is a need to build school readiness.</td></tr>
<tr><td>Who does it work for?</td><td>These core components are relevant to services working with families and carers of children to build school readiness in children 6 years of age or younger.</td></tr>
<tr><td>Core components</td><td>RELATIONSHIP BUILDING
Supportive relationships between parents/carers and teachers, and children and teachers, are fundamental to school readiness.

Flexible activities include:
Building parent-teacher relationships
Nurturing teacher-child relationships
Enhancing parent-child relationships
Activities to support building relationships include teacher-initiated phone calls to parents, class newsletters sent to parents, joint student-parent homework, parent meetings, and increased teacher responsiveness to students. Teachers play a role in enhancing the parent-child relationship by providing at-home activities for parent and child to complete together.

ACADEMIC PREPAREDNESS
Building skills in children that prepare them academically for starting school is a core component.

Flexible activities include:
Building executive functioning capacity
Progressing language development and pre-literacy competencies
Activities to support academic preparedness include letter recognition, “brain” games and exposure to books
READINESS OF THE CHILD FOR THE CLASSROOM
Children need behavioural skills for a successful transition to thriving in the school classroom environment.

Flexible activities include:
Developing skills in self-regulation
Cultivating social-emotional skills
Learning classroom protocols and behaviours
Activities to support appropriate behavioural skill building include encouragement of student engagement and on-task work, pro-social problem solving, feelings vocabulary and compliance to rule and teacher directions.</td></tr>
<tr><td>Further resources</td><td>See Appendix 14</td></tr>
</table>

Appendix 16: Summaries of Flexible Activities: School Readiness Interventions

Flexible Activities for Core Component #1: Relationship Building

Name of the flexible activities	Building teacher-parent relationships
Description	The activity of building teacher-parent relationships involves teachers consciously building trusting and warm relationships with the parents of their students. This relationship recognises the importance of parents being actively involved in their child's education and the role teachers can play in nurturing this involvement.
How can it be implemented?	This relationship can be implemented at any opportunity teachers have to interact with the parents of their students: contacting parents (telephone calls, notes sent home with students, newsletters), sending home weekly parent handouts, inviting parents to visit the classroom, connecting with parents either in small groups or larger meetings.
Who is the target group?	This flexible activity has two target groups: the parents of children in a teacher's class; the teachers of parents' children
What programs conduct this activity?	**The Incredible Years Teacher and Child Training Program (IY):** teacher-parent involvement included phone calls from the teacher to parents, newsletters, and homework activities. **Second Step Early Learning (SSEL)**: weekly handouts sent home to parents with activities that complemented classroom exercises. In addition, parent-teacher meetings were held one or two times a year.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	Consideration should be given to the sustainability of ongoing parent-teacher relationship maintenance, given the many other responsibilities and commitments teachers have. In addition, many parents are time-poor and might find it challenging to find the time to engage with their child's teacher and school. For those parents, who might not have had a positive school experience, engaging with their child's education process in general and teacher in particular might be challenging and fraught with negative memories and experiences.
Further resources	• WEBSTER- STRATTON, C., JAMILA REID, M. and STOOLMILLER, M. 2008. Preventing conduct problems and improving school readiness: evaluation of The Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and Psychiatry,* 49, 471-488. • UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. and SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. *Journal of Applied Developmental Psychology,* 62, 145-159.

Name of the flexible activities	Nurturing teacher-child relationships
Description	The activity of nurturing teacher-child relationships involves the teacher consciously building a trusting, warm and supportive relationship with students.
How can it be implemented?	This relationship can be implemented at any opportunity teachers have to interact with their students: in the classroom, playground, or when speaking to students one-on-one or in a group setting.
Who is the target group?	This flexible activity has two target groups: the students of the teachers; and the students' teachers.
What programs conduct this activity?	**Roots of Resilience**: this professional development program trains teachers to identify microsocial moments in which they can engage in supportive "serve and return" interactions with students creating a safe space for the student.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*

What else should I consider?	Consideration should be given to the sustainability of ongoing teacher-student relationship maintenance, including identifying "microsocial moments" with students in the light of the busyness that characterises most classrooms. Children who do not readily engage with school or learning might not appreciate teachers' attempts to nurture a classroom relationship.
Further resources	• LIPSCOMB, S. T., HATFIELD, B., GOKA-DUBOSE, E., LEWIS, H. and FISHER, P. A. 2021. Impacts of Roots of Resilience professional development for early childhood teachers on Young children's protective factors. *Early Childhood Research Quarterly,* 56**,** 1-14.

Name of the flexible activities	Enhancing parent-child relationships
Description	The activity of enhancing parent-child relationships involves parents being actively involved in their child's education and schooling and recognises that family relationships are the biggest influence on their child's development. A strong parent-child relationship helps the child feel secure and confident – important attributes during the transition to school when children makes new friends and tries new activities.
How can it be implemented?	This flexible activity is more commonly implemented in the home rather than school setting. It can involve young toddlers interacting with their parent while being coached, or children and parents undertaking activities sent home from school together.
Who is the target group?	This flexible activity had two target groups: parents and children.
What programs conduct this activity?	**Kids in Transition to School (KITS)**: caregivers and students receive supplementary materials such as homework assignments and home practice activities to support the implementation of new skills. In addition, the KITS program's manualised caregiver curriculum includes caregiver instructions on skills relevant to school transition, such as helping children to develop their early literacy skills, developing routines around school activities, preparing children for the kindergarten transition, and using behaviour management skills that parallel those used in the school. **Smart Beginnings**: Parent-child interactions are video-recorded, and reviewed with Smart Beginnings coaches. The coach identifies parents' strengths, promotes self-reflection, and helps parent plan for future parent-infant interactions.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	Those parents who, as a child, were parented inadequately might not have the experience or skills to build a relationship with their child nor appreciate the importance of this relationship. In addition, those parents for whom school was a negative experience might consciously or unconsciously influence their own child's perception of school.
Further resources	• ROBY, E., MILLER, E. B., SHAW, D. S., MORRIS, P., GILL, A., BOGEN, D. L., ROSAS, J., CANFIELD, C. F., HAILS, K. A., WIPPICK, H., HONOROFF, J., CATES, C. B., WEISLEDER, A., CHADWICK, K. A., RAAK, C. D. and MENDELSOHN, A. L. 2021. Improving Parent-Child Interactions in Pediatric Health Care: A Two-Site Randomized Controlled Trial. *Pediatrics,* 147**,** 1-12. • PEARS, K., FISHER, P., KIM, H., BRUCE, J., HEALEY, C. and 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. and FISHER, P. A. 2012. Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviors in kindergarten. *Children and Youth Services Review,* 34**,** 2361-2366.

Flexible Activities for Core Component #2: Academic Preparedness

Name of the flexible activities	Developing executive functioning capacity
Description	The flexible activity of developing executive functioning capacity recognises the importance of skills such as following instructions, staying focused, and using self-control for children as they transition to school.
How can it be implemented?	Training teachers to intentionally develop basic executive functioning skills in children transitioning to kindergarten and provide opportunities for these children to practise their new skills in the classroom.
Who is the target group?	This flexible activity's target group is children transitioning to school.
What programs conduct this activity?	**Second Step Early Learning**: provides strategies to reinforce executive functioning skills such as asking students to engage in "think time" before raising their hand. The daily playing of "brain builder" games provides an opportunity for children to practise attention, working memory and inhibition.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	The development of executive functioning is a complex developmental process influenced by both maturation and experience. Some children might struggle with some activities/ concepts not because they are uncooperative, but because their level of neurodevelopment might not match that of their peers. Teachers need to consider the variability in neurodevelopment levels among children in the class.
Further resources	• UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. and SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. *Journal of Applied Developmental Psychology,* 62**,** 145-159.

Name of the flexible activities	Progressing language development and pre-literacy competencies
Description	The activity of developing language and pre-literacy competencies seeks to encourage and development language and pre-literacy skills.
How can it be implemented?	This flexible activity provides an opportunity for children transitioning to school to develop their language skills as well as pre-literacy capacities such as letter names, phonological awareness, conventions of print and comprehension. This activity has also been implemented with young infants with coaches providing parents with developmentally appropriate learning material, such as a book or hand puppet, and demonstrating ways to interact with infants in ways that develop language skills (e.g., imitating infant sounds).
Who is the target group?	This flexible activity has been implemented with at least three different target groups: • Children in foster care transitioning to kindergarten • Preschoolers transitioning to school
What programs conduct this activity?	**Kids in Transition to School (KITS)**: Early literacy activities include a letter of the day (letter naming and letter–sound knowledge), a poem of the week (phonological awareness, concepts about print, and language), and storybook and dramatic activities (understanding of narrative). **Smart Beginnings**: This intervention includes providing parents with developmentally appropriate learning materials, such as a book or toy, to develop language. During regular home visits, the intervention coach briefly videorecords the parent and child interacting with the book or toy and then immediately reviews the video with the parent to identify and reinforce strengths in skill development. For example, at 6 months, the coach would talk to the parent about their child's language development and milestones (e.g., making sounds) and tips for interactions in a way that develops

	language (e.g., imitating infant sounds), provide the parent with a developmentally appropriate toy (e.g., hand puppets), record the parent and infant interacting, review the video together, highlighting strengths, and help the parent plan for opportunities to develop the language skills of their infant at home.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	Children transition to school with varying levels of language development and pre-literacy skills. For some teachers, this variability in ability and skills can be challenging. The development of these skills and capacities is also greatly influenced by the home environment, including the value parents place upon language development and literacy skill and their own learning-to-read experiences.
Further resources	• LUNKENHEIMER, E. S., DISHION, T. J., SHAW, D. S., CONNELL, A. M., GARDNER, F., WILSON, M. N. and SKUBAN, E. M. 2008. Collateral benefits of the Family Check-Up on early childhood school readiness: indirect effects of parents' positive behavior support. *Dev Psychol,* 44, 1737-52. • ROBY, E., MILLER, E. B., SHAW, D. S., MORRIS, P., GILL, A., BOGEN, D. L., ROSAS, J., CANFIELD, C. F., HAILS, K. A., WIPPICK, H., HONOROFF, J., CATES, C. B., WEISLEDER, A., CHADWICK, K. A., RAAK, C. D. and MENDELSOHN, A. L. 2021. Improving Parent-Child Interactions in Pediatric Health Care: A Two-Site Randomized Controlled Trial. *Pediatrics,* 147, 1-12. • PEARS, K., FISHER, P., KIM, H., BRUCE, J., HEALEY, C. and 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. and FISHER, P. A. 2012. Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviors in kindergarten. *Children and Youth Services Review,* 34, 2361-2366

Flexible Activities for Core Component #3: Classroom Readiness

Name of the flexible activities	Developing skills in self-regulation
Description	The activity of developing skills in self-regulation is important to children transitioning to school as it enables them to sit and listen in the classroom, behave in socially acceptable ways and make friends as they learn to take turns in games and conversations and share toys. These skills include learning to regulate reactions to strong emotions like frustration, excitement, anger, and embarrassment, calm down after something exciting or upsetting, focus on a task and control impulses.
How can it be implemented?	The development of self-regulation skills can be implemented through explicit teaching, modelling, and reinforcing
Who is the target group?	This flexible activity's target group is students transitioning to kindergarten.
What programs conduct this activity?	**Kids in Transition to School (KITS)**: This program ensures multiple opportunities for practising self-regulating skills, such as handling frustration and disappointment, controlling impulses, following multistep directions, listening, and making appropriate transitions are embedded across classroom activities. **Second Step Early Learning (SSEL)**: This program introduces children to self-regulation techniques such as self-talk and learning to calm down. **Roots of Resilience**: Teachers are trained in the use of coaching sessions that focus on self-regulation by isolating "serve and return" teacher-child interactions in which: 1) children's serves show self-

	regulation (less-regulation or more-regulation); 2) teachers exhibit self-regulation when returning children's serves; and 3) teachers return children's serves in specific ways that support children's growing self-regulation.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	Developing skills in self-regulation is a process that, for some children, takes considerable time (particularly those children with ADS or ADHD). There is a role for both teachers and parents to consider the development of these skills on an individual basis that avoids comparing one child's level of skill with another child.
Further resources	• UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. and SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. *Journal of Applied Developmental Psychology,* 62**,** 145-159. • PEARS, K., FISHER, P., KIM, H., BRUCE, J., HEALEY, C. and 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. and FISHER, P. A. 2012. Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviors in kindergarten. *Children and Youth Services Review,* 34**,** 2361-2366 • LIPSCOMB, S. T., HATFIELD, B., GOKA-DUBOSE, E., LEWIS, H. and FISHER, P. A. 2021. Impacts of Roots of Resilience professional development for early childhood teachers on Young children's protective factors. *Early Childhood Research Quarterly,* 56**,** 1-14.

Name of the flexible activities	Cultivating social-emotional skills
Description	This is the activity of developing social-emotional, or pro-social, skills such as empathy, reciprocal social interaction, social problem solving and emotional recognition.
How can it be implemented?	Social-emotional skills can be taught in the classroom using a blend of instruction, role playing and activity-based interventions.
Who is the target group?	This flexible activity's target group is students transitioning to kindergarten.
What programs conduct this activity?	**Kids in Transition to School (KITS)**: In this program, prosocial skills are taught using a blend of instruction (e.g., teachers define 'sharing', provide verbal examples, and ask the children for examples), role-playing (e.g., teachers model sharing and not sharing in a series of skits, and children are asked to differentiate between the two), and activity-based intervention (e.g., children must share materials to complete an art project). Children receive feedback and guided practice in using the target skills. **Second Step Early Learning (SSEL)**: This program integrates activities and instruction in emotion recognition, empathy, and social problem solving with self-regulation techniques such as self-talk and learning to calm down. **The Incredible Years Teacher and Child Training Program (IY)**: This program is designed to promote children's social competencies through engagement in classroom activities, anger control and emotional literacy.
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	The development of these skills takes place in many settings other than the classroom. The home environment plays a vital role in the development of social-emotional skills. Different parents and

	extended family can provide different role-models for children as they learn empathy, compassion, healthy social interactions, and emotional recognition.
Further resources	• UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. and SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. Journal of Applied Developmental Psychology, 62, 145-159. • PEARS, K., FISHER, P., KIM, H., BRUCE, J., HEALEY, C. and 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. and FISHER, P. A. 2012. Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviors in kindergarten. *Children and Youth Services Review,* 34, 2361-2366.

Name of the flexible activities	Learning classroom protocols and behaviours
Description	The activity of learning classroom protocols and behaviours
How can it be implemented?	These activities can be implemented in numerous encounters in the classroom.
Who is the target group?	This flexible activity's target group is children transitioning to kindergarten.
What programs conduct this activity?	**The Incredible Years Teacher and Child Training Program (IY)**: This curriculum includes units that provide children with opportunities to learn classroom protocols such as "Learning school rules"; and "How to be successful in school".
What local knowledge is there about this activity?	*This section will be populated by the commissioners of the evidence review after consultation with the relevant stakeholders.*
What else should I consider?	Children enter kindergarten from a range of contexts. Some children have been in daycare and/or preschool prior to entering school, and are familiar with classroom protocols, (e.g., standing in a line, putting up hands, taking turns). Others have remained at home and school is their first introduction to a structured formal learning environment. These children might be the ones to benefit most from the opportunity to learn classroom protocols and acceptable behaviours.
Further resources	• UPSHUR, C. C., WENZ-GROSS, M., RHOADS, C., HEYMAN, M., YOO, Y. and SAWOSIK, G. 2019. A randomized efficacy trial of the second step early learning (SSEL) curriculum. *Journal of Applied Developmental Psychology,* 62, 145-159. • WEBSTER- STRATTON, C., JAMILA REID, M. and STOOLMILLER, M. 2008. Preventing conduct problems and improving school readiness: evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and Psychiatry,* 49, 471-488.