Children and Families Evidence:
Findings from Six Evidence Gap Maps

Prepared for the Victorian Department of Health and Human Services

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Contents

Glossary

AMSTAR

The AMSTAR ('A Measurement Tool to Assess Systematic Reviews') is an 11-item checklist used to assess the methodological quality of systematic reviews. In using the AMSTAR, specific questions (e.g., the search strategy used to identify studies, criteria defined to include or exclude studies, procedures with which the quality of included studies was assessed) are answered with 'yes', 'no', 'can't answer' or 'not applicable'. The number of 'yes'- answers a systematic review receives is summarised and can lead to an AMSTAR score between 0 and 11.

Core components

Core components are also referred to as 'common elements' or 'kernels' of therapeutic interventions. They are discrete, reliably identifiable techniques, which are intended to influence the behaviour or well-being of a service recipient and cannot be further subdivided without being rendered inert.

Evidence Gap Map (EGM)

EGMs are a visual overview of the availability of evidence for a particular area, providing a graphical display of areas with strong, weak or non-existent evidence on the effect of interventions or initiatives. They give an accurate and accessible summary of the amount and strength of evidence that exists within a given area, highlighting where there is a weak evidence base as well as identifying key areas for research.

Jadad scale

The Jadad scale is a simple five-point, three-question scale that is widely used to quickly assess the quality of research trials. The three questions are directed at the process of randomising study participants, blinding participants and investigators, and at the number of drop-outs occurred in the trial. Points for each question are added or deducted based on the appropriateness of the processes. A study can get a maximum score of 5 points. If only the first publication of trial outcomes reported randomisation or blinding procedures, while later follow-up studies did not, these follow-up studies still received points for these procedures.

Primary study

A primary study involves the collection of original data and reports of a research study conducted by the authors. Randomised controlled trials are examples of primary studies, whereas systematic reviews represent secondary research as they build on the research from primary studies.

Randomised Controlled Trial (RCT)

An RCT is a study design (often used in medical trials but increasingly also applied within education and social welfare), which aims to reduce bias when testing the impact of a new intervention. RCTs reduce selection bias as participants are allocated at random (by chance alone) to receive a specific intervention or to receive another intervention, standard treatment, or no intervention. RCTs are considered the gold standard type of primary study used for establishing the impact and effectiveness of an intervention.

Systematic Review (SR)

A systematic review summarises the results of all available studies, usually of high quality (e.g., controlled trials), and provides a high-level synthesis of evidence on the effectiveness of clinical interventions used in human services (such as social welfare, health and education). The content of systematic reviews depends largely on available trials, their quality, and the outcomes that were measured. Often, review authors pool numerical data about effect size of the intervention (an effect size calculates the magnitude of effectiveness of an intervention) through a process called meta-analysis. Because a meta-analysis statistically combines results across several studies, findings are less biased than narrative literature reviews that rely upon informal and non-transparent synthesis methods. Well-conducted systematic reviews represent the highest level of evidence of effectiveness for health and social interventions.

Therapeutic intervention

A therapeutic intervention is an action taken by professionals to improve the health and well-being of individuals in need of support. Therapeutic interventions vary in methods and types of settings in which those methods are implemented. They can be psychological, physical, or even pharmacological; may be led or guided by a professional interventionist or mediated by caregivers and family members — with or without the help of a professional.

Trauma-informed care

Trauma-informed care refers to a framework of care that is grounded in an understanding and responsiveness to the impact of trauma on individuals. Trauma-informed interventions consider that clients have been traumatised and that a trauma, after having been internalised by an individual, worsens the problems this individual might otherwise have. The trauma can be of mental or physical character or can be a combination of both.

Acronyms

Acronym	Definition
ANZCTR	Australian and New Zealand Clinical Trials Registry
EGM	Evidence Gap Map
KEEP	Keeping Foster and Kin Parents Supported and Trained
MST	Multi-Systemic Therapy
RCT	Randomised-Controlled Trial
SR	Systematic Review
TF-CBT	Trauma-Focused Cognitive Behavioural Therapy
TFC-O	Treatment Foster Care - Oregon
Triple P	Positive Parenting Program

Executive summary

The Victorian Department of Health and Human Services (the department) commissioned The University of Melbourne to develop a series of Evidence Gap Maps (EGMs) that identify the strength of evidence on programs, services or practices intended to support vulnerable children and families.

EGMs provide a high-level overview of the evidence that exists on the impact of interventions in a particular area in order to inform decision making. The EGMs in this report were designed to provide a compilation of the available evidence on services for vulnerable children and families. Findings have informed the development of the *Children and Families Research Strategy 2017-2019*[1] and will contribute to the child and family service system evidence base. A consultative process with the department and service providers resulted in the identification of key focus areas for the EGMs:

- Aboriginal[2] children and families
- Out-of-home care
- High-risk young people
- Trauma-informed practice
- Children with disabilities and their families
- Family violence[3]

The EGMs presented in this report focus on randomised controlled trials (RCTs) and systematic reviews, providing high-level evidence in these areas across a range of outcomes (see Appendix C for an overview of outcomes for each EGM). Searches were also conducted for Australian and New Zealand evidence that did not meet this stringent standard, especially where substantial gaps were noted. An additional search for evidence concerning risk factors of child maltreatment was also conducted, however, no EGM was produced as this body of evidence does not include well-defined interventions. Finally, this report presents cross cutting EGM themes and recommendations for future research.

[1] http://www.strongfamiliessafechildren.vic.gov.au/15641/documents/57603

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

[3] In this report, the term 'family violence' incorporates other terms used to describe this type of violence including 'domestic violence' and 'intimate partner violence'.

Key results

Cross-cutting themes

Across all six EGMs, a number of topics emerge as pertinent for enhancing the evidence base for child and family services. First, **the overall number of high quality evaluations and systematic reviews** is small and varies across the six topics of interest for this report.

Second, there are **few rigorous evaluations of Australian programs** for vulnerable children and families, including a near absence of strong evaluations of Aboriginal-specific services. This should not be interpreted as meaning there is a lack of culturally-appropriate programs being delivered in Victoria. Rather, this is an indication of the need for rigorous evaluations of local programs available to Aboriginal children and families.

Several other common threads could be identified through the mapping of the evidence across six EGMs:

- The strongest evidence was found for **well-known programs treating well-defined problems** or conditions, such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for children who have faced sexual abuse and Multisystemic Therapy (MST) for high-risk adolescents.
- There is mounting evidence that **there are core components — or practice elements — common to effective interventions**, and that these can be identified and used to develop new effective interventions or integrated into existing services to make them more effective.
- The **most effective interventions were behavioural** in nature and included training and coaching parents to effectively deal with difficult child behaviour. That is, the parent or caregiver is coached to deliver known behaviour change strategies directly to their children.
- The research underpinning evidence-based programs comes mostly from studies that compare known **interventions to no services or to standard services. The interventions are rarely compared with competing interventions or with other high-quality services** available in the community.
- **Few studies addressed implementation** or tested specific aspects of the implementation process, even though there is substantial evidence that poor implementation results in highly effective interventions being rendered ineffective.
- There is **scarce evidence on the cost effectiveness of interventions**. This includes research providing information on costs related to delivering and implementing interventions, scaling them from single pilot sites to regional or state-wide dissemination, and on cost benefits when compared to other interventions or services as usual.

Aboriginal children and families

Evidence was searched that is relevant to services for Aboriginal children and families at risk of, or involved with, child protection services[4].

Existing evidence

Modest evidence exists for the effectiveness of early interventions, primarily provided to mothers and, in some cases, their children (low to moderate quality).

There are universal parenting programs, such as SafeCare and Positive Parenting Program (Triple P), but these were not developed with Aboriginal concepts and values. However, there may be core components or practice elements within these programs that are suitable to include in interventions developed specifically for Aboriginal children and families using Aboriginal concepts and values.

[4] Of the evidence reported, the one systematic review included concerns research with Australian Aboriginal children and families. The five primary studies included all concern research with Native American populations.

Evidence gaps

More evidence is needed on:

- programs or services developed using Aboriginal concepts and values that are specifically aimed at preventing child maltreatment and/or supporting vulnerable Aboriginal children and families. This is especially true for therapeutic programs
- programs or services that support the development of cultural and spiritual identity and are developed using Aboriginal concepts and values.

Out-of-home care

Evidence was searched for the effectiveness of out-of-home care services including general and intensive foster care, residential care, independent living arrangements and leaving care programs.

Existing evidence

Strong evidence exists for:

- therapeutic approaches for changing child behaviour developed in other countries, primarily the United States (US) - these include Treatment Foster Care-Oregon (TFC-O) and Keeping Foster and Kin Parents Supported and Trained (KEEP)
- kinship care leading to child outcomes that are as good or better than child outcomes in non-related out-of-home care
- prevention interventions delivered to families at risk of having their child removed especially Multisystemic Therapy (MST).

Evidence gaps

More evidence is needed on:

- interventions aiming to maintain and develop the cultural and spiritual identity of children and young people in out-of-home care
- evidence-based practices, or identified effective core components approaches specifically aimed for use with young people in out-of-home care
- interventions designed to facilitate the successful transition of young people from out-of-home care into interdependent adulthood
- the prevention of out-of-home care as a primary (i.e., non-universal) intervention
- the effectiveness of interventions to promote the safe return of young people to their birth parents
- interventions that detail child safety while in out-of-home care.

High-risk young people

Evidence was searched for interventions addressing young people with externalising behaviour problems such as aggressive, offending or criminal behaviour and truancy. Studies often include young people who are at risk of or already in out-of-home care.

Existing evidence

This is a well-developed area covering a broad range of interventions including parent mediated-interventions, re-entry and aftercare programs provided to offenders, educational youth violence prevention programs, psychosocial interventions, case management approaches, boot camps and 'Scared Straight' programs.

Strong evidence exists for:

- holistic interventions (i.e., those that integrate the young person's environment into treatment) that include strong behavioural and/or cognitive behavioural components, are parent/caregiver mediated (i.e., parents/caregivers are trained and coached to deliver behaviour change strategies) and are well-implemented.

Modest evidence exists for:

- aftercare programs supporting young people with externalising behaviour problems, some of whom may be re-entering their community from juvenile detention.

Other findings:

- there are promising indications that the core components or practice elements of effective interventions can be identified and used to develop or improve existing local services.
- Interventions aimed at changing young peoples' behaviour by 'scaring' them (e.g., 'scared straight' and boot camps) can be harmful.

Evidence gaps

More evidence is needed on:

- the comparison of manualised evidence-based programs and practices to each other or to other potentially high-quality services available in the community
- how interventions targeting high-risk young people impact the safety of young people beyond a reduction in risk-taking behaviours
- outcomes related to the spiritual and cultural identity of young people – their belonging to country, culture, and community – were not covered in any of the included studies
- how interventions addressing the 'anti-social' behaviour of high-risk young people improved their academic achievements, school engagement, problem solving and decision-making skills
- outcomes related to the wellbeing of parents and caregivers of young people with antisocial behaviours
- the implementation of interventions including the testing of specific aspects of the implementation process.

In addition to these gaps it was found that independent evaluations of programs were far less prevalent than evaluations conducted by or involving program developers or related colleagues.

Children and young people with disabilities and their families

Evidence was searched for interventions targeting children with disabilities aimed at preventing maltreatment occurrence or recurrence for children with disabilities. A broad spectrum of physical, intellectual, and behavioural disabilities was included.

Children with disabilities are at higher risk of maltreatment and sexual abuse than children without disabilities. However, evidence on effective interventions specifically designed to prevent maltreatment for these children is almost non-existent. Existing evidence and gaps in the evidence base are therefore not highlighted separately.

There are numerous studies and reviews of parenting interventions aimed at assisting caregivers to manage the challenges of raising children with various disabilities. This evidence could serve as the beginning for building an evidence base for children experiencing or at risk of experiencing child maltreatment and/or residing in out-of-home care.

Trauma-informed practice

Evidence was searched for studies of interventions that are 'trauma informed' and target vulnerable children and their families. Trauma-informed practice refers to care that is grounded in an understanding and responsiveness to the impact of trauma on individual clients.

Existing evidence

Strong evidence exists for the effectiveness of TF-CBT in addressing child trauma and related mental health symptoms such as anxiety, depression and behaviour problems among children who have been sexually abused. TF-CBT is a blend of cognitive-behavioural and trauma-informed approaches.

Evidence gaps

More evidence is needed on:

- rigorous evaluations of the effectiveness of different trauma-informed approaches for vulnerable young people who have suffered maltreatment other than child sexual abuse
- identification of the core components of TF-CBT that lead to improved outcomes for children, integrating and testing these within regularly delivered services to vulnerable children and families
- whether 'trauma-informed' approaches work without a cognitive-behavioural component
- comparisons of trauma-informed interventions to other high quality interventions.

Family violence

Evidence was searched for preventing and reducing family violence, including interventions targeting perpetrators.

Existing evidence

Strong evidence exists that indicates that current, court-mandated perpetrator intervention programs (such as the Duluth Model) are ineffective at decreasing future family violence among men who use violence against women.

Modest evidence exists for:

- support services for women who leave violent relationships improving mother and child outcomes
- couples counselling to decrease family violence of mild to moderate severity (however, more rigorous, large-scale testing is needed)
- interventions using fatherhood as an engagement strategy and behavioural intervention as a treatment approach decreasing future family violence in men who use violence against women.

Evidence gaps

More evidence is needed on:

- alternative approaches to the Duluth and other traditional perpetrator intervention programs — these have not been sufficiently tested and it is unknown whether they are effective at preventing future family violence
- the relative effectiveness of services delivered to individuals, couples, families, or groups
- effective programs / services for women (and by extension their children) who are not yet ready or who do not want to leave an abusive relationship, that promote safety and well-being
- the extent to which mainstream programs are effective for promoting safety and well-being among Aboriginal families.

Risk factors

Evidence was searched around risk factors for child maltreatment and family violence. Several factors emerged as contributing to the risk of experiencing family violence and/or maltreatment including:

- a history of previous abuse, low educational attainment, economic and social disadvantage, and unintended pregnancy are moderate to strong risk factors for violence during pregnancy
- gender, which affects the likelihood of experiencing different types of physical abuse: while physical abuse tends to be more common for males, the risk of sexual abuse is substantially higher for females
- children with disabilities are at greater risk of maltreatment than those without a disability.
- children with intellectual disabilities are at the greatest risk of emotional, physical, and sexual abuse.

Stronger evidence is required to:

- better describe the link between disability and maltreatment — few well-designed studies exist in this area
- determine how, and to what extent, risk factors contribute to reported and unreported child maltreatment.

Numerous large-scale studies outside the scope of this project strongly suggest that the presence of one or more of these risk factors (including a history of previous abuse, low educational attainment, economic and social disadvantage) place children at a considerably greater risk of maltreatment and abuse (for an Australian example, see Doidge, Higgins, Delfabbro & Segal, 2017).

Recommendations

This report identifies gaps in the current evidence that, with targeted effort, can begin to be addressed. The most important of these are listed:

- **Rigorously evaluate promising, locally-developed interventions** specific to Victorian populations to determine their effectiveness. This includes those delivered through Victorian Aboriginal children and families services.
- **Identify core components or practice elements** of effective interventions that lead to clearly articulated outcomes. Build services around these, and evaluate them against competing services, including evidence-based programs.
- **Use identified core components or practice elements to build upon and improve current practices** that have not yet been rigorously evaluated. These enhanced practices can then be evaluated in through rigorous trials (RCTs or high quality quasi-experimental trials).
- **Test the transportability and adaptation of evidence-based programs and other effective interventions** in the Victorian context.
- **Focus on testing and improving implementation**. Intervention effectiveness is strongly dependent on high quality implementation, but implementation is rarely evaluated.
- Focus efforts on **implementing and evaluating parent or carer-mediated behaviour change interventions** across all levels of the system. Parents and caregivers spend the greatest amount of time with children and young people and they are best positioned to help them achieve important outcomes.
- Where gaps exist in the literature, **look to related research on similar problems and populations** rather than relying on low-quality studies specific to child protection.
- **Include rigorous, high quality cost-benefit analyses in all commissions** for local program development, program delivery and program evaluation.
- Commission and adequately **support rigorous primary studies of promising local practices**. Register these in the proper clinical registries[5] prior to execution and support publication to build a higher quality evidence base of effective services that Victoria can draw from over time.
- Find ways to **collaborate with other governments** (such as was done in this commission) to maximise resources and build evidence more quickly.
- **Rigorously test and evaluate interventions addressing culturally and linguistically diverse populations** across child and family services.

[5] E.g., The Australian and New Zealand Clinical Trials Registry (ANZCTR) (http://www.anzctr.org.au/); or ClinicalTrials.gov (https://www.clinicaltrials.gov/)

Introduction

The Victorian Department of Health and Human Services (the department) commissioned the University of Melbourne to develop a series of Evidence Gap Maps (EGMs) that identify the extent and strength of evidence for programs, services or practices intended to support vulnerable children and families.

EGMs provide a high-level overview of the evidence that exists on the impact of interventions in a particular area in order to inform decision making. The EGMs in this report were designed to provide a compilation of the available evidence on services for vulnerable children and families. Findings have informed the development of the *Children and Families Research Strategy 2017-2019*[6] and will contribute to the child and family service system evidence base. A consultative process with the department and Victorian service providers resulted in the identification of key focus areas for the EGMs:

- Aboriginal children and families
- Out-of-home care
- High-risk adolescents
- Trauma-informed practice
- Children with disabilities and their families
- Family violence.

Additionally, it was decided to conduct a scan of the evidence available on risk factors for child maltreatment, however, this topic area is not presented as a gap map because the literature does not feature well-defined interventions and outcomes.

[6] http://www.strongfamiliessafechildren.vic.gov.au/15641/documents/57603

Evidence gap maps

EGMs are a visual overview of the evidence on 'what works' in a particular area. They provide a graphical display of strong, weak or non-existent evidence across identified interventions and outcomes in topic areas. They give an accurate and accessible summary of the amount and the strength of evidence that exists within a given area, highlighting where there is a weak evidence base to help identify key areas for research. An EGM has a basic structure (see Table 1). The rows of the EGM list the interventions, while the columns list expected outcomes.

Table 1: A generic EGM structure

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Intervention 1				
Intervention 2				
Intervention 3				

Studies are placed in the appropriate cells reflecting the correct combination of interventions tested and outcomes measured. Studies can appear in multiple cells as they may address a range of interventions and outcomes.

The EGMs in this report are colour-coded to visually represent the strength of evidence in specific outcome areas. The key is provided with the EGM, with lighter shading representing weak evidence and darker shading representing strong evidence. The studies on which the EGMs are based are located in Appendix C.

Report structure

This report presents findings for each of the six EGM focus areas. A high-level summary is provided for each EGM providing a brief description of the EGM's scope, a summary of the existing evidence, and research gaps, and recommendations for future research. The report then summarises the available evidence on risk factors for child maltreatment, however no EGM was produced as this body of evidence does not include well-defined interventions and outcomes. Finally, an overview of common threads and themes across all EGMs and a set of recommendations for developing a strategy to support research related to the child and family service system is provided.

Appendix A provides an overview of the detailed methodology applied to source and select eligible publications, extract study findings, and analyse relevant data to be included in the EGMs. The six visual representations of the EGMs are also presented in the appendices. Detailed search terms can be retrieved from the research team upon request. Appendix B provides detail on the Jadad and AMSTAR scoring systems. Appendix C provides the bibliography for each EGM.

Results

EGM 1: Aboriginal children and families

Aboriginal children and families experience intergenerational trauma related to colonisation and by policies such as the forced removal of children. This is reflected in the overrepresentation of Aboriginal families who are in contact with child protection. Currently there is limited rigorous evidence concerning what works for vulnerable Aboriginal children and a stronger body of evidence is required to inform culturally safe practices, programs and associated implementation requirements that lead to improved outcomes for Aboriginal children and families.

Scope

This EGM identifies evidence that is relevant to Aboriginal children and families at risk of, or involved with, child protection. Six articles, five primary studies and one systematic review, met the EGM inclusion criteria. Of these articles, only the systematic review concerns research with Australian Aboriginal children and families. The five primary studies included all concern research with Native American populations.

Evidence summary

Overall, there was limited rigorous evidence for Aboriginal children and family services. Of the evidence identified, all studies were evaluations of early interventions that primarily provided services to mothers, and in some cases, to their children. Within this limited body of evidence, several positive outcomes were reported for services or programs delivered to Aboriginal children and families, including positive mental health of caregivers and children, caregiver social well-being, and improved parenting skills.

Evidence from overseas aboriginal communities

A New Zealand study reported on two programs for Maori women who were under a Protection Order for family violence (Cram, 2012). The content of the intervention was built on Maori concepts and values. The first program included an additional component for children, while the second included an additional component for perpetrators. The study is a qualitative evaluation of 16 participants who completed either of the two 12-week programs. Participants reported a change in their own views, behaviours, self-esteem, and confidence, and they reported that these gave them the ability to keep themselves safe. They also reported that the program had increased their knowledge of resources and supports that could be relied on in times of crisis. Participants appreciated that the program was built upon Maori values and felt this provided a strong foundation for healing.

Chaffin et al.'s (2012) primary study of SafeCare, a manualised parenting program designed to work with parent/caregivers referred to child protection for child neglect and/or physical abuse, was adapted for use with Native American children and families. This high-quality study found similar or better results for Native American children when compared to non-Native American children, and the program was effective across several outcomes for both groups. These results are promising given that SafeCare is a well-evidenced parenting program focusing on child neglect, and a substantial proportion of Aboriginal families involved in the child protection system have been reported for this type of maltreatment concern.

Evidence gaps

- No strong evidence exists for programs or services developed using Aboriginal concepts and values that are specifically aimed at preventing child maltreatment and/or supporting vulnerable Aboriginal children and families at risk for involvement in child protection. This is especially true for therapeutic programs.
- There are universal parenting programs (e.g., Triple P) and at least one therapeutic program (i.e., SafeCare) that have been used with Aboriginal families, but these were not developed using Aboriginal concepts and values. However, there may be universal components within these programs that are suitable to include in interventions developed specifically for Aboriginal children and families using Aboriginal concepts and values.
- No strong evidence exists for programs or services that support the development of cultural and spiritual identity and are developed using Aboriginal concepts and values.

Recommendations

There is limited, rigorously-derived evidence for services specifically targeted at Aboriginal children and families at risk of, or involved with, child protection. Future research should:

- *Rigorously evaluate promising local interventions developed by Aboriginal services and communities, using Aboriginal concepts and values, delivered through Victorian Aboriginal children and family services, to determine their effectiveness and to continuously improve their content and delivery.*
- *Identify universal components of high-quality programs that meet the needs and values of Aboriginal communities and thus may be suitable for inclusion in services developed for vulnerable Aboriginal children and families.*

Given that Aboriginal children and families are historically and currently overrepresented in the child protection system, research is needed to evaluate the long-term, intergenerational impact of services and programs delivered to Aboriginal children and families.

- *Research is required on the long-term impact of early intervention services for Aboriginal children and their families, including those that entail home visiting and parenting components.*

Any development of services and associated research targeting Aboriginal children and families should consult with, and directly involve in the development process, the Aboriginal communities in which they will be implemented. This will help to ensure that services are developed in a way that reflects the needs and norms of this population.

- *Service development and research for and with Aboriginal children and families should be conducted in full partnership with Aboriginal services and communities, and should be sensitive and responsive to Aboriginal culture and values.*
- *Research on services provided to Aboriginal children and families should measure outcomes that, in addition to outcomes that are important for all children and families receiving services, are distinctly important to Aboriginal children and families. These outcomes should be identified by the Aboriginal communities in which the services are delivered and the research is conducted.*

EGM 2: Out-of-home care[7]

The cohort of children in out-of-home care are particularly vulnerable having significant contact with child protection services and, in many cases, experiencing some form of family violence. This is a relatively well-researched area of the child and family services system with knowledge of what works in terms of supporting child behavioural change and placement stability. However, there is a need for a stronger evidence base concerning the core practice elements of interventions that lead to sustained good health and wellbeing outcomes during and after care, including family reunification where appropriate.

Scope

This EGM includes studies assessing the effectiveness of any form of out-of-home care or program. Types of out-of-home care living arrangements included were general and intensive foster care, residential care, supported independent living and supported family group homes. There is some overlap with the evidence base retrieved for the EGM on high-risk young people, namely for the areas of out-of-home care prevention and treatment foster care.

Studies in this EGM focused on:

- children and young people aged 0 to 18 years in out-of-home care; or
- carers of these children and young people.

One hundred and twenty-one studies; 93 primary studies and 28 systematic reviews met the EGM inclusion criteria.

Evidence summary

Programs or services delivered to the general out-of-home care population had the most evaluations (69 primary studies and 29 systematic reviews). These were followed by out-of-home care programs (51 primary studies and 14 systematic reviews) that include a therapeutic intervention -- e.g., Treatment Foster Care Oregon (TFC-O) and its caregiver-focused support program Keeping Foster and Kin Parents Supported and Trained (KEEP).

Within preventative services, a sizeable body of evidence exists for the effectiveness of interventions delivered to families at risk of their children being placed in out-of-home care, in particular Multisystemic Therapy (MST). Kinship care is represented with three primary studies and four systematic reviews. Of importance, a high-quality systematic review (Winokur et al., 2009) and its full update (Winokur et al., 2014) highlight that kinship care is, on average, at least as good as non-related foster care with respect to measured outcomes for young people, and for some measures (placement stability, mental and behavioural health, risk of re-abuse) even better.

Next to mental health outcomes, the child and youth outcomes of greatest interest across primary studies and systematic reviews are the social and cognitive functioning of children in out-of-home care, and the permanency of their living arrangements.

[7] This EGM is based on a separate report compiled by the Centre for Evidence and Implementation and the University of Melbourne for the New South Wales Department of Family and Community Services.

Evidence gaps

- The largest knowledge gap identified is the lack of studies examining interventions aiming to maintain and develop the cultural and spiritual identity of children and young people in out-of-home care. This is particularly concerning when considering that – if recent conditions for the growth of out-of-home care populations remain the same – the number of Aboriginal children is projected to triple over the next twenty years[8].
- Beyond manualised programs such as TFC-O or MST, there are few examples of integrating evidence-based practices, or identified effective core practice components of programs within out-of-home care. This gap is surprising given that the literature has pointed to several pathways to improve out-of-home care through greater integration of evidence into practice.
- There are few studies that:
    - evaluate the success of interventions designed to facilitate the successful transition of young people from out-of-home care into interdependent adulthood
    - examine the prevention of out-of-home care as a primary (i.e., non-universal) intervention
    - explore the effectiveness of interventions to promote the safe return of young people to their birth parents
    - detail child safety while in out-of-home care.

Recommendations

The examination of the effectiveness of culturally sensitive, competent, and sustainable interventions in out-of-home care is more pertinent than ever. There is a need to investigate the integration of cultural and spiritual components into out-of-home care, and to test the effectiveness of such targeted interventions on the positive development of young peoples' cultural and spiritual identity.

- *Examine the effectiveness of culturally-sensitive, competent, and sustainable services and interventions in out-of-home care.*

More evidence-based interventions should be independently evaluated for effectiveness in the Victorian context.

- *Conduct rigorous, independent impact evaluations to test the treatment and cost effectiveness of existing, manualised interventions that are transported to Victoria from other locations.*
- *Incentivise providers to develop and deliver locally relevant, innovative interventions that are built upon known effective core components.*
- *Test manualised and evidence-based interventions against other high quality interventions that use core components that have shown to be effective for the same outcomes.*

The ways in which out-of-home care services can support a child or young person's cognitive and academic development is not well understood.

- *Test and identify ways to effectively support the cognitive development and educational achievements of children in out-of-home care.*

Mixed, low-quality evidence exists on the effectiveness of a variety of programs designed to support young people transitioning from out-of-home care and into adult independent living situations.

- *Adopt, adapt and develop transition interventions for young people as they move into adulthood.*
- *Rigorously test and improve these interventions over time — promising international examples exist but are only available as grey literature (Skemer & Jacobs, 2016).*

[8] http://www.familymatters.org.au/wp-content/uploads/2016/12/Family_Matters_Report_2016.pdf

EGM 3: High-risk young people

Young people with high-risk behaviour such as aggressive behaviour, truancy and theft are at risk of entering out-of-home care or detention. Similar to the out-of-home care EGM, this area is well-developed in terms of the amount of high quality evidence. To further build evidence on effective interventions for high-risk young people in the child and family services system, there is a need to identify core practice components of effective interventions. Furthermore, interventions aiming to improve the cultural wellbeing, cognitive development, school engagement and decision-making skills of young people at risk need to be tested in greater detail.

Scope

This EGM includes studies on young people at high risk of an out-of-home placement and with externalised behaviours such as aggression and criminal, truancy and similar behaviours. Studies may include young people who are at risk of, or already placed in, out-of-home care.

Studies included in this EGM were focused on:

- young people aged 10 to 18 years
- with externalising behaviour problems (e.g., aggressive and/or offending behaviours).

Studies that were excluded from this EGM tested interventions targeting:

- young people already in out-of-home care
- internalising behaviours (e.g., behaviours associated with depression and anxiety)
- the transition of young people from out-of-home care into adult independent living
- young people in detention.

Ninety-five studies: 48 primary studies and 47 systematic reviews met the EGM inclusion criteria.

Evidence summary

This EGM yielded a comprehensive research base, including testing of a broad range of interventions such as parent-mediated interventions, re-entry and aftercare programs for young offenders, educational youth violence prevention programs, psychosocial interventions targeting young people directly, youth courts, case management approaches and boot camps.

It includes a considerable number of primary studies that tested different evidence-based programs, namely:

- Multisystemic Therapy (MST; n=22)
- Communities that Care (CTC; n=5)
- Multidimensional Family Therapy (MDFT; n=1)
- Brief Strategic Family Therapy (BSFT; n=1).

This variety is also reflected in the included systematic reviews, which included the interventions listed above in addition to:

- Aggression Replacement Training (ART)
- Functional Family Therapy (FFT)
- Motivational Interviewing (MI)
- Cognitive Behavioural Therapy (CBT).

There is strong evidence for interventions directed at young people with antisocial behaviour (aggressive or offending behaviour that disrupts or disregards the rights of others) that mediates or improves this behaviour. Aftercare programs supporting young people re-entering their community from detention were also well represented and show promise.

There is also strong evidence that therapeutic, risk-reduction interventions targeting high-risk young people and delivered through their parents (i.e., parent-mediated interventions or parenting programs) can reduce risky behaviours.

Two high-quality systematic reviews (Dretzke et al., 2005; Woolfenden et al., 2001) confirmed that parenting interventions can be effective in decreasing young people's problem behaviours.

The most evaluated parenting intervention in the identified literature is MST, which is represented by 22 primary studies and five systematic reviews, three of which focus solely on MST. The systematic review of highest quality (Littell et al., 2005) concluded that MST is no more effective than usual services in preventing out-of-home care placements and convictions. However, a more recent, high quality systematic review that included more recent studies documented small but significant effects of MST on youth delinquency, psychopathology, substance use, family factors, out-of-home placement, and peer factors (van der Stouwe et al., 2014).

Several studies documented the positive effects of different evidence-based programs on youth behaviour, with Lipsey et al. (2009) providing the best insight into what contributes to the effectiveness of different programs: a strong therapeutic intervention philosophy, serving high-risk offenders (as opposed to lower risk), and high-quality implementation.

There was also strong evidence that interventions aimed at changing the behaviour of young people by 'scaring' them can be harmful, having negative effects and worsening behavioural problems in young people. This is documented by primary studies and systematic reviews of two programs: 1) 'Scared Straight': organised visits to prisons by juvenile delinquents or pre-delinquents aimed at deterring them from delinquency, and 2) 'Boot Camps': military-style camps aimed at instilling discipline in young people.

Evidence from Australian and New Zealand studies

Three Australian and one New Zealand study evaluated interventions addressing high-risk young people with externalising behaviours. These are:

- Trust Program (Pawsey, 1996): a family behavioural treatment that reduced juvenile theft in those who completed the program. No control group was used and improvements therefore cannot be solely attributed to the treatment.
- Mindfields Programme (Carroll, 2012): for young people with a history of delinquency in Queensland which significant reduced delinquency and impulsivity, but employed a weak study design.
- Standard Teen Triple P (Salari, 2014): delivered to 33 families in Brisbane who were compared to 29 control families, which successfully decreased teen disruptive behaviours by reducing parents' use of ineffective parenting strategies.
- MST (Curtis, 2009): results from this benchmarking study were compared to results achieved through three RCTs conducted in the US to test for adaptability of the program in New Zealand. The New Zealand results were clinically equivalent to US outcomes and included a significant reduction in the frequency of offending behaviour and its severity. However, the number of days spent in out-of-home care was not improved at 12 month follow up.

One recent systematic review of Australian studies (Cox, 2016) evaluates the effectiveness of youth violence prevention programs. Interventions in included studies aimed to reduce or prevent bullying (n=4), alcohol and other drug related violence (n=5), and antisocial or violent behaviour (n=10). The authors concluded that the evidence relating to effectiveness was mixed but that the more successful programs tended to address known risk factors and to enhance protective factors.

Evidence gaps

- Few studies compared manualised evidence-based programs to each other or to other potentially high-quality interventions available in the community.
- No studies were identified that assessed how interventions targeting high-risk young people impact the safety of young people beyond a reduction in risk-taking behaviours.
- Outcomes related to the spiritual and cultural identity of young people — their belonging to country, culture, and community — were not covered in any of the included studies.
- Very little is known about whether and how interventions addressing the anti-social behaviour of high-risk young people improved their academic achievements, school engagement, problem solving and decision-making skills.
- Only a few studies covered outcomes related to the wellbeing of parents and caregivers of young people with antisocial behaviours. Given that a large proportion of high-quality interventions rely on parents or caregivers to deliver portions of the intervention, this is a large and important gap.
- Independent evaluations of studies were less prevalent than evaluations conducted by program developers.
- Beyond model fidelity, few primary studies addressed implementation or tested specific aspects of the implementation process.

Recommendations

Trials of interventions targeting high-risk young people should include an active control group that is receiving a different evidence-based practice or a high-quality community service.

- *Rigorously and independently trial evidence-based interventions targeting high-risk young people to determine if they are effective in the Victorian context.*
- *These trials should compare evidence-based interventions with high quality Victorian interventions, rather than comparing them to interventions of known lower quality.*

There is limited but promising evidence that the core components or practice elements of effective interventions in this area can be combined and built into tailored interventions that are effective for improving behavioural outcomes.

- *Identify core components or practice elements of effective interventions, use these to develop tailored interventions and then test these for effectiveness.*

The lack of culturally sensitive, effective programs for high-risk young people prompts a recommendation for trialling such interventions or adaptations of existing mainstream interventions that are culturally sensitive and supportive.

- *Develop culturally sensitive and driven interventions, incorporate these into mainstream interventions and then test these for effectiveness in the same way other interventions are supported and evaluated.*

Well-designed parenting interventions and aftercare programs may hold the strongest promise for improvements in outcomes. Little is known about the effect of these interventions on young people's academic and cognitive development.

- *Test interventions that target and monitor the cognitive development of high-risk young people and improve educational achievements as these are strongly linked with long-term success in life.*

Poor implementation is the cause of many failed programs, even those that are 'evidence-based'.

- *Incorporate and test implementation when trialling interventions to both assess their implementability and ensure interventions are delivered with fidelity.*

EGM 4: Trauma-informed practice

Trauma-informed practice refers to a framework grounded in an understanding and responsiveness to the impact of trauma. The framework emphasises physical, psychological, and emotional safety for both providers and victim/survivors, and opportunities for victim/survivors to rebuild a sense of control and empowerment. Trauma-informed practice incorporates an awareness of the impact of trauma and traumatic stress, recognising their potential for long-term, negative consequences to an individual's sense of control, safety, ability to self-regulate, sense of self, self-efficacy and interpersonal relationships. In essence, trauma-informed interventions specifically aim to address the negative outcomes that are often associated with exposure to trauma.

Scope

This EGM includes studies assessing interventions that are 'trauma informed' and that target vulnerable children and their families.

Studies included in this EGM:

- targeted children aged 0 to 18 years, who were vulnerable (i.e., at risk of or exposed to child maltreatment); and
- tested interventions identified as being trauma informed.

Thirty-eight articles; 25 primary studies and 13 systematic reviews met the criteria for this EGM.

Evidence summary

Only four primary studies (Cohen, 2011; Dorsey, 2014; Farkas, 2010; Overbeek, 2013) and two systematic reviews (Fraser, 2013; Leenarts, 2013) were concerned with trauma-informed practice and vulnerable children. The remaining studies — eleven primary studies and nine systematic reviews — included a broader population of children and young people who had faced trauma of varying types and/or children and young people who presented symptoms and met the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). An additional ten primary studies and two systematic reviews assessed interventions for child sexual abuse. Attempts were made to locate studies focused on sexual abuse perpetrated by a family member, but studies did not adequately separate familial from non-familial abuse.

Strong evidence exists for Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), a well-known evidence-based therapeutic intervention originally developed for child sexual abuse. TF-CBT was consistently found to be effective for improving child mental health symptoms such as anxiety, depression, and behaviour problems in child welfare populations (Cary & McMillen, 2012; Fomeris et al., 2013; Jensen et al., 2017; James et al., 2015; Leenarts et al., 2013). In one of the few high-quality reviews that compared the effectiveness of two trauma-informed interventions, Gillies et al. (2016) found that TF-CBT was more effective than Eye Movement Desensitization and Reprocessing in decreasing PTSD symptoms in the short term.

Overall, TF-CBT is the primary intervention that has the greatest promise for addressing trauma-related symptoms in children, young people, and families facing trauma, especially those who have been sexually abused. However, TF-CBT has been used almost exclusively for children who have been sexually abused (i.e., there is less evidence of its effectiveness for other types of trauma such as physical abuse and exposure to domestic violence). It also requires high levels of caregiver engagement, which can be challenging to achieve in vulnerable families.

Most studies included in this EGM focused on outcomes related to the mental health of children and caregivers. Overall, the evidence suggests that trauma-informed practice is associated with improved functioning for diagnosed mental health conditions. These included PTSD, depression, anxiety, and substance use.

Evidence from Australian and New Zealand studies

Two primary studies evaluated a trauma-informed intervention for vulnerable children in an Australian context (Feather & Ronan, 2006; Feather, 2009). Both were conducted by the same authors and evaluated a model of TF-CBT that they specifically adapted to the context of child maltreatment. Both found that TF-CBT significantly reduced symptoms of PTSD while increasing child coping skills. The authors concluded that the TF-CBT adaptation for child maltreatment shows reliability and promise, however, these conclusions should be interpreted with caution as the studies used low-quality designs.

Evidence gaps

- Rigorous testing of different trauma-informed interventions specifically targeted to the broad range of child maltreatment. While strong evidence was found supporting TF-CBT, there may exist barriers to delivering this intervention with vulnerable families as the model requires considerable engagement from caregivers. Additionally, TF-CBT has been used almost exclusively with children who have been sexually abused – more evidence is needed for its use with children who have been exposed to physical abuse, family violence and other forms of trauma.
- Rigorous testing of trauma-informed interventions that address outcomes such as child safety, permanency, child development, or other forms of wellbeing. Currently research focuses mostly on mental health outcomes.
- Studies that compared trauma-informed interventions with other high-quality interventions were sparse.
- No studies were found that assessed the effectiveness of preventative interventions. This may be explained by the nature of the topic: trauma that results in the need for clinical treatment is not a universal experience and can be difficult to predict or prevent. As such, trauma-informed interventions tend to target more clinical populations.

Recommendations

TF-CBT and other interventions have not been sufficiently adapted and/or rigorously tested for addressing trauma deriving from child maltreatment other than child sexual abuse. Also unclear is whether it is the 'TF', the 'CBT' or the combination of both that make it effective.

- *Rigorously test and evaluate TF-CBT and other trauma-informed interventions to determine if these lead to improved outcomes for children who have experienced trauma as a result of any form of maltreatment (not specifically sexual abuse) prior to their widespread implementation. This includes designing RCTs or building up to one or more RCTs; or conducting high-quality quasi-experimental studies.*
- *Test and compare the effect of other trauma-informed approaches to the well-documented standard: TF-CBT.*
- *Test and compare adaptations of mainstream programs with high quality approaches that consider trauma but are not necessarily in the 'trauma-informed' family.*

It may well be that TF-CBT has a set of core components or practice elements that can and should be integrated into regularly delivered services to children who have been maltreated. Research identifying and testing these core components could substantially improve services for all vulnerable children.

- *Identify and test the effectiveness of core components or practice elements of the TF-CBT model.*
- *Test and compare TF-CBT to more standard cognitive behavioural interventions to determine when and whether a specific trauma-informed approach is warranted as opposed to a competently delivered cognitive behavioural therapy.*

The evidence of the effectiveness of TF-CBT and, to a lesser extent, other trauma-informed approaches on mental health symptoms is strong, but little is known about the impact of these interventions on child safety and wellbeing outcomes.

- *If trauma-informed interventions are going to be recommended for a broad array of outcomes, these outcomes should be measured when trialling and evaluating trauma-informed interventions.*

While there are indications that individual, rather than group, approaches are more effective at treating the consequences of trauma, these have not been tested across a range of intervention types.

- *Test and compare the effectiveness of different trauma-informed interventions when delivered in group or individually.*

Aboriginal children, families, and communities have suffered high rates of intergenerational trauma. However, no strong evidence exists on the effectiveness of trauma-informed services for Aboriginal children and families. This does not mean that these services do not exist or are not effective, but rather that they are unlikely to have been rigorously evaluated.

- *Rigorously evaluate trauma-informed programs designed by Aboriginal services that take into consideration the unique sources of trauma within this population.*

TF-CBT has been tested enough for its general effectiveness in responding to child sexual abuse. It is extremely likely that the consistent findings of effectiveness for this intervention will easily translate into the mainstream Australian context.

- *Research on TF-CBT for child sexual abuse should focus on implementation and variations in delivery or target population.*

EGM 5: Children and young people with disabilities and their families

Children and young people with disabilities are at a higher risk of maltreatment than those without disabilities, and the prevalence of physical violence and emotional abuse may be particularly high among children with mental or intellectual disabilities (Jones et al., 2012). A recent population-based record-linkage study in Western Australia found that, between 1990 and 2010, 29% of all substantiated maltreatment allegations involved a child with a disability, and the risk of maltreatment was particularly high for children with mental and intellectual disabilities (Maclean et al., 2017).

No primary studies could be located in the search. Therefore, this EGM included only two systematic reviews.

Scope

Studies included in this EGM focused on:

- children with moderate to severe physical, intellectual, or behavioural disability who are specifically targeted for social services; and
- interventions to prevent or reduce child maltreatment.

Evidence summary

Two systematic reviews were identified (Strunk, 2010; Ziviani et al., 2012). The first systematic review focused on respite care for families of children with special needs (Strunk, 2010). Only one of the fifteen studies included was directly related to child maltreatment and vulnerable families. This primary study (Cowen & Reed, 2002) found that high levels of caregiver stress decrease through the provision of respite care.

The second systematic review centred on interventions to support children with challenging behaviours related to a disability within out-of-home care settings (Ziviani et al., 2012). This review aimed to identify interventions that support the management of challenging behaviours sometimes displayed by children with disabilities, which have been found to relate to maltreatment. In other words, none of the studies directly tested interventions to prevent maltreatment, but rather tended to focus on training parents and caregivers to manage challenging behaviours, thereby decreasing the likelihood of future maltreatment. Interventions described in this systematic review included tailored case management, group-based training on the management of challenging behaviour, and parent-child interaction therapy. Three of the four included studies in this review reported positive outcomes for children, while the fourth study failed to identify any positive changes.

Evidence from Australian and New Zealand studies

No studies conducted in Australia or New Zealand could be identified for this topic.

Evidence gaps

Overall, the evidence base is too scarce to draw any reasonable conclusions about what may be effective for decreasing risk of maltreatment harm and improving outcomes for children with disabilities in the vulnerable child and family service system. That said, there are hundreds of high quality studies describing effective behaviour management programs, practices, and services for parents and caregivers of children with disability and challenging behaviours who are not involved with, or at risk of being involved with, the child protection system.

Recommendations

The limited evidence on the effectiveness of interventions specifically designed to prevent maltreatment of children with disabilities along with high prevalence rates of maltreatment for this population indicate that this is an area that requires a great deal of research.

- *Test interventions specifically designed to prevent the maltreatment of children with disabilities.*

There are numerous studies and reviews of parenting programs, practices and services geared toward assisting parents and caregivers to manage the challenges of raising children with disabilities (Murray et al., 2017; Skotarczak et al., 2015; Coates et al., 2015; Whittingham et al., 2011).

- *The broad evidence base on interventions to support parents and caregivers of children with disabilities can serve as a beginning for intervention and service development in the child protection area, focusing on the specific needs of children with disabilities and their families and finding or developing interventions that meet their specific needs.*

Focusing on parent and caregiver stress and burden is likely to lead to improved child and parent and caregiver outcomes, both in terms of prevention and early intervention as well as later stages of involvement in the child protection system. These are services that can decrease parenting challenges, potentially leading to decreased parenting stress, improved adult/child relationships, and improved overall health and well-being.

- *Develop and test interventions in the disability context that focus on responding to parenting challenges and stress, such as skill-based behavioural and parenting training, respite care, home health aides, and parent and caregiver social support services.*

Potential ethical concerns around conducting research with this population (e.g., issues of child assent and of parental consent when maltreatment is involved) while well-intended, raise a social justice issue — namely that the research guiding practice and polity in this area is limited and may result in lower quality programs and services delivered to this highly vulnerable population. There are ways around this potential impasse. Large numbers of small-scale trials of interventions have been conducted for the broader population of children with disabilities, including intellectual disabilities, particularly in areas where little is known and consent can be reasonably attained. These smaller trials can be aggregated up into meta-analyses to generate a reasonable effect estimate. Similarly, N of 1 or single-subject designs have potential as a vehicle for measuring the effect of behavioural interventions and can also be meta-analysed for estimates of overall effect.

- *Where ethical issues are particularly difficult to navigate, consider smaller, time limited trials and well-executed Nof1 studies that can be statistically combined with other studies to generate estimates of effect for the larger population.*

EGM 6: Family violence

Family violence reports are increasing in Victoria and are a key driver of child protection reports. While there is some evidence for early intervention and support services to victim survivors, there is a need to build evidence on what works to increase the safety of children and young people in the context of family violence and how to best support children and young people who are victim survivors of family violence.

Scope

This EGM gathered evidence for preventing and reducing family violence, including interventions targeting perpetrators.

Studies that were included in this EGM tested interventions:

- for domestic violence, family violence, or intimate partner violence, that specifically mentioned children
- that were delivered in a social service setting.

Studies that were excluded in this EGM tested interventions dealing with:

- divorce, martial and inter-parental conflict and problematic relationships
- other relationship challenges that do not involve violence
- dating violence.

Additionally, studies that concerned interventions delivered in a health care setting were not included.

Evidence summary

In general, services can be separated into three broad categories: preventative, early intervention, and therapeutic. Within each of these, the most commonly researched were:

- home visits for vulnerable expectant mothers (preventative)
- home visits for vulnerable new mothers (early intervention)
- shelter services for female victims/survivors of family violence and their children (therapeutic)
- specific support services such as housing, assistance with court orders, safety planning, and financial assistance
- counselling/therapy for distress related to family violence
- intervention programs for male perpetrators, mostly court-mandated (therapeutic).

Much of the evidence fell into one of the three categories: (1) interventions for women/children who are victims/survivors of family violence, (2) interventions for male perpetrators and (3) prevention and early intervention with at risk families.

Women and children who are victims/survivors of family violence

Interventions targeted at women and children to help them escape from and/or overcome the aftermath of family violence such as receiving shelter and other family violence services mostly had a positive impact on the child's and/or mother's emotional and psychological well-being. The evidence for such interventions was of moderate quality (see quality assessments provided as an attachment to this report). While there is evidence that treatment can be of some benefit, the details are thin with respect to specific therapeutic interventions and their timing, duration, and frequency.

Male perpetrators

There is a substantial, high-quality body of evidence that suggests that current models of court-ordered interventions are not effective for decreasing violent behaviour. This is true for the most commonly used program (i.e., the Duluth Model), which uses a group-based approach to help men understand the negative effects of violence and to encourage them to take responsibility for their behaviour. There is limited evidence, either for or against, alternative models of treatment, though those engaging men in parenting (e.g., through fatherhood engagement strategies) may hold promise. There is a small body of evidence suggesting that violence of lower severity can be addressed using couple-based approaches. In all, it is unclear whether group-based or individually-based approaches are best, nor is it clear whether behavioural interventions are superior to other approaches.

Prevention and early intervention

Preventative and early interventions for children and their caregivers (including home visiting for pregnant women and co-parenting counselling programs, home visiting for non-pregnant women and psycho-educational programs) have been found to improve the safety as well as the emotional and social well-being of children and their caregivers.

Evidence from Australian and New Zealand studies

There is a dearth of Australian and New Zealand evidence on family violence interventions. Two high-quality primary studies were identified that target child maltreatment in the context of family violence.

The Domestic Abuse Program (DAP) (Australia) is a program delivered by Corrective Services NSW (Blatch, 2016) to men with a case history of family violence or related offences serving a custodial sentence. DAP participants experienced a reduction in reoffending and a longer time to reconviction, especially for violent reconviction.

The 'Early Start' (New Zealand) (Fergusson, 2005) home visitation program for families facing stress and difficulty had a positive impact on: increased use of available child health services, lower hospital presentations, increased enrolment in preschool education, increased positive and non-punitive parenting, lower rates of severe assault on children, and reduced rates of child problem behaviours.

Evidence gaps

- Alternative approaches (such as engagement in parenting and, in particular, fatherhood) to traditional, court-ordered perpetrator intervention programs (such as Duluth) are being introduced into the international, Australian and Victorian context. However, their level of evidence of effectiveness is unknown.
- The format and mode of delivery of interventions is a crucial consideration for any intervention in terms of both effectiveness and cost, but there is little evidence regarding whether individual or group-based approaches work best to decrease ongoing and future family violence.
- While there is some evidence to suggest that family violence of low to moderate severity can be effectively treated using a couples-based approach, this evidence is limited as is evidence regarding which couples are most likely to benefit and which approaches are most effective. As well, there is little evidence to guide the implementation of this approach, which is crucial given its potentially controversial approach to treating the couple (rather than assisting women to leave or focusing entirely on men who use violence against women).

- For women (and by extension their children) who are not yet ready or who do not want to leave an abusive relationship, little is known about:
  - The types and dose[9] of different interventions that are most likely to be effective for promoting safety and well-being
  - The most effective way to develop and execute safety plans.
- For Aboriginal families, little is known about the extent to which:
  - Mainstream prevention, early intervention and treatment services/programs are effective for promoting safety and well-being
  - Culturally sensitive/culturally adapted programs, including those that are community-based, are more effective than mainstream services for promoting safety and well-being.

Recommendations

There is a need to systematically and rigorously build evidence on what works to decrease future family violence when families stay together after one or more known incidents of family violence. While there is no evidence that perpetrator programs are effective at reducing family violence, this does not mean that nothing will work. There is emerging evidence that a focus on parenting and in particular fatherhood, coupled with well-executed behavioural interventions, may be effective for several key outcomes.

- *Rigorously test – using RCTs or high quality quasi-experimental designs – newly emerging alternative perpetrator intervention programs as well as approaches that support families who stay together where violence is occurring.*

Some couples-based interventions for family violence have been tested with lower level designs and some high-quality designs, but suffer from a limited number of studies with small samples. Their positive findings should now be replicated using larger, high-quality study designs.

- *Replicate findings from couples-based interventions for family violence using large-scale, rigorous study designs. These trial protocols should be registered in a clinical trial registry to ensure that regional and international evidence is built up in this area.*

Behavioural interventions that have been effective in other areas have a strong theoretical basis for effectiveness in a family violence context (e.g., CBT) but have not shown as much promise for men who use violence against women. It is unclear whether this is a result of poor implementation, poor targeting (e.g., wrong level of severity), poor delivery (e.g., individual v. group-based), the mandatory nature of the intervention, or if it is because the intervention is just insufficient on its own and must be matched with another approach (e.g., substance misuse interventions).

- *Test and evaluate behavioural interventions with family violence perpetrators as they have demonstrated cost-efficiency and effectiveness with other social and psychological problems.*

No rigorous evidence exists for family violence interventions delivered to Aboriginal children and families.

- *Develop an evidence-base for culturally sensitive and relevant family violence interventions for Aboriginal children and families across the continuum of services, from prevention and early intervention to therapeutic approaches.*

[9] 'Dose' describes the intensity with which a service should be delivered to create a change in a client. For example, it can be described through weeks of delivery; number of weekly sessions; and session length.

Risk factors for child maltreatment

The six EGMs looked at evidence on interventions targeted at a range of vulnerable children and family cohorts. To complement this work, this report also includes evidence regarding risk factors for child maltreatment. A search was conducted for systematic reviews examining the risk factors associated with child maltreatment, focusing also on risk factors specifically related to each of the EGM areas.

There were few systematic reviews that met the search criteria (n = 11). The quality of the systematic reviews was moderate overall (AMSTAR average = 5). Six of the reviews were international in scope, and five others each concentrated on specific regions.

Family violence

A large proportion of the systematic reviews related to family violence (n = 4). Three of these focused on the prevalence and/or the risk factors for family violence during pregnancy. A history of previous abuse, low education level, low socioeconomic status, and unintended pregnancy were identified as moderate to strong risk factors for violence during pregnancy (Kashif, Murtaza & Kirkman, 2010; James, Brody & Hamilton, 2013; Han & Stewart, 2014). One systematic review analysed intimate partner violence as a risk factor for sexual abuse and other forms of child maltreatment, reporting their co-occurrence as ranging between 12 – 70% (Bidarra, Lessard & Dumont, 2016).

Children and young people with disabilities

One high-quality (AMSTAR = 10) systematic review with a meta-analysis (Jones et al., 2012) measured the prevalence and risk of child maltreatment for children with disabilities (overall maltreatment: 26.7%; physical abuse: 20.5%; sexual abuse: 13.7%; emotional abuse: 18.1%; neglect: 9.5%;). The study found that the risk of maltreatment was greater for children with disabilities than it was for those who did not have a disability. In this review, children with intellectual disabilities were most likely to experience any form of maltreatment, and were at a significantly greater risk of emotional, physical, and sexual abuse. The authors note, however, that there is a lack of consistency in how both disability and maltreatment are measured across studies, and that few well-designed studies exist in this area.

Gender

Multiple reviews found a gender difference in the forms of child maltreatment experienced by children; physical abuse was more common for males, whereas the risk of sexual abuse was substantially higher for females.

The literature search also revealed an overall lack of information about how and to what extent risk factors contribute to child maltreatment. It should be noted, though, that numerous large-scale studies outside the scope of this project strongly suggest that the presence of one or more of these risk factors place children at a considerably greater risk of maltreatment and abuse (for an Australian example, see Doidge, Higgins, Delfabbro & Segal, 2017).

Cross-cutting themes and recommendations

This section provides an overview of common themes across all EGMs, highlighting gaps in the evidence needed to support the delivery of children and family services, and to guide the strategic commissioning of research in this area.

The overall number of international, high-quality primary studies and systematic reviews is small. This is especially the case within the key areas of services targeting Aboriginal children and families and children with disabilities.

Most of the primary studies that were found were conducted in the U.S. This is also the case with systematic reviews, as these are primarily based on the primary studies. Across the six different EGM topics, the proportion of primary studies conducted in Australia was small (see Table 3).

Table 3: Primary Studies by location

Topic	Total	Australia	U.S.
Aboriginal children and families	5	0	5
Out-of-home care	93	0	72
High-Risk young people	48	1	39
Trauma-informed practice	25	0	17
Children with disabilities and their families	0	0	0
Family violence	33	1	26
TOTAL	**204**	**2 (0.01%)**	**159 (77.9%)**

- *Recommendation: Rigorously test and adapt high-quality evidence-based programs designed to support vulnerable children and families to assess their transportability to the Australian context and measure barriers and facilitators of implementation.*

There is an overall lack of high-quality evaluations of Aboriginal programs[10] , thus few existing evaluations met the strict inclusion criteria for this report. Given the history of unequal treatment, forced removal of Aboriginal children from their families, and the continued overrepresentation of Aboriginal young people in out-of-home care, it is important to develop a strong evidence base for programs that can effectively support vulnerable Aboriginal children and families and that lead to improved outcomes.

- *Recommendation: Determine the effectiveness, through rigorous evaluation, of promising interventions that have been locally developed or adapted to specific Victorian populations, particularly those delivered through Victorian Aboriginal children and families services.*
    - *Research with Aboriginal children and families should be conducted in full partnership with Aboriginal services and communities, and should be sensitive and responsive to Aboriginal culture and values.*

Most interventions targeting children and families that have a high level of evidence are well-known manualised programs. However, there is mounting evidence that there is a set of core or universal components common to effective interventions. These can be identified and harnessed to develop new, effective interventions or can be integrated into existing services to make them more effective. This process has the advantages of adapting effective interventions for specific contexts and, over the medium and long-term, being less costly. While the identification and use of core components is still in its infancy and considerable challenges exist in both identifying and using them effectively, the future of effective services clearly lies in this direction.

- *Recommendation: Invest in the identification of core components or practice elements of effective interventions and their integration into new or existing services. This is particularly important for Aboriginal services that are in the position of having to culturally and contextually adapt existing programs or create purpose-built new ones.*

The best evidence was found for well-known programs treating well-defined problems or conditions. Some of the challenges are that child maltreatment is difficult to define, is not easy to properly assess, and its presence can prompt numerous compounding problems that can last a lifetime. Due to this complexity and the severity of issues, programs and services may 'do what they can' to be helpful. A better pathway to positive outcomes can be developed.

- *Recommendation: When developing and testing interventions, clearly define the problem being addressed, the specific intervention being administered, the specific outcomes being sought and how these will be measured. A clearly articulated logic model brings these elements together, drives the selection of a valid intervention and enables effectiveness to be measured.*

Common features across most of the high-quality effective interventions for vulnerable children and their families are the involvement of parents and caregivers and the inclusion of a behavioural component. That is, the parent or caregiver is trained, coached, and is the primary delivery vehicle for a clearly defined intervention that involves behavioural change.

- *Recommendation: Focus efforts on developing and implementing interventions that support parent and caregiver capacity to deliver high-quality parenting in challenging circumstances.*

[10] For a detailed report on this topic, refer to Hudson (2017). Evaluating Indigenous programs: A toolkit for change.

The research underpinning well-known programs is almost exclusively derived from studies that compare known interventions to no services or to low-quality services. Known interventions are rarely compared to competing interventions or to other high-quality services available in the community.

- *Recommendation: Conduct comparative effectiveness research that compares well-known interventions against other well-known interventions or high-quality interventions built upon, or that substantially incorporate, effective core components or practice elements.*

A high proportion of programs and services contained in these EGMs deliver interventions in a group-based format. While potentially cost effective and possibly helpful in terms of social support, there are contra-indications to this format (e.g., negative influence of peers) and a fair number of effective interventions can and should be delivered in the home or individually.

- *Recommendation: Selected interventions should carefully consider the setting in which program content is best delivered and whether content should be presented in a group-based or individually-based format.*

There is large body of literature on effective services for specific problems. When evidence does not specifically exist for the child protection population, this wider body of literature can serve as a starting point for the development and/or adaptation of interventions that are likely to be effective.

- *Recommendation: Where gaps exist in the literature, look to related high-quality research on similar problems and/or populations rather than relying on low-quality studies specific to child protection.*

None of the EGMs included interventions designed to facilitate the development of a cultural or spiritual identity. Similarly, there were very few studies that described cultural or contextual adaptations of interventions. This is an important gap, as Aboriginal communities have repeatedly identified the importance of culture for healing and strengthening individuals and community[11]. None of the studies identified outcomes that are distinctly Aboriginal (in contrast to outcomes that are not specified by population). While this is one of the most apparent gaps for Aboriginal children and families, it also has relevance for non-Aboriginal children and families who may have cultural and religious backgrounds that are important to service delivery.

- *Recommendation: Identify specific and measurable outcomes that relate to cultural and spiritual identity, and any other area of interest to cultural communities. Integrate them into the outcomes framework and begin a program of continuous quality improvement geared toward achieving these outcomes.*

[11] Although the distinction between individual and community is made here for greater clarity, this is not meant to imply that they are separate.

Beyond model fidelity, few primary studies even addressed implementation or tested specific aspects of the implementation process even though there is a growing body of literature suggesting that poor implementation is often the undoing of otherwise effective programs and services. Implementation science offers a substantial body of evidence specifically designed to successfully implement programs and services and, increasingly, to adapt such programs and services to context.

- *Recommendation: Include the conduct and measurement of implementation (this extends far beyond measures of compliance, incorporating strategies to increase model fidelity and overcome challenges to successful implementation) in all commissions for program development, program delivery and program evaluation.*

The evidence on the cost effectiveness of interventions is scarce. Very few studies could be identified that provide information on the expenses emerging from the use of programmes, their implementation and scaling, and their cost benefits when compared to other interventions or services as usual. One notable exception is the Washington State Institute for Public Policy or WSIPP[12]. Given the increased interest in identifying cost-effective interventions and transporting these to new service settings and contexts, there is great need for reliable cost benefit analyses that can provide guidance to policy developers and service agencies when selecting and adapting interventions. Although the methods for conducting such analyses are hotly contested (including those for WSIPP), their contribution to informing policy can be substantial.

- *Recommendation: Include cost analyses and cost-benefit analyses in all commissions for program development, program delivery, and program evaluation. Consider the development and maintenance of a central repository of rigorous cost benefit evaluation data for Australian interventions similar to the work conducted by the WSIPP.*

The scant literature found for these EGMs is, at least in part, a result of limited efforts on the part of governments internationally to commission high-quality research and transparently disclose findings. There is greater support in the U.S. and this is reflected in the larger number of high-quality studies conducted there.

- *Recommendation: Commission and support rigorous primary studies and make their methods and results transparent by mandating registration in a clinical trials registry such as the Australia New Zealand Clinical Trials Registry (www.anzctr.org.au). In addition, commission rigorous systematic reviews that are publishable in high quality, open source/accessible journals in areas where there exist adequate primary studies. This will serve to build the evidence base needed to make informed decisions in the years to come.*

12 http://www.wsipp.wa.gov.

References

Amlani, A., Grewal, G. S., & Feldman, M. D. (2016). Malingering by Proxy: A literature review and current perspectives. *Journal of Forensic Sciences, 61*(S1).

Bidarra, Z. S., Lessard, G., & Dumont, A. (2016). Co-occurrence of intimate partner violence and child sexual abuse: prevalence, risk factors and related issues. *Child Abuse & Neglect, 55,* 10-21.

Carroll, A., Ashman, A., Hemingway, F., Bower, J., & Houghton, S. (2012). A preliminary evaluation of mindfields: A self-regulatory cognitive behavioural program for school-aged adolescent offenders. *The Australian Educational and Developmental Psychologist,* 29(2), 81.

Coates, J., Taylor, J. A., & Sayal, K. (2015). Parenting interventions for ADHD: A systematic literature review and meta-analysis. *Journal of attention disorders, 19*(10), 831-843.

Curtis, N. M., Ronan, K. R., Heiblum, N., & Crellin, K. (2009). Dissemination and effectiveness of multisystemic treatment in New Zealand: a benchmarking study. *Journal of Family Psychology, 23*(2), 119.

Doidge, J. C., Higgins, D. J., Delfabbro, P., & Segal, L. (2017). Risk factors for child maltreatment in an Australian population-based birth cohort. *Child Abuse & Neglect, 64*, 47-60.

Han, A., & Stewart, D. E. (2014). Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region. *International Journal of Gynecology & Obstetrics, 124*(1), 6-11.

Hudson, S. (2017). *Evaluating Indigenous Programs: A toolkit for change*. Centre for Independent Studies research report: RR28.

James, L., Brody, D., & Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence and Victims, 28*(3), 359-380.

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., ... & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet, 380*(9845), 899-907.

Kashif, M., Murtaza, K., & Kirkman, M. (2012). Violence against women during pregnancy in some Asian countries: a review of the literature. *Italian Journal of Public Health, 7*(2).

Kloppen, K., Haugland, S., Svedin, C. G., Mæhle, M., & Breivik, K. (2016). Prevalence of child sexual abuse in the Nordic countries: a literature review. *Journal of Child Sexual Abuse, 25*(1), 37-55.

Murray, D. W., Lawrence, J. R., & LaForett, D. R. (2017). The Incredible Years® Programs for ADHD in Young Children: A Critical Review of the Evidence. *Journal of Emotional and Behavioral Disorders*, 1063426617717740.

Pawsey, R. (1996). A family behavioural treatment of persistent juvenile theft. *Australian Psychologist, 31*(1), 28-33.

Reupert, A., & Maybery, D. (2016). What do we know about families where parents have a mental illness? A systematic review. *Child & Youth Services, 37*(2), 98-111.

Riley, C. L., Sarani, B., Sullivan, J. A., Upperman, J. S., Kane-Gill, S. L., Bailey, H., & Society of Critical Care Medicine. (2015). Critical violent injury in the United States: a review and call to action. *Critical Care Medicine, 43*(11), 2460-2467.

Salari, R., Ralph, A., & Sanders, M. R. (2014). An efficacy trial: Positive parenting program for parents of teenagers. *Behaviour Change, 31*(1), 34-52.

Skemer, M., & Jacobs, E. (2016). Striving for Independence: Two-Year Impact Findings from the Youth Villages Transitional Living Evaluation.

Skotarczak, L., & Lee, G. K. (2015). Effects of parent management training programs on disruptive behavior for children with a developmental disability: A meta-analysis. *Research in developmental disabilities, 38*, 272-287.

Sundin, E. C., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 50*(2), 183-194.

Timmerman, M. C., & Schreuder, P. R. (2014). Sexual abuse of children and youth in residential care: An international review. *Aggression and Violent Behavior,19*(6), 715-720.

Whittingham, K., Wee, D., & Boyd, R. (2011). Systematic review of the efficacy of parenting interventions for children with cerebral palsy. *Child: care, health and development, 37*(4), 475-483.

WHO - World Health Organisation (2017). Indigenous Populations. Retrieved from: http://www.who.int/topics/health_services_indigenous/en/

Appendices

Appendix A: Methodology

EGMs are a visual overview of available research evidence for a particular area and provide a summary of the amount of evidence and their strength. Therefore, they can be used to identify the areas with strong, weak or non-existent evidence and are useful for identifying key areas that warrant research. They usually focus on published evidence and assess the quality of included studies using standard rating tools.

For this report, the focus was on high quality evidence (i.e., systematic reviews and randomised controlled trials (RCTs)) conducted in developed countries. These findings were supplemented by non-RCTs and comparative observational studies conducted in Australia and New Zealand. The scope of the evidence that focused on risk factors for child maltreatment was also assessed based on the systematic reviews of epidemiological studies identified from the search.

Database search

The following six electronic databases were searched in March 2017 to identify relevant studies:

- Medline (Ovid)
- PsycINFO (Ovid)
- CINAHL Complete
- Family and Society Studies Worldwide
- SocIndex
- Scopus.

Search strategy

The search strategy for each EGM consisted of two main components.

- A component unique to each question:
  - Question specific MeSH terms were combined with relevant key words to form the unique component of the search strategy for the five review questions.
- A general component that was used across all five questions as filters (i.e., RCTs, systematic reviews and Australia and New Zealand studies):
  - The output of the individual searches was filtered for RCTs, SRs and studies conducted in Australia and New Zealand using the search strategy given in Table 1.

Table 1: Medline (Ovid) search filters used across searches

Filter	Search Terms
RCT	((random or randomly or randomized or randomised or blinded or double blind* or doubleblind*) adj3 (trial* or study or participant*)).mp.
SR	(metaanal* or meta anal* or (systematic adj1 review*) or systematic synthesis or realist synthesis or realist review*).mp.
ANZ	exp australia/ or australia*.mp. or new zealand.mp. or victoria.mp. or new south wales.mp. or queensland.mp. or tasmania.mp. OR (australia* or new zealand or victoria or new south wales or queensland or tasmania).in.
Population	(infan* or child* or minor or minors or toddler* or baby or babies or adolescen* or teen* or young person or youth* or young people).mp.

The above search strategy was used in Ovid Medline and was adapted accordingly to use in other databases. The complete list of search strategies for each question and the databases are provided as an attachment to this report.

Upon retrieval of search output, the following three-step process was used to identify relevant studies.

Step 1:

All RCTs and Systematic reviews were retrieved for each topic.

Step 2:

Databases were searched for additional studies conducted in Australia and/or New Zealand. Due to the high volume of citations, titles and abstracts were screened with the word 'control' to limit the output to manageable level. The search for Australian and New Zealand studies for interventions for high-risk young people was amended with additional search terms to narrow the scope of the search. This added search strategy was conducted in Medline (Ovid) and PsycINFO (Ovid) databases and is provided as an attachment to this report.

Step 3:

SRs retrieved for the five searches were merged into one library and filtered with relevant key words such as: 'epidemiology', 'incidence', 'prevalence' and 'maltreat'. The goal of this search was to identify studies that could provide insights into the epidemiology of child maltreatment, in particular its prevalence and the risk factors of child maltreatment commonly identified across studies.

Eligibility criteria

The inclusion and exclusion criteria varied between the five EGM topics.

Across all topics, studies – systematic reviews or RCTs – were only included if they had been conducted in high income countries comparable to Australia. Studies conducted in low and middle income countries were excluded. So too were studies published in languages other than English. No restrictions were placed on outcomes measured by different studies. Studies that evaluated interventions delivered in hospital or in school settings were not eligible – interventions had to be delivered in the home or in social care/community settings.

EGM 1: Aboriginal children and families

Studies of interventions addressing Aboriginal children, from prenatal to 18 years old, who were at risk of maltreatment or being maltreated were included.

Studies that included Aboriginal and Torres Strait Islanders in Australia, Indigenous populations in New Zealand (Maori), the U.S. (Indians, Native Americans), Canada (First Nations, Inuit, Métis), and Scandinavia (Sami, Inuit) were eligible for inclusion.

Studies involving non-Indigenous children (i.e., Caucasian populations; culturally and linguistically diverse populations such as refugees, immigrants, etc.) as well as studies of Aboriginal children who were not maltreated or were not exposed to the risk of being maltreated were excluded. Studies evaluating interventions that did not address maltreatment and focused on other issues only (e.g., parental and/or child mental health only, child behaviour only, parental and/or child substance abuse only) were excluded.

EGM 2: Out-of-home care

To be included, studies had to focus on children aged 0-18, who were in out-of-home care. Different types of out-of-home care living arrangements are available to children and young people in Australia, including residential care, family groups homes, home based care, independent living arrangements, and other comparable interventions. The definitions of included out-of-home care living arrangements were based on the Australian National Standards for out-of-home care.

Studies involving persons over 18 years were included only if most the population was within this age limit. We also included studies on carers of children in out-of-home care living arrangements if the main objective of the study was to assess outcomes of the children.

EGM 3: High-risk young people

Studies of interventions addressing young people aged 10-18 years prone to externalised behaviours (i.e., aggressive, problematic, violent, anti-social or criminal behaviours) were included. If a study included younger children or older emerging adults, it was only eligible if the majority of the study population belonged to the 10-18 years' age range.

Studies of interventions aimed at preventing or reducing problem or externalised behaviour or conduct problems were eligible for inclusion. Studies that evaluated interventions aimed at preventing entry or re-entry to youth justice or juvenile justice programmes were also eligible. Excluded were studies of interventions to prevent or reduce internalising problem behaviours in young people (e.g., cutting, eating disorders etc.), substance misuse and abuse only (e.g., if the study trialled a substance abuse programme), depression, anxiety and comparable mental health challenges, teenage pregnancies and problem sexual behaviour. Excluded, too, were studies that evaluated interventions for young people who were in detention or out-of-home care (out-of-home care is covered in the out-of-home care EGM).

EGM 4: Trauma-informed practice

Studies containing children (0-18 years old) who were vulnerable to psychological or physical maltreatment (or by a combination of both) were included. Studies including children who were traumatised by non-maltreatment-related events were excluded. Studies of any intervention classified as 'trauma-informed care' were considered for inclusion.

In selecting studies, 'trauma-informed care' was defined as any intervention that explicitly considers and addresses trauma experienced by individuals both in terms of assessment and intervention. This trauma could be mental or physical in nature, or be a combination of both.

EGM 5: Children with disabilities and their families

Studies of interventions addressing children aged prenatal to 18 years with a physical, intellectual, or behavioural disability, and at risk of maltreatment or being maltreated were included. Studies of interventions targeting children with disabilities who were not vulnerable were excluded.

Studies evaluating interventions aiming to prevent or reduce maltreatment in children with physical, intellectual, or behavioural disabilities were eligible. Interventions could address the child, the caregiver, or the entire family.

Physical disabilities included those that limit a child's physical functioning, (e.g., mobility, hearing, speech or visual impairments) and physical issues such as paralysis, epilepsy, and functional impairments. Intellectual disabilities comprised age adjusted issues that limit a child's intellectual functioning and adaptive behaviours (i.e., conceptual, social and practical skills that place a child substantially below their same-aged peers). Conditions such as autism spectrum disorders, Downs syndrome, fragile X syndrome, foetal alcohol syndrome, Apert syndrome, Williams syndrome and any type of learning disability were eligible. Finally, behavioural disabilities such as Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), Obsessive Compulsive Disorder (OCD), disruptive behavioural disorders and comparable disabilities were all eligible for inclusion.

EGM 6: Family violence services

Studies of women and/or children who had been maltreated or of vulnerable children and families were included. Studies (systematic reviews and RCTs) evaluating interventions that did not include women or children were excluded (e.g., childless, male homosexual couples). Studies of interventions for perpetrators of family violence were included even if these studies did not explicitly report on children or family wellbeing outcomes. The decision to include these studies was based on the assumption that a large proportion of men receiving interventions could be fathers but that this is not documented consistently in the literature.

Studies evaluating the effectiveness of interventions addressing family violence, including domestic and intimate partner violence, which had been delivered within a social care setting were included. Both preventive interventions and those aimed at treating existing family violence were eligible. Any comparative intervention was accepted including control groups that received services typically available in the community. Studies evaluating screening methods for family violence (e.g., screening tools for primary care providers and tools used in emergency departments to identify family violence) were not eligible. Interventions that focused on marital relationships or conflict between parents, but were not explicitly focused on violence within the relationship were excluded.

Australian and New Zealand studies

For studies conducted in Australia or New Zealand, studies had to evaluate interventions that addressed child maltreatment or risk of maltreatment and had not been identified in previous searches.

Reviews were included only when their inclusion criteria specifically stipulated Australian and/or New Zealand studies. All inclusion and exclusion criteria described above for each EGM topic had to be met, except the criterion for the study design (SR or RCT).

Studies were excluded if:

- the intervention or programme was delivered in a non-social service setting (e.g., hospital, primary care practice, school setting)
- the study did not examine the application of an intervention (e.g., epidemiological studies, surveys, interviews with a single person, policy documents)
- the study was not conducted in Australia or New Zealand (e.g., the researcher was connected to an Australian or New Zealand University but the trial had been conducted outside these countries).

Epidemiology studies

Systematic reviews that covered the incidence and prevalence of child maltreatment, and in particular the risk factors or predictors of child maltreatment were eligible for inclusion.

Screening studies for eligibility

The main results from all searches are summarised in Table 2 below. Detailed charts summarising the flow of studies through the screening process are provided in Appendix D.

Table 2: Number of studies identified and included by EGM

Topic	Database Search	Following de-Duplication (for EGMs) or filtering (for ANZ and EPI studies)	Full texts Retrieved	Final Included	N
EGM 1: Aboriginal Services	2,586	860	103	6	RCT:5 SR:1
EGM 2: Out-of-home care	5,821	NA	251	118	RCT: 93 SR:25
EGM 3: High-risk young people	3,196	1,864	374	95	RCT:48 SR:47
EGM 4: Trauma-informed practice	1,280	1,188	211	38	RCT:25 SR:13
EGM 5: Children with Disabilities and their families	1,665	1,561	133	2	RCT:0 SR:2
EGM 6: Family violence	3,598	1,814	562	52	RCT:33 SR:19
Australian / New Zealand Studies	11,447	1,206	82	9	Other:9
Epidemiology studies	4,643	532	62	11	SR:11
Total	**28,415**	**9,025**	**1,527**	**213**	**RCT: 111 SR: 93 Other: 9**

Two reviewers independently assessed titles and abstracts for eligibility. Any disagreement was resolved through consensus or by a third reviewer. Two independent reviewers also assessed full texts for eligibility, and disagreements were resolved by discussion or by a third reviewer.

Quality Assessment of Studies

The quality of included systematic reviews was assessed using the "Assessing the Methodological Quality of Systematic Reviews" (AMSTAR) tool. The quality of included RCTs was assessed using the Jadad scale. One reviewer conducted the quality assessment for both study types. The AMSTAR tool and the Jadad scale can be found in Appendix B.

Data extraction and management

The following data were extracted for systematic reviews: name of the first author, year of publication, population of interest, number of studies and study designs included, countries of included studies, information about the intervention(s) of interest, information about the comparison condition(s), outcomes of interest, whether a meta-analysis of studies included was conducted, and a brief description of study results.

The following data were extracted for RCTs: name of the first author, year of publication, study design, population of interest, number of study participants, intervention, number of participants in the intervention group, the comparison condition (alternative intervention, no intervention, or standard practice), the number of participants in the comparison condition, outcomes reported, and a brief description of study results.

The information about the intervention(s) was used to categorise each study (RCT or SR) under the relevant intervention category. The information about the outcome(s) was used to categorise the study under relevant outcome category or domain(s). If the scope of the study was broad, it could be categorised under more than one intervention and/or outcome theme.

The interventions were grouped within three major categories. These are briefly defined in Table 3.

Table 3: EGM Intervention Categories

Intervention Category	Description
Preventative interventions	Any intervention aimed at preventing the maltreatment of children in general populations.
Early interventions	Any intervention aimed at preventing the maltreatment of children in populations identified as being 'at risk'.
Therapeutic / risk reduction interventions	Any intervention aimed at preventing the maltreatment of children and / or treating the consequences of child maltreatment in vulnerable populations.

Each of the intervention categories was structured into three types of focus-client: 'parents/caregivers'; 'child/young people'; and 'family'. Any interventions aimed at parents (i.e., mother or father or both) or caregivers were categorised under 'parents/caregivers', any intervention addressing the child/children were categorised under 'child/young people', and any intervention that involved both parent(s)/caregivers and the child or children were assigned to the 'family' category.

Outcomes reported in included studies were extracted and assigned across two major outcome categories: child-related or parent/caregiver/family-related outcomes. Within each of these categories, outcomes could be assigned to different outcome domains, which are listed and characterised in Table 4.

Finally, a third outcome category was established for outcomes describing cost-related results from interventions trialled in included studies.

Based on the interventions included and outcomes reported, each study was placed in one or more cells of a map. Information about the study design and country of origin of each study was used to highlight each study in the correct colour on the EGM. Finally, information about the quality of each study was used to decide on the font size with which each study was added to the EGM.

The following section provides high-level summaries of the essence of each EGM, including the epidemiology of child maltreatment and an overview of common themes and findings found across the five different EGMs.

Table 4: EGM outcome categories and domains

Outcome Category	Outcome Domain	Outcome Domain Details
Child Outcomes	Safety	Protection from abuse & neglect / maltreatment occurrence or recurrence.
	Permanency	Permanency in living conditions (legal permanence such as placement prevention, reunification with birth parents, guardianship, adoption), restrictiveness of living conditions (e.g., step down from group care to foster care), placement stability, transition to adulthood.
	Physical health & wellbeing	Overall health, BMI, health related risk- avoidance behaviour.
	Mental health	Improvement in diagnosed or named mental health condition, emotional intelligence, self-efficacy, motivation, self-control, pro-social behaviour, positive outlook, coping, internalising / externalising behaviours, trauma symptoms.
	Social wellbeing	Peer relationships, social skills, social functioning, high quality relationships.
	Cultural & spiritual identity	Knowledge of culture, family history, attendance / involvement in cultural / spiritual events, positive cultural / spiritual identity.
	Child development	Developmental milestones.
	Cognitive functioning, education & learning	Academic achievements, school engagement, problem solving and decision-making skills.
Parent/Caregiver Outcomes	Safety	Protection from physical and/or sexual violence.
	Parenting	Parenting skills, parenting knowledge.
	Education and learning	Educational attainment, grades, employment skills.
	Physical health and wellbeing	Overall health, BMI, health related risk- avoidance behaviour (includes substance abuse, safe sex practices).
	Mental health	Functioning for diagnosed or named mental health condition (e.g., depression, PTSD), substance abuse.
	Social Wellbeing	Peer and/or community relationships, social functioning, quality of relationships.
	Cultural wellbeing	Knowledge of culture, family history, attendance / involvement in cultural/spiritual events, positive cultural / spiritual identity.
	Structural wellbeing	Economic self-sufficiency, employment, housing, poverty.
	Family functioning	Family relationships, level of appropriateness of individual roles in family structure.
Costs, cost-effectiveness, cost benefits		Any cost-related results associated with intervention delivery (e.g., costs per client, cost savings, cost comparisons etc.).

Appendix B: AMSTAR and Jadad tools

The AMSTAR tool

#	Criteria	Rating
1	**Was an 'a priori' design provided?** The research question and inclusion criteria should be established before the conduct of the review. *Note: Need to refer to a protocol, ethics approval, or pre-determined/a priori published research objectives to score a "yes."*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
2	**Was there duplicate study selection and data extraction?** There should be at least two independent data extractors and a consensus procedure for disagreements should be in place. *Note: 2 people do study selection, 2 people do data extraction, consensus process or one person checks the other's work.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
3	**Was a comprehensive literature search performed?** At least two electronic sources should be searched. The report must include years and databases used (e.g., Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found. *Note: If at least 2 sources + one supplementary strategy used, select "yes" (Cochrane register/Central counts as 2 sources; a grey literature search counts as supplementary).*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
4	**Was the status of publication (i.e., grey literature) used as an inclusion criterion?** The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc. *Note: If review indicates that there was a search for "grey literature" or "unpublished literature," indicate "yes." SIGLE database, dissertations, conference proceedings, and trial registries are all considered grey for this purpose. If searching a source that contains both grey and non-grey, must specify that they were searching for grey/unpublished literature.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
5	**Was a list of studies (included and excluded) provided?** A list of included and excluded studies should be provided. *Note: Acceptable if the excluded studies are referenced. If there is an electronic link to the list but the link is dead, select "no."*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
6	**Were the characteristics of the included studies provided?** In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analysed e.g., age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported. *Note: Acceptable if not in table format as long as they are described as above.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable

#	Criteria	Rating
7	**Was the scientific quality of the included studies assessed and documented?** 'A priori' methods of assessment should be provided (e.g., for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant. *Note: Can include use of a quality scoring tool or checklist, e.g., Jadad scale, risk of bias, sensitivity analysis, etc., or a description of quality items, with some kind of result for EACH study ("low" or "high" is fine, as long as it is clear which studies scored "low" and which scored "high"; a summary score/ range for all studies is not acceptable).*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
8	**Was the scientific quality of the included studies used appropriately in formulating conclusions?** The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations. *Note: Might say something such as "the results should be interpreted with caution due to poor quality of included studies." Cannot score "yes" for this question if scored "no" for question 7.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
9	**Were the methods used to combine the findings of studies appropriate?** For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (i.e., Chi-squared test for homogeneity, I2). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (i.e., is it sensible to combine?). *Note: Indicate "yes" if they mention or describe heterogeneity, i.e., if they explain that they cannot pool because of heterogeneity/variability between interventions.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
10	**Was the likelihood of publication bias assessed?** An assessment of publication bias should include a combination of graphical aids (e.g., funnel plot, other available tests) and/or statistical tests (e.g., Egger regression test, Hedges-Olken). *Note: If no test values or funnel plot included, score "no". Score "yes" if mentions that publication bias could not be assessed because there were fewer than 10 included studies.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable
11	**Was the conflict of interest included?** Potential sources of support should be clearly acknowledged in both the systematic review and the included studies. *Note: To get a "yes," must indicate source of funding or support for the systematic review AND for each of the included studies.*	☐ Yes ☐ No ☐ Can't answer ☐ Not applicable

Source: Shea et al. BMC Medical Research Methodology 2007 7:10 doi:10.1186/1471-2288-7-10. Additional notes (in italics) made by Michelle Weir, Julia Worswick, and Carolyn Wayne based on conversations with Bev Shea and/or Jeremy Grimshaw in June and October 2008 and July and September 2010.

JADAD scale

Item	Maximum points	Description
Randomisation	2	1 point if randomization is mentioned.
		1 additional point if the method of randomisation is appropriate.
		Deduct 1 point if the method of randomization is inappropriate (minimum 0).
Blinding	2	1 point if blinding is mentioned.
		1 additional point if the method of blinding is appropriate.
		Deduct 1 point if the method of blinding is inappropriate (minimum 0).
An account of all patients	1	The fate of all patients in the trial is known. If there are no data, the reason is stated.

Reproduced from: Halpern S.H., Douglas M.J. (2005). Evidence-based obstetric anaesthesia. Malden, Mass. BMJ Books: Blackwell Pub, (p 237).

Appendix C: Bibliography of included studies

EGM 1: Aboriginal children and families

Systematic Reviews
Shea, B., Nahwegahbow, A., Andersson, N. (2010). Reduction of family violence in Aboriginal communities: A systematic review of interventions and approaches. *Pimatziwin, 8*(2), 35-60.
Randomised Controlled Trials
Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., ..., Walkup, J.T. (2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. *American Journal of Psychiatry, 170*(1), 83-93.
Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R. ..., Walkup, J.T. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154-162.
Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., ..., Walkup, J. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: a randomized trial. *Archives of Pediatrics & Adolescent Medicine, 160*(11), 1101-1107.
Chaffin, M., Bard, D., Bigfoot, D.S., Maher, E.J. (2012). Is a Structured, Manualized, Evidence-Based Treatment Protocol Culturally Competent and Equivalently Effective Among American Indian Parents in Child Welfare? *Child Maltreatment, 17*(3), 242-252.
Walkup, J.T., Barlow, A., Mullany, B.C., Pan, W., Goklish, N., Hasting, R., ..., Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(6), 591-601.
Australian / New Zealand Studies
Cram, F., Pihama, L., Jenkins, K., Karehana, M. (2002). *Evaluation of programmes for Maori adult protected persons under the Domestic Violence Act 1995*. New Zealand.

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Systematic Reviews
Al, C.M., Stams, G.J.J., Bek, M.S., Damen, E.M., Asscher, J.J., van der Laan, P.H. (2012) A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review. 34(*8),1472-1479.
Donkoh, C., Underhill, K., Montgomery, P. (2006). Independent living programmes for improving outcomes for young people leaving the care system. *Cochrane Database Systematic Review*. (3),CD005558.
Downes, M.J., Lakhani, A., Maujean, A., Macfarlane, K., Kendall, E. (2016). Evidence for Using Farm Care Practices to Improve Attachment Outcomes in Foster Children: A Systematic Review. *British Journal of Social Work. 46*(5),1241-1248.
Everson-Hock, E.S., Jones, R., Guillaume, L., et al. (2011). Supporting the transition of looked-after young people to independent living: a systematic review of interventions and adult outcomes. *Child: Care, Health & Development. 37*(6),767-779.
Everson-Hock, E.S., Jones, R., Guillaume, L., et al. (2012). The effectiveness of training and support for carers and other professionals on the physical and emotional health and well-being of looked-after children and young people: a systematic review. *Child: Care, Health & Development. 38*(2),162-174.
Goemans, A., van Geel, M., Vedder, P. (2015). Over three decades of longitudinal research on the development of foster children: a meta-analysis. *Child Abuse & Neglect. 42*, 121-134.
Goemans, A., van Geel, M., van Beem, M., Vedder, P. (2016). Developmental Outcomes of Foster Children: A Meta-Analytic Comparison With Children From the General Population and Children at Risk Who Remained at Home. *Child Maltreatment. 21*(3),198-217.
Hahn, R.A., Bilukha, O., Lowy, J., et al. (2005). The effectiveness of therapeutic foster care for the prevention of violence: a systematic review. *American Journal of Preventive Medicine. 28*(2 Suppl 1),72-90.
Heerde, J.A., Hemphill, S.A., Broderick, D., Florent, A. (2012). Associations between leaving out-of-home care and post-transition youth homelessness: A review. *Developing Practice*. (32),36-52.
Heerde, J.A., Hemphil,l S.A., Scholes-Balog, K.E. (2016). The impact of transitional programmes on post-transition outcomes for youth leaving out-of-home care: a meta-analysis. *Health & Social Care in the Community. 24*, 24.
Hermenau, K., Goessmann, K., Rygaard, N.P., Landolt, M.A., Hecker, T. (2016). Fostering Child Development by Improving Care Quality: A Systematic Review of the Effectiveness of Structural Interventions and Caregiver Trainings in Institutional Care. *Trauma Violence & Abuse, 12*, 12.
Hiles, D., Moss, D., Wright, J., Dallos, R. (2013). Young people's experience of social support during the process of leaving care: A review of the literature. *Children and Youth Services Review. 35*(12),2059-2071.
Kerr, L., & Cossar, J. (2014). Attachment interventions with foster and adoptive parents: A systematic review. *Child Abuse Review. 23*(6),426-439.
Kinsey, D., & Schlosser, A. (2013). Interventions in foster and kinship care: A systematic review. *Clinical Child Psychology and Psychiatry. 18*(3),429-463.
Knorth, E.J., Harder, A.T., Zandberg, T., Kendrick, A.J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review. 30*(2),123-140.
Liabo, K., Gray, K., Mulcahy, D. (2013). A systematic review of interventions to support looked-after children in school. *Child & Family Social Work. 18*(3),341-353.
Lin, C-H. (2014). Evaluating services for kinship care families: A systematic review. *Children and Youth Services Review. 36*,32-41.

Littell, J.H., Popa, M., Forsythe, B. (2005). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Campbell Systematic Reviews. 1*.

Macdonald, G. & Turner, W. (2008). Treatment foster care for improving outcomes in children and young people. *The Cochrane Library*.

Maclean, M.J., Sims, S., O'Donnell, M., Gilbert, R. (2016). Out-of-home care versus in-home care for children who have been maltreated: A systematic review of health and wellbeing outcomes. *Child Abuse Review. No Pagination Specified*.

Montgomery, P., Donkoh, C., Underhill, K. (2006). Independent living programs for young people leaving the care system: The state of the evidence. *Children and Youth Services Review.* (28), 1435-1448.

Rock, S., Michelson, D., Thomson, S., Day, C. (2015). Understanding foster placement instability for looked after children: A systematic review and narrative synthesis of quantitative and qualitative evidence. *British Journal of Social Work. 45*(1),177-203.

Thompson, A.E., Greeson, J.K., Brunsink, A.M. (2016). Natural mentoring among older youth in and aging out of foster care: A systematic review. *Children and Youth Services Review. 61*,40-50.

Van Andel, H.W., Grietens, H., Strijker, J., Van der Gaag, R.J, Knorth EJ. (2014). Searching for effective interventions for foster children under stress: A meta-analysis. *Child & Family Social Work. 19*(2),149-155.

van der Stouwe, T., Asscher, J. J., Stams, G. J. J., Deković, M., & van der Laan, P. H. (2014). The effectiveness of Multisystemic Therapy (MST): a meta-analysis. *Clinical psychology review, 34*(6), 468-481.

Winokur, M., Holtan, A., Valentine, D. (2009). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Cochrane Database Systematic Reviews*. (1), CD006546.

Winokur, M., Holtan, A., Batchelder, K.E. (2014). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Cochrane Database Systematic Reviews. 1*, CD006546.

Ziviani, J., Feeney, R., Cuskelly, M., Meredith, P., Hunt, K. (2012). Effectiveness of support services for children and young people with challenging behaviours related to or secondary to disability, who are in out-of-home care: A systematic review. *Children and Youth Services Review. 34*(4),758-770.

Randomised Controlled Trials

Almas, AN, Degnan KA, Walker OL, et al. (2015). The Effects of Early Institutionalization and Foster Care Intervention on Children's Social Behaviors at Age 8. *Social Development. 24*(2),225-239.

Bergström, M., & Höjman, L. (2015). Is multidimensional treatment foster care (MTFC) more effective than treatment as usual in a three-year follow-up? Results from MTFC in a Swedish setting. *European Journal of Social Work. 19*(2),219-235.

Bick, J., Zhu, T., Stamoulis, C., Fox, N.A., Zeanah, C., Nelson, C.A. (2015). Effect of early institutionalization and foster care on long-term white matter development: a randomized clinical trial. *JAMA Pediatrics. 169*(3),211-219.

Bruce, J., McDermott, J.M., Fisher, P.A., Fox, N.A. (2009). Using behavioral and electrophysiological measures to assess the effects of a preventive intervention: a preliminary study with preschool-aged foster children. *Prevention Science. 10*(2),129-140.

Butler, S,, Baruch, G., Hickey, N., Fonagy, P. (2011). A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child and Adolescent Psychiatry. 50*(12),1220-1235 e1222.

Bywater, T., Hutchings, J., Linck, P., et al. (2011). Incredible Years parent training support for foster carers in Wales: a multi-centre feasibility study. *Child Care Health & Development. 37*(2),233-243.

Chamberlain, P., Leve, L.D., Degarmo, D.S. (2007). Multidimensional treatment foster care for girls in the juvenile justice system: 2-year follow-up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology. 75*(1),187-193.

Chamberlain, P., Moreland, S., Reid, K. (1992). Enhanced services and stipends for foster parents: effects on retention rates and outcomes for children. *Child Welfare. 71*(5),387-401.

Chamberlain, P., Price, J., Leve, L.D., Laurent, H., Landsverk, J.A., Reid, J.B. (2008). Prevention of behavior problems for children in foster care: outcomes and mediation effects. *Prevention Science. 9*(1), 17-27.

Chamberlain, P., & Reid, J.B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology. 66*(4), 624-633.

Clark, H.B., Prange, M.E., Lee, B., Boyd, L., McDonald, B.A., Stewart, E.S. (1994) Improving adjustment outcomes for foster children with emotional and behavioral disorders: Early findings from a controlled study on individualized services. *Journal of Emotional and Behavioral Disorders. 2*(4), 207-218.

Dorsey, S., Pullmann, M.D., Berliner, L., Koschmann, E., McKay, M., Deblinger, E. (2014) Engaging foster parents in treatment: a randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. *Child Abuse & Neglect. 38*(9), 1508-1520.

Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., Peloso, E. (2009). Effects of a Foster Parent Training Program on Young Children's Attachment Behaviors: Preliminary Evidence from a Randomized Clinical Trial. *Child & Adolescent Social Work Journal. 26*(4), 321-332.

Dozier, M., Peloso, E., Lewis, E., Laurenceau, J.P., Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development & Psychopathology. 20*(3), 845-859.

Dozier, M., Peloso, E., Lindhiem, O., et al. (2006). Developing Evidence-Based Interventions for Foster Children: An Example of a Randomized Clinical Trial with Infants and Toddlers. *Journal of Social Issues. 62*(4), 767-785.

Eddy, J., Whaley, R.B., Chamberlain, P. (2004). The Prevention of Violent Behavior by Chronic and Serious Male Juvenile Offenders: A 2-Year Follow-up of a Randomized Clinical Trial. *Journal of Emotional and Behavioral Disorders. 12*(1), 2-8.

Evans, M.E., Armstrong, M.I., Kuppinger, A.D. (1996). Family-centred intensive case management: a step toward understanding individualized care. *Journal of Child and Family Studies. 5*(1), 55-65.

Farmer, E.M., Burns, B.J., Wagner, H.R., Murray, M., Southerland, D.G. (2010). Enhancing "usual practice" treatment foster care: findings from a randomized trial on improving youths' outcomes. *Psychiatric Services. 61*(6), 555-561.

Fisher, P.A., Burraston, B., Pears, K. (2005). The early intervention foster care program: permanent placement outcomes from a randomized trial. *Child Maltreatment. 10*(1), 61-71.

Fisher, P.A., & Kim, H.K. (2007). Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. *Prevention Science. 8*(2), 161-170.

Fisher, P.A., Kim, H.K., Pears, K.C. (2009). Effects of Multidimensional Treatment Foster Care for Pre-schoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review. 31*(5), 541-546.

Fisher, P.A., & Stoolmiller, M. (2009). Intervention effects on foster parent stress: associations with child cortisol levels. *Development & Psychopathology. 20*(3), 1003-1021.

Fisher, P.A., Stoolmiller, M., Gunnar, M.R., Burraston, B.O. (2007). Effects of a therapeutic intervention for foster preschoolers on diurnal cortisol activity. *Psychoneuroendocrinology. 32*(8-10), 892-905.

Fisher, P.A., Stoolmiller, M., Mannering, A.M., Takahashi, A., Chamberlain, P. (2011). Foster placement disruptions associated with problem behavior: mitigating a threshold effect. *Journal of Consultative and Clinical Psychology. 79*(4), 481-487.

Fox, N.A., Almas, A.N., Degnan, K.A., Nelson, C.A., Zeanah, C.H. (2011) The effects of severe psychosocial deprivation and foster care intervention on cognitive development at 8 years of age: findings from the Bucharest Early Intervention Project. *Journal of Child Psychology and Psychiatry. 52*(9), 919-928.

Gaviţa, O.A., David, D., Bujoreanu, S., Tiba, A., Ionuţiu, D.R. (2012). The efficacy of a short cognitive–behavioral parent program in the treatment of externalizing behavior disorders in Romanian foster care children: Building parental emotion-regulation through unconditional self- and child-acceptance strategies. *Children and Youth Services Review. 34*(7), 1290-1297.

Geenen, S., Powers, L.E., Powers, J., et al. (2013). Experimental Study of a Self-Determination Intervention for Youth in Foster Care. *Career Development and Transition for Exceptional Individuals. 36*(2), 84-95.

Green, J.M., Biehal, N., Roberts, C., et al. (2014). Multidimensional Treatment Foster Care for Adolescents in English care: Randomised trial and observational cohort evaluation. *British Journal of Psychiatry. 204*(3), 214-221.

Haight, W., Black, J., Sheridan, K. (2010). A Mental Health Intervention for Rural, Foster Children from Methamphetamine-involved Families: Experimental Assessment with Qualitative Elaboration. *Child and Youth Services Review. 32*(10), 1146-1457.

Hansson, K., & Olsson, M. (2012). Effects of multidimensional treatment foster care (MTFC): Results from a RCT study in Sweden. *Children and Youth Services Review. 34*(9), 1929-1936.

Harold, G.T., Kerr, D.C., Van Ryzin, M., DeGarmo, D.S., Rhoades, K.A., Leve, L.D. (2013). Depressive symptom trajectories among girls in the juvenile justice system: 24-month outcomes of an RCT of Multidimensional Treatment Foster Care. *Prevention Science. 14*(5), 437-446.

Henggeler, S.W., Pickrel, S.G., Brondino, M.J. (1999). Multisystemic treatment of substance-abusing and dependent delinquents: outcomes, treatment fidelity, and transportability. *Mental Health Services Research. 1*(3), 171-184.

Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry. 42*(5), 543-551.

Herbert, M., & Wookey, J. (2007). The Child Wise Programme: a course to enhance the self-confidence and behaviour management skills of foster carers with challenging children. *Adoption & Fostering. 31*(4), 27-37.

Holden, E.W., O'Connell, S.R., Liao, Q., et al. (2007). Outcomes of a randomized trial of continuum of care services for children in a child welfare system. *Child welfare. 86*(6), 89-114.

Humphreys, K.L., Gleason, M.M., Drury, S.S., et al. (2015). Effects of institutional rearing and foster care on psychopathology at age 12 years in Romania: follow-up of an open, randomised controlled trial. *Lancet Psychiatry. 2*(7), 625-634.

Humphreys, K.L., McGoron, L., Sheridan, MA., et al. (2015). High-Quality Foster Care Mitigates Callous-Unemotional Traits Following Early Deprivation in Boys: A Randomized Controlled Trial. *Journal of the American Academy of Child and Adolescent Psychiatry. 54*(12), 977-983.

Kerr, D.C., DeGarmo, D.S., Leve, L.D., Chamberlain, P. (2014). Juvenile justice girls' depressive symptoms and suicidal ideation 9 years after Multidimensional Treatment Foster Care. *Journal of Consultative and Clinical Psychology. 82*(4), 684-693.

Kerr, D.C., Leve, L.D., Chamberlain, P. (2009). Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. *Journal of Consultative and Clinical Psychology. 77*(3), 588-593.

Kim, H.K., & Leve, L.D. (2011). Substance use and delinquency among middle school girls in foster care: a three-year follow-up of a randomized controlled trial. *Journal of Consultative and Clinical Psychology. 79*(6), 740-750.

Kim, H.K., Pears, K.C., Leve, L.D., Chamberlain, P.C., Smith, D.K. (2013). Intervention Effects on Health-Risking Sexual Behavior Among Girls in Foster Care: The Role of Placement Disruption and Tobacco and Marijuana Use. *Journal of Child and Adolescent Substance Abuse. 22*(5), 370-387.

Laurent, H.K., Gilliam, K.S., Bruce, J., Fisher, P.A. (2014). HPA stability for children in foster care: mental health implications and moderation by early intervention. *Developmental Psychobiology. 56*(6), 1406-1415.

Leathers, S.J., Spielfogel, J.E., Gleeson, J.P., Rolock, N. (2012). Behavior problems, foster home integration, and evidence-based behavioral interventions: What predicts adoption of foster children? *Children and Youth Services Review. 34*(5), 891-899.

Lee, K. (2016). Head Start's Impact on Cognitive Outcomes for Children in Foster Care. *Child Abuse Review. 25*(2), 128-141.

Letourneau, E.J., Henggeler, S.W., Borduin, C.M., et al. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology. 23*(1), 89-102.

Leve, L.D., Chamberlain, P. (2007). A randomized evaluation of multidimensional treatment foster care: effects on school attendance and homework completion in juvenile justice girlds. *Research on Social Work Practice. 17*(6), 657-663.

Leve, L.D., Chamberlain, P., Reid, J.B. (2005) Intervention outcomes for girls referred from juvenile justice: effects on delinquency. *Journal of Consultative and Clinical Psychology. 73*(6), 1181-1185.

Leve, L.D., Kerr, D.C., Harold, G.T. (2013). Young Adult Outcomes Associated with Teen Pregnancy Among High-Risk Girls in an RCT of Multidimensional Treatment Foster Care. *Journal of Child and Adolescent Substance Abuse. 22*(5), 421-434.

Leve, L.D., Chamberlain, P. (2005). Association with delinquent peers: intervention effects for youth in the juvenile justice system. *Journal of Abnormal Child Psychology. 33*(3), 339-347.

Lewis-Morrarty, E., Dozier, M., Bernard, K., Terracciano, S.M., Moore, S.V. (2012). Cognitive flexibility and theory of mind outcomes among foster children: preschool follow-up results of a randomized clinical trial. *Journal of Adolescent Health. 51*(2 Suppl), S17-22.

Linares, L.O., Li, M., Shrout, P.E. (2012). Child training for physical aggression?: Lessons from foster care. *Children and Youth Services Review. 34*(12), 2416-2422.

Linares, L.O., Montalto, D., Li, M., Oza, V.S. (2006). A promising parenting intervention in foster care. *Journal of Consultative and Clinical Psychology. 74*(1), 32-41.

Love, S.M., Koob, J.J., Hill, L.E. (2008). The effects of using community mental health practitioners to treat foster children: Implications for child welfare planners. The Scientific Review of Mental Health Practice: *Objective Investigations of Controversial and Unorthodox Claims in Clinical Psychology, Psychiatry, and Social Work. 6*(1), 31-39.

Lynch, F.L., Dickerson, J.F., Saldana, L., Fisher, P.A. (2014). Incremental net benefit of early intervention for preschool-aged children with emotional and behavioral problems in foster care. *Children and Youth Services Review. 36*, 213-219.

Maaskant, A.M., van Rooij, F.B., Overbeek, G.J., Oort, F.J., Hermanns, J.M.A. (2016). Parent training in foster families with children with behavior problems: Follow-up results from a randomized controlled trial. *Children and Youth Services Review. 70*, 84-94.

Macdonald, G., & Turner, W. (2005). An Experiment in Helping Foster-Carers Manage Challenging Behaviour. *The British Journal of Social Work. 35*(8), 1265-1282.

McMillen, J.C., Narendorf, S.C., Robinson, D., et al. (2015). Development and piloting of a treatment foster care program for older youth with psychiatric problems. *Child Adolescent Psychiatry Mental Health. 9*, 23.

Mersky, J.P., Topitzes, J., Grant-Savela, S.D., Brondino, M.J., McNeil, C.B. (2016). Adapting Parent-Child Interaction Therapy to Foster Care: Outcomes from a Randomized Trial. *Research on Social Work Practices. 26*(2), 157-167.
Mersky, J.P., Topitzes, J., Janczewski, C.E., McNeil, C.B. (2015). Enhancing foster parent training with parent-child interaction therapy: Evidence from a randomized field experiment. *Journal of the Society for Social Work and Research. 6*(4), 591-616.
Minnis, H., Pelosi, A.J., Knapp, M., Dunn, J. (2001). Mental health and foster carer training. *Archives of Disease in Childhood. 84*(4), 302-306.
N'Zi, A.M., Stevens, M.L., Eyberg, S.M. (2016). Child Directed Interaction Training for young children in kinship care: A pilot study. *Child Abuse & Neglect. 55*, 81-91.
Nelson, CA., Zeanah, C.H., Fox, N.A., Marshall, P.J., Smyke, A.T., Guthrie, D. (2007). Cognitive recovery in socially deprived young children: the Bucharest Early Intervention Project. *Science. 318*(5858), 1937-1940.
Nelson, E.M., & Spieker, S.J. (2013). Intervention Effects on Morning and Stimulated Cortisol Responses Among Toddlers in Foster Care. *Infant Mental Health Journal. 34*(3).
Ogden, Terje, Hagen, Kristine. (2006). Multisystemic Treatment of Serious Behaviour Problems in Youth: Sustainability of Effectiveness Two Years after Intake. *Child and Adolescent Mental Health. 11*(3), 142-149.
Painter, K. (2009). Multisystemic Therapy as Community-Based Treatment for Youth With Severe Emotional Disturbance. *Research on Social Work Practices. 19*(3), 314-324.
Pears, K.C., Fisher, P.A., Bronz, K.D. (2007). An Intervention to Promote Social Emotional School Readiness in Foster Children: Preliminary Outcomes From a Pilot Study. *School Psychology Review. 36*(4), 665-673.
Pears, K.C., Fisher, P.A., Bruce, J., Kim, H.K., Yoerger, K. (2010). Early elementary school adjustment of maltreated children in foster care: The roles of inhibitory control and caregiver involvement. *Child Development. 81*(5), 1550-1564.
Pears, K.C., Fisher, P.A., Kim, H.K., Bruce, J., Healey, C.V., Yoerger, K. (2013) Immediate Effects of a School Readiness Intervention for Children in Foster Care. *Early Education and Development. 24*(6), 771-791.
Pears, K.C., Kim, HK., 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*(12), 2361-2366.
Poulton, R., Van Ryzin, M.J., Harold, G.T., et al. (2014). Effects of multidimensional treatment foster care on psychotic symptoms in girls. *Journal of the American Academy of Child and Adolescent Psychiatry. 53*(12), 1279-1287.
Powers, L.E., Geenen, S., Powers, J., et al. (2012). My life: Effects of a longitudinal, randomized study of self-determination enhancement on the transition outcomes of youth in foster care and special education. *Children and Youth Services Review. 34*(11), 2179–2187.
Pratt, M.E., Lipscomb, S.T., Schmitt, S.A. (2015). The effect of head start on parenting outcomes for children living in non-parental care. *Journal of Child and Family Studies. 24*(10), 2944-2956.
Price, J.M., Chamberlain, P., Landsverk, J., Reid, J.B., Leve, L.D., Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment. 13*(1), 64-75.
Price, J.M., Roesch, S., Walsh, N.E. (2012). Effectiveness of the KEEP Foster Parent Intervention during an Implementation Trial. *Child Youth Services Review. 34*(12), 2487-2494.
Price, J.M., Roesch, S., Walsh, N.E., Landsverk, J. (2015).e Effects of the KEEP Foster Parent Intervention on Child and Sibling Behavior Problems and Parental Stress During a Randomized Implementation Trial. (5), 685-695.

Reddy, S.D., Negi, L.T., Dodson-Lavelle, B., et al. (2013). Cognitive-Based Compassion Training: A Promising Prevention Strategy for At-Risk Adolescents. *Journal of Child and Family Studies. 22*(2), 219-230.

Rhoades, K.A., Leve, L.D., Harold, G.T., Kim, H., Chamberlain, P. (2014). Drug Use Trajectories After a Randomized Controlled Trial of MTFC: Associations with Partner Drug Use. Journal of Research Adolescents. 24(1), 40-54.

Rowland, M.D., Halliday-Boykins, C.A., Henggeler, S.W., et al. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix class youths. *Journal of Emotional & Behavioral Disorders. 13*(1), 13-23.

Sinclair, I., Parry, E., Biehal, N., et al. (2016). Multi-dimensional Treatment Foster Care in England: differential effects by level of initial antisocial behaviour. *European Child and Adolescent Psychiatry. 25*(8), 843-852.

Smith, D.K., Leve, L.D., Chamberlain, P. (2011). Preventing Internalizing and Externalizing Problems in Girls in Foster Care as they Enter Middle School: Immediate Impact of an Intervention. *Prevention science. 12*(3), 269-277.

Spieker, S.J., Oxford, M.L., Fleming, C.B. (2014). Permanency Outcomes for Toddlers in Child Welfare Two Years After a Randomized Trial of a Parenting Intervention. *Child and Youth Services Review. 44*, 201-206.

Spieker, S.J., Oxford, M.L., Kelly, J.F., Nelson, E.M., Fleming, C.B. (2012). Promoting First Relationships: Randomized Trial of a Relationship-Based Intervention for Toddlers in Child Welfare. *Child Maltreatment. 17*(4), 271-286.

Sprang, G. (2009). The Efficacy of a Relational Treatment for Maltreated Children and their Families. *Child and Adolescent Mental Health. 14*(2), 81-88.

Stein, T.J., & (1977). Facilitating Decision Making in Foster Care: The Alameda Project. *Social Service Review. 51*(3), 502-513.

Sundell, K., Hansson, K., Lofholm, C.A., Olsson, T., Gustle, L.H., Kadesjo, C. (2008). The Transportability of Multisystemic Therapy to Sweden: Short-Term Results From a Randomized Trial of Conduct-Disordered Youths. *Journal of Family Psychology. 22*(4), 550-560.

Taussig, H.N., & Culhane, S.E. (2010). Impact of a mentoring and skills group program on mental health outcomes for maltreated children in foster care. *Archives of Pediatric Adolescent Medicine. 164*(8), 739-746.

Taussig, H.N., Culhane, S.E., Garrido, E., Knudtson, M.D. (2012). RCT of a mentoring and skills group program: placement and permanency outcomes for foster youth. *Pediatrics. 130*(1), e33-39.

Tibu, F., Humphreys, K.L., Fox, N.A., Nelson, C.A., Zeanah, C.H. (2014). Psychopathology in young children in two types of foster care following institutional rearing. *Infant Mental Health Journal. 35*(2), 123-131.

Van Ryzin, M.J., & Leve, L.D. (2012). Affiliation with delinquent peers as a mediator of the effects of multidimensional treatment foster care for delinquent girls. *Journal of Consultative and Clinical Psychology. 80*(4), 588-596.

Westermark, P.K., Hansson, K., Olsson, M. (2011). Multidimensional treatment foster care (MTFC): Results from an independent replication. *Journal of Family Therapy. 33*(1), 20-41.

Valentine, E.J., Skemer, M., Courtney, M.E. (2015). Becoming Adults; One year impact findings from the youth villages transition living evaluation. Manpower Demonstration Research Corporation. Manpower Demonstration Research Corporation.

Vandivere, S., Malm, K.E., Allen, T.J., Williams, S.C., McKlindon, Z. (2007). A randomised controlled trial of family finding: A relative search and engagement intervention for youth lingering in foster care. *Evaluation Review*. 1-26.

EGM 3: High-risk young people

Systematic Reviews
Abrams, L. S., Mizel, M. L., Nguyen, V., & Shlonsky, A. (2014). Juvenile reentry and aftercare interventions: is mentoring a promising direction? *Journal of Evidence-Based Social Work, 11*(4), 404-422.
Arbesman, M., Bazyk, S., & Nochajski, S. M. (2013). Systematic review of occupational therapy and mental health promotion, prevention, and intervention for children and youth. American Journal of Occupational Therapy, 67(6), e120-130.
Baldwin, S. A., Christian, S., Berkeljon, A., & Shadish, W. R. (2012). The effects of family therapies for adolescent delinquency and substance abuse: a meta-analysis. Journal of Marital & Family Therapy, 38(1), 281-304.
Beelmann, A., & Raabe, T. (2009). The effects of preventing antisocial behavior and crime in childhood and adolescence: Results and implications of research reviews and meta-analyses. *European Journal of Developmental Science, 3*(3), 260-281.
Bouchard, J., & Wong, J. S. (2017). Examining the Effects of Intensive Supervision and Aftercare Programs for At-Risk Youth. *International Journal of Offender Therapy & Comparative Criminology*, 306624X17690449.
Bradshaw, W., Roseborough, D., & Umbreit, M. S. (2006). The effect of victim offender mediation on juvenile offender recidivism: A meta-analysis. *Conflict Resolution Quarterly, 24*(1), 87-98.
Brännström, L., Kaunitz, C., Andershed, A.-K., South, S., & Smedslund, G. (2016). Aggression replacement training (ART) for reducing antisocial behavior in adolescents and adults: *A systematic review. Aggression & Violent Behavior, 27*, 30-41.
Cary, M., Butler, S., Baruch, G., Hickey, N., & Byford, S. (2013). Economic Evaluation of Multisystemic Therapy for Young People at Risk for Continuing Criminal Activity in the UK. *PLoS ONE, 8*(4).
Charles, J. M., Bywater, T., & Edwards, R. T. (2011). Parenting interventions: a systematic review of the economic evidence. *Child: Care, Health & Development, 37*(4), 462-474.
Connor, D. F., Carlson, G. A., Chang, K. D., Daniolos, P. T., Ferziger, R., Findling, R. L., . . . Steiner, H. (2006). Juvenile maladaptive aggression: a review of prevention, treatment, and service configuration and a proposed research agenda. *Journal of Clinical Psychiatry, 67*(5), 808-820.
Cox, E., Leung, R., Baksheev, G., Day, A., Toumbourou, J. W., Miller, P., . . . Walker, A. (2016). Violence prevention and intervention programmes for adolescents in Australia: A systematic review. *Australian Psychologist, 51*(3), 206-222.
Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: a meta-analysis of outcome studies. *J Fam Psychol, 18*(3), 411-419.
Daykin, N., de Viggiani, N., Pilkington, P., & Moriarty, Y. (2013). Music making for health, well-being and behaviour change in youth justice settings: a systematic review. *Health Promotion International, 28*(2), 197-210.
Dretzke, J., Frew, E., Davenport, C., Barlow, J., Stewart-Brown, S., Sandercock, J., . . . Taylor, R. (2005). The effectiveness and cost-effectiveness of parent training/education programmes for the treatment of conduct disorder, including oppositional defiant disorder, in children. *Health Technology Assessment (Winchester, England), 9*(50), iii, ix-x, 1.
Evans-Chase, M., & Zhou, H. (2014). A systematic review of the juvenile justice intervention literature: What it can (and cannot) tell us about what works with delinquent youth. *Crime & Delinquency, 60*(3), 451-470.
Fossum, S., Handegård, B., Adolfsen, F., Vis, S., & Wynn, R. (2016). A Meta-Analysis of Long-Term Outpatient Treatment Effects for Children and Adolescents with Conduct Problems. *Journal of Child & Family Studies, 25*(1), 15-29.

Garrido Genoves, V., Anyela Morales, L., & Sanchez-Meca, J. (2006). What works for serious juvenile offenders? A systematic review. *Psicothema, 18*(3), 611-619.

Goense, P. B., Assink, M., Stams, G.-J., Boendermaker, L., & Hoeve, M. (2016). Making 'what works' work: A meta-analytic study of the effect of treatment integrity on outcomes of evidence-based interventions for juveniles with antisocial behavior. *Aggression & Violent Behavior, 31*, 106-115.

Gould, N., & Richardson, J. (2006). Parent-training/education programmes in the management of children with conduct disorders: developing an integrated evidence-based perspective for health and social care. *Journal of Children's Services, 1*(4), 47-60.

Grove, A. B., Evans, S. W., Pastor, D. A., & Mack, S. D. (2008). A meta-analytic examination of follow-up studies of programs designed to prevent the primary symptoms of oppositional defiant and conduct disorders. *Aggression and Violent Behavior, 13*(3), 169-184.

Jackson, K. F., Hodge, D. R., & Vaughn, M. G. (2010). A Meta-Analysis of Culturally Sensitive Interventions Designed to Reduce High-Risk Behaviors Among African American Youth. *Journal of Social Service Research, 36*(3), 163-173.

Johnson, M. H., George, P., Armstrong, M. I., Lyman, D. R., Dougherty, R. H., Daniels, A. S., . . . Delphin-Rittmon, M. E. (2014). Behavioral management for children and adolescents: assessing the evidence. *Psychiatric Services, 65*(5), 580-590.

Knight, A., Shakeshaft, A., Havard, A., Maple, M., Foley, C., & Shakeshaft, B. (2017). The quality and effectiveness of interventions that target multiple risk factors among young people: a systematic review. *Australian & New Zealand Journal of Public Health, 41*(1), 54-60.

Kremer, K. P., Maynard, B. R., Polanin, J. R., Vaughn, M. G., & Sarteschi, C. M. (2015). Effects of after-school programs with at-risk youth on attendance and externalizing behaviors: a systematic review and meta-analysis. *Journal of Youth & Adolescence, 44*(3), 616-636.

Lee, B. R., Ebesutani, C., Kolivoski, K. M., Becker, K. D., Lindsey, M. A., Brandt, N. E., . . . Barth, R. P. (2014). Program and practice elements for placement prevention: A review of interventions and their effectiveness in promoting home-based care. *American Journal of Orthopsychiatry, 84*(3), 244-256.

Limbos, M. A., Chan, L. S., Warf, C., Schneir, A., Iverson, E., Shekelle, P., & Kipke, M. D. (2007). Effectiveness of Interventions to Prevent Youth Violence: A Systematic Review. *American Journal of Preventive Medicine, 33*(1), 65-74.

Lipsey, M. W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. *Victims & Offenders, 4*(2), 124-147.

Lipsey, M. W. (1999). Can Intervention Rehabilitate Serious Delinquents? *The Annals of the American Academy of Political and Social Science, 564*(1), 142-166.

Littell, J. H., Popa, M., & Forsythe, B. (2005). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17.

Livingstone, N., Macdonald, G., & Carr, N. (2013). Restorative justice conferencing for reducing recidivism in young offenders (aged 7 to 21). *Cochrane Database of Systematic Reviews*(2), CD008898.

Madell, D., Thom, K., & McKenna, B. (2013). A systematic review of literature relating to problem-solving youth courts. *Psychiatry, Psychology and Law, 20*(3), 412-422.

Meade, B., & Steiner, B. (2010). The total effects of boot camps that house juveniles: A systematic review of the evidence. *Journal of Criminal Justice, 38*(5), 841-853.

Metzger, I., Cooper, S. M., Zarrett, N., & Flory, K. (2013). Culturally Sensitive Risk Behavior Prevention Programs for African American Adolescents: A Systematic Analysis. *Clinical Child and Family Psychology Review, 16*(2), 187-212.

Montgomery, P., & Maunders, K. (2015). The effectiveness of creative bibliotherapy for internalizing, externalizing, and prosocial behaviors in children: A systematic review. *Children & Youth Services Review, 55*, 37-47.

Ozabaci, N. (2011). Cognitive behavioural therapy for violent behaviour in children and adolescents: A meta-analysis. *Children and Youth Services Review, 33*(10), 1989-1993.

Petrosino, A., Turpin-Petrosino, C., & Buehler, J. (2002). "Scared Straight" and other juvenile awareness programs for preventing juvenile delinquency. *Cochrane Database of Systematic Reviews*(2), CD002796.

Schwalbe, C. S., Gearing, R. E., MacKenzie, M. J., Brewer, K. B., & Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review, 32*(1), 26-33.

Stein, D. M., Deberard, S., & Homan, K. (2013). Predicting success and failure in juvenile drug treatment court: a meta-analytic review. *Journal of Substance Abuse Treatment, 44*(2), 159-168.

Stein, D. M., Homan, K. J., & DeBerard, S. (2015). The effectiveness of juvenile treatment drug courts: A meta-analytic review of literature. *Journal of Child & Adolescent Substance Abuse, 24*(2), 80-93.

van der Stouwe, T., Asscher, J. J., Stams, G. J., Dekovic, M., & van der Laan, P. H. (2014). The effectiveness of Multisystemic Therapy (MST): a meta-analysis. *Clin Psychol Rev, 34*(6), 468-481.

von Sydow, K., Retzlaff, R., Beher, S., Haun, M. W., & Schweitzer, J. (2013). The efficacy of systemic therapy for childhood and adolescent externalizing disorders: a systematic review of 47 RCT. F*amily Process, 52*(4), 576-618.

Weaver, R. D., & Campbell, D. (2015). Fresh start: A meta-analysis of aftercare programs for juvenile offenders. *Research on Social Work Practice, 25*(2), 201-212.

Whitehead, J. T., & Lab, S. P. (1989). A Meta-Analysis of Juvenile Correctional Treatment. *Journal of Research in Crime & Delinquency, 26*(3), 276-295.

Wilson, H. A., & Hoge, R. D. (2013). The Effect of Youth Diversion Programs on Recidivism: A Meta-Analytic Review. *Criminal Justice and Behavior, 40*(5), 497-518.

Wilson, S. J., Lipsey, M. W., & Soydan, H. (2003). Are mainstream programs for juvenile delinquency less effective with minority youth than majority youth? A meta-analysis of outcomes research. *Research on Social Work Practice, 13*(1), 3-26.

Wong, J. S., Bouchard, J., Gravel, J., Bouchard, M., & Morselli, C. (2016). Can at-risk youth be diverted from crime? A meta-analysis of restorative diversion programs. *Criminal Justice and Behavior, 43*(10), 1310-1329.

Woolfenden, S. R., Williams, K., & Peat, J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. *Cochrane Database of Systematic Reviews(2), CD003015.*

Randomised Controlled Trials

Bank, L., Marlowe, J. H., Reid, J. B., Patterson, G. R., & Weinrott, M. R. (1991). A comparative evaluation of parent-training interventions for families of chronic delinquents. *Journal of Abnormal Child Psychology, 19*(1), 15-33.

Berry, V., Little, M., Axford, N., & Cusick, G. R. (2009). An Evaluation of Youth at Risk's Coaching for Communities Programme. *Howard Journal of Criminal Justice, 48*(1), 60-75.

Bottcher, J., & Ezell, M. E. (2005). Examining the effectiveness of boot camps: A randomized experiment with a long-term follow up. *Journal of Research in Crime and Delinquency, 42*(3), 309-332.

Burke, J. D., & Loeber, R. (2014). The Effectiveness of the Stop Now and Plan (SNAP) Program for Boys at Risk for Violence and Delinquency. *Prevention Science, 16*(2), 242-253.

Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(12), 1220-1235.e2.

Chorpita, B. F., Weisz, J. R., Daleiden, E. L., Schoenwald, S. K., Palinkas, L. A., Miranda, J., . . . Gibbons, R. D. (2013). Long-term outcomes for the Child STEPs randomized effectiveness trial: A comparison of modular and standard treatment designs with usual care. *Journal of Consulting and Clinical Psychology, 81*(6), 999-1009.

Dakof, G. A., Henderson, C. E., Rowe, C. L., Boustani, M., Greenbaum, P. E., Wang, W., . . . Liddle, H. A. (2015). A randomized clinical trial of family therapy in juvenile drug court. *Journal of Family Psychology, 29*(2), 232-241.

Deković, M., Manders, W. A., Asscher, J. J., Prins, P. J. M., & Van Der Laan, P. (2012). Within-Intervention Change: Mediators of Intervention Effects During Multisystemic Therapy. *Journal of Consulting and Clinical Psychology, 80*(4), 574-587.

Dembo, R., Schmeidler, J., Wareham, J., Briones-Robinson, R., Winters, K. C., & Ungaro, R. (2016). Impact of Brief Intervention Services on Drug-Using Truant Youths' Self-Reported Delinquency and Arrest Charges: A Longitudinal Study. *Journal of Child & Adolescent Substance Abuse, 25*(5), 458-479.

Douglas-Siegel, J. A., & Ryan, J. P. (2013). The effect of recovery coaches for substance-involved mothers in child welfare: impact on juvenile delinquency. *Journal of Substance Abuse Treatment, 45*(4), 381-387.

Foster, E. M. (2010). Costs and effectiveness of the fast track intervention for antisocial behavior. *The Journal of Mental Health Policy & Economics, 13*(3), 101-119.

Havighurst, S. S., Kehoe, C. E., & Harley, A. E. (2015). Tuning in to teens: Improving parental responses to anger and reducing youth externalizing behavior problems. *Journal of Adolescence, 42*, 148-158.

Hawkins, J. D., Oesterle, S., Brown, E. C., Abbott, R. D., & Catalano, R. F. (2014). Youth problem behaviors 8 years after implementing the communities that care prevention system: a community-randomized trial. *JAMA Pediatrics, 168*(2), 122-129.

Hawkins, J. D., Oesterle, S., Brown, E. C., Arthur, M. W., Abbott, R. D., Fagan, A. A., & Catalano, R. F. (2009). Results of a type 2 translational research trial to prevent adolescent drug use and delinquency: a test of Communities That Care. *Archives of Pediatrics & Adolescent Medicine, 163*(9), 789-798.

Hawkins, J. D., Oesterle, S., Brown, E. C., Monahan, K. C., Abbott, R. D., Arthur, M. W., & Catalano, R. F. (2012). Sustained decreases in risk exposure and youth problem behaviors after installation of the Communities That Care prevention system in a randomized trial. *Archives of Pediatrics & Adolescent Medicine, 166*(2), 141-148.

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., Shapiro, S. B., & Chapman, J. E. (2006). Juvenile drug court: enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology, 74*(1), 42-54.

Henggeler, S. W., McCart, M. R., Cunningham, P. B., & Chapman, J. E. (2012). Enhancing the effectiveness of juvenile drug courts by integrating evidence-based practices. *Journal of Consulting and Clinical Psychology, 80*(2), 264-275.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: the role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology, 65*(5), 821-833.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: an effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60*(6), 953-961.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family Preservation Using Multisystemic Treatment: Long-Term Follow-Up to a Clinical Trial with Serious Juvenile Offenders. *Journal of Child & Family Studies, 2*(4), 283-293.

Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1999). Multisystemic treatment of substance-abusing and dependent delinquents: outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*(3), 171-184.

Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J., . . . Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. Journal of the American Academy of Child and Adolescent Psychiatry, 42(5), 543-551.

Henry, D. B. (2012). Mediators of effects of a selective family-focused violence prevention approach for middle school students. *Prevention Science, 13*(1), 1-14.

Horigian, V. E., Feaster, D. J., Robbins, M. S., Brincks, A. M., Ucha, J., Rohrbaugh, M. J., . . . Szapocznik, J. (2015). A cross-sectional assessment of the long term effects of brief strategic family therapy for adolescent substance use. *American Journal on Addictions, 24*(7), 637-645.

Kelley, T. M., Kennedy, D. B., & Homant, R. J. (2003). Evaluation of an individualized treatment program for adolescent shoplifters. Adolescence, 38(152), 725-733.

Klein, N. C., Alexander, J. F., & Parsons, B. V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: a model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.

Klietz, S. J., Borduin, C. M., & Schaeffer, C. M. (2010). Cost-benefit analysis of multisystemic therapy with serious and violent juvenile offenders. *Journal of Family Psychology, 24*(5), 657-666.

Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., & Saldana, L. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology, 23*(1), 89-102.

Lochman, J. E., Dishion, T. J., Powell, N. P., Boxmeyer, C. L., Qu, L., & Sallee, M. (2015). Evidence-based preventive intervention for preadolescent aggressive children: One-year outcomes following randomization to group versus individual delivery. *Journal of Consulting and Clinical Psychology, 83*(4), 728-735.

Löfholm, C. A., Olsson, T., Sundell, K., & Hansson, K. (2009). Multisystemic therapy with conduct-disordered young people: stability of treatment outcomes two years after intake. Evidence & Policy: *A Journal of Research, Debate and Practice, 5*(4), 373-397.

McCarter, S. A. (2016). Holistic representation: A randomized pilot study of wraparound services for first-time juvenile offenders to improve functioning, decrease motions for review, and lower recidivism. *Family Court Review, 54*(2), 250-260.

Oesterle, S., Hawkins, J. D., Fagan, A. A., Abbott, R. D., & Catalano, R. F. (2010). Testing the universality of the effects of the communities that care prevention system for preventing adolescent drug use and delinquency.[Erratum appears in Prev Sci. 2010 Dec;11(4):424]. *Prevention Science, 11*(4), 411-423.

Oesterle, S., Hawkins, J. D., Fagan, A. A., Abbott, R. D., & Catalano, R. F. (2014). Variation in the sustained effects of the communities that care prevention system on adolescent smoking, delinquency, and violence. *Prevention Science, 15*(2), 138-145.

Ogden, T., Hagen, K. A., & Andersen, O. (2007). Sustainability of the effectiveness of a programme of multisystemic treatment (MST) across participant groups in the second year of operation. *Journal of Children's Services, 2*(3), 4-14.

Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. *Child and Adolescent Mental Health, 9*(2), 77-83.

Ollendick, T. H., Greene, R. W., Austin, K. E., Fraire, M. G., Halldorsdottir, T., Allen, K. B., . . . Wolff, J. C. (2016). Parent management training and collaborative & proactive solutions: A randomized control trial for oppositional youth. *Journal of Clinical Child and Adolescent Psychology, 45*(5), 591-604.

Olsson, T. M. (2010). Intervening in youth problem behavior in Sweden: a pragmatic cost analysis of MST from a randomized trial with conduct disordered youth. *International Journal of Social Welfare, 19*(2), 194-205.

Rohde, P., Clarke, G. N., Mace, D. E., Jorgensen, J. S., & Seeley, J. R. (2004). An efficacy/effectiveness study of cognitive-behavioral treatment for adolescents with comorbid major depression and conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(6), 660-668.

Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J. P., & Shapiro, S. B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix class youths. *Journal of Emotional & Behavioral Disorders, 13*(1), 13-23.

Sawyer, A. M., & Borduin, C. M. (2011). Effects of multisystemic therapy through midlife: a 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 79*(5), 643-652.

Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 73*(3), 445-453.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., Pickrel, S. G., & Patel, H. (1996). Multisystemic therapy treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. *Journal of Child and Family Studies, 5*(4), 431-444.

Sieving, R. E., McMorris, B. J., Secor-Turner, M., Garwick, A. W., Shlafer, R., Beckman, K. J., . . . Seppelt, A. M. (2014). Prime time: 18-month violence outcomes of a clinic-linked intervention. *Prevention Science, 15*(4), 460-472.

Stuart, R. B., Tripodi, T., Jayaratne, S., & Camburn, D. (1976). An experiment in social engineering in serving the families of predelinquents. *Journal of Abnormal Child Psychology, 4*(3), 243-261.

Sundell, K., Hansson, K., Lofholm, C. A., Olsson, T., Gustle, L. H., & Kadesjo, C. (2008). The transportability of multisystemic therapy to Sweden: short-term results from a randomized trial of conduct-disordered youths. *Journal of Family Psychology, 22*(4), 550-560.

Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An independent effectiveness trial of multisystemic therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology, 35*(2), 227-236.

Wagner, D. V., Borduin, C. M., Sawyer, A. M., & Dopp, A. R. (2014). Long-term prevention of criminality in siblings of serious and violent juvenile offenders: a 25-year follow-up to a randomized clinical trial of multisystemic therapy. *Journal of Consulting and Clinical Psychology, 82*(3), 492-499.

Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of multisystemic therapy with non-court-referred adolescents with serious conduct problems. *Journal of Consulting and Clinical Psychology, 81*(6), 1027-1039.

Australian / New Zealand Studies

Carroll, A., Ashman, A., Hemingway, F., Bower, J., Houghton, S. (2012) A preliminary evaluation of Mindfields: A self-regulatory cognitive behavioural program for school-aged adolescent offenders. *The Australian Educational and Developmental Psychologist, 29*(2), 81-94.

Curtis, N.M., Heiblum, N., Ronan, K.R., Crellin, K. (2009) Dissemination and effectiveness of multisystemic treatment in New Zealand: A benchmarking study. *Journal of Family Psychology, 23*(2), 119-129.

Pawsey, R. (1996). A family behavioural treatment of persistent juvenile theft. *Australian Psychologist, 31*(1), 28-33.

Salari, R., Ralph, A., Sanders, M.R. (2014). An efficacy trial: Positive parenting program for parents of teenagers. *Behaviour Change, 31*(1), 34-52.

EGM 4: Trauma-informed practice

Systematic Reviews
Cary, C. E., & McMillen, J. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*(4), 748-757.
de Arellano, M. A., Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., . . . Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive-behavioral therapy for children and adolescents: assessing the evidence. *Psychiatric Services, 65*(5), 591-602.
Forneris, C. A., Gartlehner, G., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., . . . Lohr, K. N. (2013). Interventions to prevent post-traumatic stress disorder: a systematic review. American Journal of Preventive Medicine, 44(6), 635-650.
Fraser, J. G., Lloyd, S., Murphy, R., Crowson, M., Zolotor, A. J., Coker-Schwimmer, E., & Viswanathan, M. (2013). A comparative effectiveness review of parenting and trauma-focused interventions for children exposed to maltreatment. *Journal of Developmental & Behavioral Pediatrics, 34*(5), 353-368.
Gillies, D., Maiocchi, L., Bhandari, A. P., Taylor, F., Gray, C., & O'Brien, L. (2016). Psychological therapies for children and adolescents exposed to trauma. *Cochrane Database of Systematic Reviews*, 10, CD012371.
Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Reviews*, 12, CD006726.
Kramer, D. N., & Landolt, M. A. (2011). Characteristics and efficacy of early psychological interventions in children and adolescents after single trauma: a meta-analysis. *European Journal of Psychotraumatology, 2*.
Leenarts, L. E., Diehle, J., Doreleijers, T. A., Jansma, E. P., & Lindauer, R. J. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. *European Child & Adolescent Psychiatry, 22*(5), 269-283.
Lenz, A., & Hollenbaugh, K. (2015). Meta-analysis of trauma-focused cognitive behavioral therapy for treating PTSD and co-occurring depression among children and adolescents. *Counseling Outcome Research and Evaluation, 6*(1), 18-32.
Morina, N., Koerssen, R., & Pollet, T. V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta-analysis of comparative outcome studies. *Clinical Psychology Review, 47*, 41-54.
Passarela, C. D. M., Mendes, D. D., & De Jesus Mari, J. (2010). A systematic review to study the efficacy of cognitive behavioral therapy for sexually abused children and adolescents with posttraumatic stress disorder. *Revista de Psiquiatria Clinica, 37*(2), 63-73.
Sanchez-Meca, J., Rosa-Alcazar, A. I., & Lopez-Soler, C. (2011). The psychological treatment of sexual abuse in children and adolescents: A meta-analysis. *International Journal of Clinical and Health Psychology, 11*(1), 67-93.
Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 156-183.

Randomised Controlled Trials
Berkowitz, S. J., Stover, C. S., & Marans, S. R. (2011). The Child and Family Traumatic Stress Intervention: secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 52*(6), 676-685.
Capaldi, S., Asnaani, A., Zandberg, L. J., Carpenter, J. K., & Foa, E. B. (2016). Therapeutic Alliance during Prolonged Exposure Versus Client-Centered Therapy for Adolescent Posttraumatic Stress Disorder. *Journal of Clinical Psychology, 72*(10), 1026-1036.
Classen, C. C., Palesh, O. G., Cavanaugh, C. E., Koopman, C., Kaupp, J. W., Kraemer, H. C., . . . Spiegel, D. (2011). A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(1), 84-93.
Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(4), 393-402.
Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine, 165*(1), 16-21.
Cohen, J. A., Mannarino, A. P., Jankowski, K., Rosenberg, S., Kodya, S., & Wolford, G. L., 2nd. (2016). A Randomized Implementation Study of Trauma-Focused Cognitive Behavioral Therapy for Adjudicated Teens in Residential Treatment Facilities. *Child Maltreatment, 21*(2), 156-167.
Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*(2), 135-145.
Cohen, J. A., Mannarino, A. P., Perel, J. M., & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(7), 811-819.
Coulter, S. (2011). Systemic family therapy for families who have experienced trauma: A randomised controlled trial. *British Journal of Social Work, 41*(3), 502-519.
Danielson, C. K., McCart, M. R., Walsh, K., de Arellano, M. A., White, D., & Resnick, H. S. (2012). Reducing substance use risk and mental health problems among sexually assaulted adolescents: a pilot randomized controlled trial. *Journal of Family Psychology, 26*(4), 628-635.
Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. *Depression & Anxiety, 28*(1), 67-75.
Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. (2015). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry, 24*(2), 227-236.
Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: a randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. *Child Abuse & Neglect, 38*(9), 1508-1520.
Farkas, L., Cyr, M., Lebeau, T. M., & Lemay, J. (2010). Effectiveness of MASTR/EMDR Therapy for Traumatized Adolescents. *Journal of Child & Adolescent Trauma, 3*(2), 125-142.
Holt, T., Jensen, T. K., & Wentzel-Larsen, T. (2014). The change and the mediating role of parental emotional reactions and depression in the treatment of traumatized youth: results from a randomized controlled study. *Child & Adolescent Psychiatry & Mental Health [Electronic Resource], 8*, 11.

Jensen, T. K., Holt, T., & Ormhaug, S. M. (2017). A Follow-Up Study from a Multisite, Randomized Controlled Trial for Traumatized Children Receiving TF-CBT. *Journal of Abnormal Child Psychology, 2*6, 26.

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., . . . Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology, 43*(3), 356-369.

Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-focused cognitive-behavioral therapy for children: sustained impact of treatment 6 and 12 months later. *Child Maltreatment, 17*(3), 231-241.

McLean, C. P., Yeh, R., Rosenfield, D., & Foa, E. B. (2015). Changes in negative cognitions mediate PTSD symptom reductions during client-centered therapy and prolonged exposure for adolescents. *Behaviour Research & Therapy, 68*, 64-69.

Najavits, L. M., Gallop, R. J., & Weiss, R. D. (2006). Seeking safety therapy for adolescent girls with PTSD and substance use disorder: a randomized controlled trial. J*ournal of Behavioral Health Services & Research, 33*(4), 453-463.

Overbeek, M. M., de Schipper, J. C., Lamers-Winkelman, F., & Schuengel, C. (2013). Effectiveness of specific factors in community-based intervention for child-witnesses of interparental violence: a randomized trial. *Child Abuse & Neglect, 37*(12), 1202-1214.

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: a randomized clinical trial. *J Child Psychol Psychiatry, 52*(8), 853-860.

Shirk, S. R., DePrince, A. P., Crisostomo, P. S., & Labus, J. (2014). Cognitive behavioral therapy for depressed adolescents exposed to interpersonal trauma: An initial effectiveness trial. *Psychotherapy, 51*(1), 167-179.

Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: a preliminary randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(8), 1051-1061.

Zandberg, L., Kaczkurkin, A. N., McLean, C. P., Rescorla, L., Yadin, E., & Foa, E. B. (2016). Treatment of Adolescent PTSD: The Impact of Prolonged Exposure Versus Client-Centered Therapy on Co-Occurring Emotional and Behavioral Problems. *Journal of Traumatic Stress, 29*(6), 507-514.

Australian / New Zealand Studies

Feather, J.S., Ronan, K.R. (2006). Trauma-Focused Cognitive-Behavioural Therapy for Abused Children with Posttraumatic Stress Disorder: A Pilot Study. *New Zealand Journal of Psychology, 5*(3), 132-145.

Feather, J.S., Ronan, K.R. (2009). Trauma-focused CBT with maltreated children: A clinic-based evaluation of a new treatment manual. *Australian Psychologist, 44*(3), 174-194.

EGM 5: Children with disabilities and their families

Systematic Reviews
Strunk, J.A. (201). Respite care for families of special needs children: A systematic review. *Journal of Developmental and Physical Disabilities, 22*(6), 615-630.
Ziviani, J., Feeney, R., Cuskelly, M., Meredith, P., Hunt, K. (2012). Effectiveness of support services for children and young people with challenging behaviours related to or secondary to disability, who are in out-of-home care: A systematic review. *Children and Youth Services Review, 34*(4), 758-770.
Randomised Controlled Trials
No studies identified
Australian / New Zealand Studies
No studies identified

EGM 6: Family violence

Systematic Reviews
Akoensi, T. D., Koehler, J. A., Losel, F., & Humphreys, D. K. (2013). Domestic violence perpetrator programs in Europe, Part II: A systematic review of the state of evidence. *International Journal of Offender Therapy & Comparative Criminology, 57*(10), 1206-1225.
Bilukha, O., Hahn, R. A., Crosby, A., Fullilove, M. T., Liberman, A., Moscicki, E., . . . Briss, P. A. (2005). The Effectiveness of Early Childhood Home Visitation in Preventing Violence: A Systematic Review. *American Journal of Preventive Medicine, 28*(2, Suppl1), 11-39.
Geeraert, L., Van Den Noortgate, W., Grietens, H., & Onghena, P. (2004). The Effects of Early Prevention Programs for Families With Young Children At Risk for Physical Child Abuse and Neglect: *A Meta-Analysis. Child Maltreatment, 9*(3), 277-291.
Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Reviews, 12*, CD006726.
Hackett, S., McWhirter, P. T., & Lesher, S. (2015). The Therapeutic Efficacy of Domestic Violence Victim Interventions. *Trauma, Violence, and Abuse, 17*(2), 123-132.
Howell, K. H., Miller-Graff, L. E., Hasselle, A. J., & Scrafford, K. E. (2017). The unique needs of pregnant, violence-exposed women: A systematic review of current interventions and directions for translational research. *Aggression and Violent Behavior*.
Jahanfar, S., Howard, L. M., & Medley, N. (2014). Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews*(11), CD009414.
Jahanfar, S., Janssen, P. A., Howard, L. M., & Dowswell, T. (2013). Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane database of systematic reviews* (Online), 2.
Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine, 156*(11), 796-808.
Prosman, G. J., Lo Fo Wong, S. H., van der Wouden, J. C., & Lagro-Janssen, A. L. (2015). Effectiveness of home visiting in reducing partner violence for families experiencing abuse: a systematic review. *Family Practice, 32*(3), 247-256.
Rizo, C. F., Macy, R. J., Ermentrout, D. M., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behavior, 16*(2), 144-166.
Sharps, P. W., Campbell, J., Baty, M. L., Walker, K. S., & Bair-Merritt, M. H. (2008). Current evidence on perinatal home visiting and intimate partner violence. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37*(4), 480-490.
Shea, B., Nahwegahbow, A., & Andersson, N. (2010). Reduction of Family Violence in Aboriginal Communities: A Systematic Review of Interventions and Approaches. *Pimatziwin, 8*(2), 35-60.
Stover, C. S., Meadows, A. L., & Kaufman, J. (2009). Interventions for Intimate Partner Violence: Review and Implications for Evidence-Based Practice. *Professional Psychology: Research and Practice, 40*(3), 223-233.
Van Parys, A. S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate partner violence and pregnancy: A systematic review of interventions. *PLoS ONE [Electronic Resource], 9*(1).
Waller, B. (2016). Broken fixes: A systematic analysis of the effectiveness of modern and postmodern interventions utilized to decrease IPV perpetration among Black males remanded to treatment. *Aggression and Violent Behavior, 27*, 42-49.

Whitaker, D. J., Morrison, S., Lindquist, C., Hawkins, S. R., O'Neil, J. A., Nesius, A. M., . . . Reese, L. R. (2006). A critical review of interventions for the primary prevention of perpetration of partner violence. *Aggression and Violent Behavior, 11*(2), 151-166.

Whitaker, D. J., Murphy, C. M., Eckhardt, C. I., Hodges, A. E., & Cowart, M. (2013). Effectiveness of primary prevention efforts for intimate partner violence. *Partner Abuse, 4*(2), 175-195.

Wilson, I. M., Graham, K., & Taft, A. (2014). Alcohol interventions, alcohol policy and intimate partner violence: a systematic review. *BMC Public Health, 14*, 881.

Randomised Controlled Trials

Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: a randomized controlled trial of the Hawaii Healthy Start Home Visitation Program. *Archives of Pediatrics & Adolescent Medicine, 164*(1), 16-23.

Barlow, J., Davis, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007). Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. *Archives of Disease in Childhood, 92*(3), 229-233.

Bugental, D. B., Ellerson, P. C., Lin, E. K., Rainey, B., Kokotovic, A., & O'Hara, N. (2002). A cognitive approach to child abuse prevention. *Journal of Family Psychology, 16*(3), 243-258.

Carrion, V. G., Kletter, H., Weems, C. F., Berry, R. R., & Rettger, J. P. (2013). Cue-centered treatment for youth exposed to interpersonal violence: a randomized controlled trial. *Journal of Traumatic Stress, 26*(6), 654-662.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., . . . Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500-510.

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine, 165*(1), 16-21.

Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: impact in reducing parental risk factors. *Child Abuse & Neglect, 28*(6), 623-643.

Duggan, A., Fuddy, L., McFarlane, E., Burrell, L., Windham, A., Higman, S., & Sia, C. (2004). Evaluating a statewide home visiting program to prevent child abuse in at-risk families of newborns: fathers' participation and outcomes. *Child Maltreatment, 9*(1), 3-17.

Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-Focused Prevention at the Transition to Parenthood, a Randomized Trial: Effects on Coparenting, Parenting, Family Violence, and Parent and Child Adjustment. *Prevention Science, 17*(6), 751-764.

Florsheim, P., McArthur, L., Hudak, C., Heavin, S., & Burrow-Sanchez, J. (2011). The Young Parenthood Program: Preventing Intimate Partner Violence Between Adolescent Mothers and Young Fathers. *Journal of Couple & Relationship Therapy, 10*(2), 117-134.

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: can treatment help those at highest risk? *Child Abuse & Neglect, 35*(7), 504-513.

Graham-Bermann, S. A., & Miller-Graff, L. (2015). Community-based intervention for women exposed to intimate partner violence: A randomized control trial. *Journal of Family Psychology, 29*(4), 537-547.

Graham-Bermann, S. A., Miller-Graff, L. E., Howell, K. H., & Grogan-Kaylor, A. (2015). An Efficacy Trial of an Intervention Program for Children Exposed to Intimate Partner Violence. *Child Psychiatry & Human Development, 46*(6), 928-939.

Howell, K. H., Miller, L. E., Lilly, M. M., Burlaka, V., Grogan-Kaylor, A. C., & Graham-Bermann, S. A. (2015). Strengthening positive parenting through intervention: evaluating the Moms' Empowerment Program for women experiencing intimate partner violence. *Journal of Interpersonal Violence, 30(2), 232-252.*

Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing conduct pro blems among children exposed to intimate partner violence: a randomized clinical trial examining effects of Project Support. *Journal of Consulting & Clinical Psychology, 77*(4), 705-717.

Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank, P. R., Stephens, N., . . . Buzy, W. M. (2001). Reducing conduct problems among children of battered women. *Journal of Consulting & Clinical Psychology, 69*(5), 774-785.

Kan, M. L., & Feinberg, M. E. (2014). Can a family-focused, transition-to-parenthood program prevent parent and partner aggression among couples with young children? *Violence & Victims, 29*(6), 967-980.

Kiely, M., El-Mohandes, A. A., El-Khorazaty, M. N., Blake, S. M., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial.[Erratum appears in Obstet Gynecol. 2011 May;117(5):1232 Note: Blake, Susan M [added]]. *Obstetrics & Gynecology, 115*(2 Pt 1), 273-283.

Labriola, M., Rempel, M., & Davis, R. C. (2008). Do Batterer Programs Reduce Recidivism? Results from a Randomized Trial in the Bronx. *JQ: Justice Quarterly, 25*(2), 252-282.

Langhinrichsen-Rohling, J., & Turner, L. A. (2012). The efficacy of an intimate partner violence prevention program with high-risk adolescent girls: a preliminary test. *Prevention Science, 13*(4), 384-394.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(12), 1241-1248.

Mbilinyi, L. F., Neighbors, C., Walker, D. D., Roffman, R. A., Zegree, J., Edleson, J., & O'Rourke, A. (2011). A telephone intervention for substance-using adult male perpetrators of intimate partner violence. *Research on Social Work Practice, 21*(1), 43-56.

McDonald, R., Jouriles, E. N., & Skopp, N. A. (2006). Reducing conduct problems among children brought to women's shelters: intervention effects 24 months following termination of services. *Journal of Family Psychology, 20*(1), 127-136.

McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2005). Behaviors of children following a randomized controlled treatment program for their abused mothers. *Issues in Comprehensive Pediatric Nursing, 28*(4), 195-211.

McWhirter, P. T. (2011). Differential therapeutic outcomes of community-based group interventions for women and children exposed to intimate partner violence. *Journal of Interpersonal Violence, 26*(12), 2457-2482.

Mejdoubi, J., van den Heijkant, S. C., van Leerdam, F. J., Heymans, M. W., Hirasing, R. A., & Crijnen, A. A. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. *PLoS ONE [Electronic Resource], 8*(10), e78185.

Melendez, R. M., Hoffman, S., Exner, T., Leu, C. S., & Ehrhardt, A. A. (2003). Intimate partner violence and safer sex negotiation: effects of a gender-specific intervention. *Archives of Sexual Behavior, 32*(6), 499-511.

Mills, L. G., Barocas, B., & Ariel, B. (2013). The next generation of court-mandated domestic violence treatment: A comparison study of batterer intervention and restorative justice programs. *Journal of Experimental Criminology, 9*(1), 65-90.

Overbeek, M. M., de Schipper, J. C., Lamers-Winkelman, F., & Schuengel, C. (2013). Effectiveness of specific factors in community-based intervention for child-witnesses of interparental violence: a randomized trial. *Child Abuse & Neglect, 37*(12), 1202-1214.

Sharps, P. W., Bullock, L. F., Campbell, J. C., Alhusen, J. L., Ghazarian, S. R., Bhandari, S. S., & Schminkey, D. L. (2016). Domestic Violence Enhanced Perinatal Home Visits: The DOVE Randomized Clinical Trial. *Journal of Women's Health, 25*(11), 1129-1138.

Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., . . . 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*(8), 1435-1444.

Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers' AdvocateS In the Community (MOSAIC)--non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomised trial in primary care. *BMC Public Health, 11*, 178.

Tiwari, A., Leung, W. C., Leung, T. W., Humphreys, J., Parker, B., & Ho, P. C. (2005). A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: An International Journal of Obstetrics & Gynaecology, 112*(9), 1249-1256.

Australian / New Zealand Studies

Blatch, C., O'Sullivan, K., Delaney, JJ., van Doorn, G., Sweller, T. (2016). Evaluation of an Australian domestic abuse program for offending males. *Journal of Aggression, Conflict and Peace Research, 8*(1), 4-20.

Fergusson, D.M., Grant, H., Horwood, L.J., Ridder, E.M. (2005). Randomized Trial of the Early Start Program of Home Visitation. *Pediatrics, 116*(6): e803-e809.

Risk factors for maltreatment studies

Amlani, A., Grewal, G. S., & Feldman, M. D. (2016). Malingering by Proxy: A Literature Review and Current Perspectives. *J Forensic Sci, 61 Suppl 1*, S171-176
Bidarra, Z. S., Lessard, G., & Dumont, A. (2016). Co-occurrence of intimate partner violence and child sexual abuse: Prevalence, risk factors and related issues. *Child Abuse & Neglect, 55*, 10-21.
Han, A., & Stewart, D. E. (2014). Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region. *Int J Gynaecol Obstet, 124*(1), 6-11.
James, L., Brody, D., & Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence & Victims, 28(3), 359-380.*
Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., . . . Shakespeare, T. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet, 380*(9845), 899-907.
Kashif, M., Murtaza, K., & Kirkman, M. (2010). Violence against women during pregnancy in some Asian countries: A review of the literature. *Italian Journal of Public Health, 7*(2), 6-11.
Kloppen, K., Haugland, S., Svedin, C. G., Mæhle, M., & Breivik, K. (2016). Prevalence of Child Sexual Abuse in the Nordic Countries: A Literature Review. *Journal of Child Sexual Abuse, 25*(1), 37-55.
Reupert, A., & Maybery, D. (2016). What do we know about families where parents have a mental illness? A systematic review. *Child & Youth Services, 37*(2), 98-111.
Riley, C. L., Sarani, B., Sullivan, J. A., Upperman, J. S., Kane-Gill, S. L., Bailey, H., & Society of Critical Care, M. (2015). Critical Violent Injury in the United States: A Review and Call to Action. *Critical Care Medicine, 43*(11), 2460-2467.
Sundin, E. C., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. *Social Psychiatry & Psychiatric Epidemiology, 50*(2), 183-194.
Timmerman, M. C., & Schreuder, P. R. (2014). Sexual abuse of children and youth in residential care: An international review. *Aggression and Violent Behavior, 19*(6), 715-720.

Evidence gap maps - Appendix D

Contents

Key to EGM Grids

Cell content contains at least:	Evidence
No high quality studies	blank cell
1 RCT	very weak
At least 2 RCTs (moderate to high quality)	weak
1 SR low to moderate	weak
1 SR low to moderate plus 2 or more RCTs (high quality)	weak to moderate
2 or more SR low to moderate quality	weak to moderate
2 or more SR of moderate quality	moderate
1 SR of high quality	moderate
1 SR of high quality plus at least 2 RCTs high quality	moderate to high
2 or more SR of moderate quality plus 2 or more RCTs high quality	moderate to high
2 or more SRs of moderate to high	moderate to high
2 or more SRs of moderate to high plus 2 or more RCTS high quality	high
2 or more SRs of high quality	high
4 or more SR high quality	very high

EGM 1: Services for Aboriginal children and families

		CHILD OUTCOMES								PARENT/CAREGIVER OUTCOMES									COST-EFFECTIVENESS
Intervention type	Main intervention focus	Child Safety	Placement Permanency	Physical Health and Wellbeing	Mental Health	Social Wellbeing	Cultural and Spiritual Identity	Child Development	Cognitive functioning, education and learning	Safety	Parenting skills and knowledge	Education and Learning	Physical Health and Wellbeing	Mental Health	Social Wellbeing	Cultural Wellbeing	Employment and Housing	Family Functioning	Cost-effectiveness
Preventative Interventions	Parents. Caregivers									Weak									
	Child, Children																		
	Family, household																		
Early Interventions	Parents, Caregivers	Very weak			Weak					Very weak	Weak			Weak	Very weak				
	Child, Children																		
	Family, household																		
Therapeutic Interventions and Risk Reduction	Parents, Caregivers																		
	Child, Children				Very weak														
	Family, household																		

EGM 2: Out-of-home care

Type of OOHC	Safety	Family Functioning	Placement permanency	Cognitive functioning	Physical health and development	Mental Health	Social functioning	Cultural and spiritual identity	OOHC Prevention
General Foster Care	Strong	Strong	Strong	Strong		Very strong	Strong		
Intensive Foster Care or Treatment Foster Care	Moderate	Moderate	Strong	Moderate	Moderate	Strong	Moderate		
Residential Care	Moderate	Moderate	Very weak	Moderate to strong	Moderate	Moderate	Moderate		
Kinship Care	Strong	Strong	Strong	Strong		Strong	Strong		
Supported independent living		Weak	Moderate	Moderate	Moderate	Moderate	Weak		
Supported family group home									
Temporary and respite									
OOHC Prevention		Moderate to strong	Moderate	Strong	Moderate	Strong	Very weak		Moderate to strong
Mixed or Unspecified Care Type	Very weak	Very weak	Moderate	Moderate	Weak	Moderate to strong	Weak		

EGM 3: Interventions for young people with high risk behaviours

		CHILD OUTCOMES								PARENT/CAREGIVER OUTCOMES								COST-EFFECTIVENESS
Intervention type	Main intervention focus	Child Safety	Placement permanency	Physical health and Wellbeing	Mental Health	Social Wellbeing	Cultural and Spiritual Identity	Child development	Cognitive functioning, education and learning	Safety	Parenting skills and knowledge	Education and Learning	Physical health and Wellbeing	Mental Health	Social Wellbeing	Cultural Wellbeing	Housing and employment	Family Functioning	Cost-effectiveness
Preventative Interventions (e.g. education, campaigning)	Parents, Caregivers				Weak	Weak													
	Child, Children			Weak	Moderate	Weak	Weak		Weak										
	Family, household				Weak	Weak													
Early Interventions (e.g. parenting programs such as Triple P)	Parents, Caregivers				Weak	Weak					Very weak								
	Child, Children			Very weak	Weak to moderate	Weak			Very weak										
	Family, household				Weak	Weak			Very weak										Weak
Therapeutic Interventions and Risk Reduction (e.g. Multisystemic Therapy, Aggression Replacement Therapy)	Parents, Caregivers		Strong	Strong	Very strong	Weak			Strong		Moderate			Moderate				Weak	Moderate
	Child, Children		Very weak	Moderate	Very strong	Strong			Moderate		Moderate			Very weak				Moderate	Very weak
	Family, household			Weak	Moderate to strong	Weak					Moderate			Very weak				Moderate	Very weak

EGM 4: Trauma-informed services

		CHILD OUTCOMES								PARENT/CAREGIVER OUTCOMES									COST-EFFECTIVENESS
Intervention type	Main intervention focus	Child Safety	Placement permanency	Physical Health and Wellbeing	Mental Health	Social Wellbeing	Cultural & Spiritual Identity	Child Development	Cognitive functioning, education and learning	Safety	Parenting skills and knowledge	Education and Learning	Physical Health and Wellbeing	Mental Health	Social Wellbeing	Cultural Wellbeing	Housing and employment	Family Functioning	Cost-effectiveness
Early interventions	Parents, Caregivers																		
	Child, Children	Moderate			Very strong														
	Family, household	Very weak			Very weak									Very weak					
Therapeutic interventions and risk reduction	Parents, Caregivers				Weak to moderate						Weak			Weak					
	Child, Children	Moderate			Strong	Weak					Weak			Weak	Very weak				
	Family, household				Moderate	Weak					Weak			Very weak					

EGM 5: Children with disabilities

		CHILD OUTCOMES								PARENT/CAREGIVER OUTCOMES								COST-EFFECTIVENESS
Intervention type	Main intervention focus	Child Safety	Placement permanency	Physical health and Wellbeing	Mental health	Social wellbeing	Cultural and Spiritual Identity	Child development	Cognitive functioning, education and learning	Safety	Parenting skills and knowledge	Education and Learning	Physical health and Wellbeing	Mental health	Social wellbeing	Cultural wellbeing	Housing and employment	Family functioning	Cost-effectiveness
Preventative interventions (e.g. reporting, support services, etc.)	Parents, Caregivers																		
	Child, Children	Weak												Weak					
	Family, household																		
Early Interventions (e.g. home visiting for pregnant women and new parents)	Parents, Caregivers																		
	Child, Children																		
	Family, household																		
Therapeutic interventions and risk reduction (e.g. respite care)	Parents, Caregivers										Moderate			Moderate					
	Child, Children		Moderate		Moderate				Moderate										
	Family, household																		

EGM 6: Family violence

		CHILD OUTCOMES							ADULT OUTCOMES								COST EFFECTIVENESS
INTERVENTION TYPE	FOCUS CLIENT	Child Safety	Physical health and Development	Mental health	Social wellbeing	Cultural and spiritual Identity	Childhood Development	Education and Learning	Safety	Parenting Skills and Knowledge	Education and Learning	Physical health & Wellbeing	Mental health	Social wellbeing	Cultural wellbeing	Housing and employment	Cost effectiveness
Preventative Interventions (e.g. adolescent school-based programs)	Parents[1]	Weak	Strong	Weak					Strong	Very weak			Strong				
	Child							Weak									
	Family			Very weak					Weak				Very weak				
	Perpetrator																
Early Interventions	Parents	Weak	Strong	Very weak					Strong	Weak		Very weak	Strong	Weak			
	Child																
	Family	Very weak	Very weak	Weak	Very weak				Moderate	Very weak		Very weak	Very weak				
	Perpetrator																
Therapeutic interventions and risk reduction	Parents	Weak		Weak	Weak				Weak to moderate	Weak			Weak				
	Child	Weak	Very weak	Weak	Weak		Very weak		Weak to moderate	Weak			Weak				
	Family	Weak to moderate		Moderate	Weak		Very weak		Weak to moderate	weak			Moderate	Very weak		Very weak	
	Perpetrator			Very weak					Weak to moderate			Very weak	Weak to moderate				

[1] This term refers to mother and/or father, and/or carers.

Children and Families Evidence

Findings from Six Evidence Gap Maps

Prepared for the Victorian Department of Health and Human Services