Accident Compensation Corporation

Review of evidence for primary prevention of child abuse and neglect (including child sexual abuse)

Julie Artus and Malin Niemi

22 August 2016 (final report)

sapere research group

About Sapere Research Group Limited

Sapere Research Group is one of the largest expert consulting firms in Australasia and a leader in provision of independent economic, forensic accounting and public policy services. Sapere provides independent expert testimony, strategic advisory services, data analytics and other advice to Australasia's private sector corporate clients, major law firms, government agencies, and regulatory bodies.

Wellington Level 9, 1 Willeston St PO Box 587 Wellington 6140 Ph: +64 4 915 7590 Fax: +64 4 915 7596	**Auckland** Level 8, 203 Queen St PO Box 2475 Auckland 1140 Ph: +64 9 909 5810 Fax: +64 9 909 5828	
Sydney Level 14, 68 Pitt St GPO Box 220 NSW 2001 Ph: +61 2 9234 0200 Fax: +61 2 9234 0201	**Canberra** Unit 3, 97 Northbourne Ave Turner ACT 2612 GPO Box 252 Canberra City, ACT 2601 Ph: +61 2 6267 2700 Fax: +61 2 6267 2710	**Melbourne** Level 2, 65 Southbank Boulevard GPO Box 3179 Melbourne, VIC 3001 Ph: +61 3 9626 4333 Fax: +61 3 9626 4231

For information on this report please contact:

Name: Julie Artus

Telephone: 04 915 7590

Mobile: 021 206 6667

Email: jartus@srgexpert.com

Contents

Executive summary ..... **vii**

1. Introduction **13**

1.1 Context 13
1.1.1 The role of ACC in prevention of violence 13
1.1.2 Key definitions 13
1.2 Scope 14
1.2.1 Purpose of this report 14
1.2.2 Clarifying our interpretation of scope for the review 14
1.3 Approach 15

2. Risk and protective factors **16**

2.1 Introduction 16
2.1.1 Why address risk and protective factors? 16
2.1.2 Some important context and caveats 16
2.1.3 Use of secondary reference sources 18
2.2 Risk factors for child maltreatment 19
2.2.1 The child/individual level 19
2.2.2 The relationship level 21
2.2.3 Risk factors at the community and societal level 23
2.3 Assessing the relative size of effect for risk factors for child maltreatment 24
2.4 Risk factors specifically relating to child sexual abuse 25
2.4.1 CSA risk factors (for children of all ages) 25
2.4.2 Sexual development in pre-school children 27
2.5 Protective factors 29

3. Delivery mechanisms for primary prevention programmes **31**

3.1 Classification of delivery mechanisms 31
3.1.1 Universal delivery mechanisms 31
3.1.2 Selective delivery mechanisms 32
3.2 Effectiveness of delivery models 33

4. Evidence for primary prevention of CAN and CSA in pre-schoolers **36**

4.1 Programmes with the strongest evidence of effectiveness 36
4.1.1 Examples of effective programmes that seek to reduce CAN 36
4.1.2 Case studies of effective prevention programmes 38
4.2 Key conclusions from review articles 45
4.2.1 Meta-review of CAN prevention interventions for pre-schoolers (excluding CSA interventions) 45
4.2.2 Meta-review of CAN prevention interventions for children of all ages (including pre-schoolers) 45
4.2.3 Meta-review of CSA primary prevention programmes for pre-schoolers 46

4.3 New Zealand programmes with some evidence of effectiveness from less robust evaluations 49

5. What can we learn from the evidence for New Zealand? 50

5.1 Limitations of the literature 50
5.1.1 Validity and reliability of the evidence base 50
5.1.2 Relevance of the evidence to the NZ context 51
5.2 What approaches look most promising? 51
5.2.1 Universal versus selective approaches 51
5.2.2 What initiatives are most effective? 52
5.2.3 What works? Common features of effective interventions 54
5.3 Some further insights from the literature 58
5.3.1 Theoretical and cultural perspectives 58
5.3.2 The target population for primary prevention 59
5.3.3 Approach and scope of coverage 60
5.3.4 Supporting sustainable change 60
5.3.5 Implementation 61
5.4 Some final reflections 61

6. References 63

Appendices

Appendix 1 – Theoretical foundations 73

Appendix 2 – Search strategy 76

Appendix 3 – Comparative effect sizes for risk factors 79

Appendix 4 – Evidence for robustly evaluated initiatives 81

Appendix 5 – Examples of NZ programmes 88

Appendix 6 – Risk prediction modelling 93

Tables

Table 1: Child/individual level – risk factors for child maltreatment 19

Table 2: Parental and family risk factors for child maltreatment 22

Table 3: Community and societal risk factors for perpetration of CAN and CSA 23

Table 4: Relative effect sizes from evidence relating to risk factors for child physical abuse and neglect (Stith, et al., 2009). 24

Table 5: Protective factors that may assist in reducing likelihood of child maltreatment (relevant to children of all ages) 29

Table 6: Strength of evidence for the impact of different delivery mechanisms used for universal programme (adapted from WHO, 2013) 34

Table 7: Strength of evidence for the impact of different delivery mechanisms used for selective programmes (adapted from WHO, 2013) 35

Table 8: Knowledge of sexual abuse – review of evidence for CSA programmes for pre-schoolers 46

Table 9: Outcome measure 2: Adverse effects – review of evidence for CSA programmes for pre-schoolers 48

Table 10: Other outcome measures for which there was no evidence available – review of evidence for CSA programmes for pre-schoolers 48

Table 11: Advantages and disadvantages of universal approaches (New Zealand Government, 2012) 51

Table 12: Definitions for the four domains in the socio-ecological model of violence 74

Table 13: Summary of evidence relating to effective and robustly evaluated primary prevention initiatives targeted at pre-school children 81

Table 14: Examples of child maltreatment primary prevention programmes in New Zealand, with some evidence of effectiveness but subject to less robust evaluation 88

Figures

Figure 1: Levels of prevention showing the scope for our review 15

Figure 2: Christchurch Schools Toolkit for Safer Children – created & compiled by the Methodist Mission (2009) 28

Figure 3: The socio-ecological model of violence and violence prevention 73

Executive summary

Purpose

This report summarises the evidence in relation to what works for the primary prevention of child abuse and neglect (CAN) including child sexual abuse (CSA) with a focus on children aged 0-5 and the adults around them.

The review addresses the following research questions:

1. What are the risk and protective factors for CAN and CSA within a socio-ecological framework?
2. What are the various delivery mechanisms for CAN & CSA prevention interventions?
3. What are some examples of effective CAN and CSA prevention, locally and internationally (including funding approaches, delivery models and core competencies for professionals providing the interventions)?
4. What is the extent of evidence for effective CAN and CSA prevention?

Risk and protective factors

Risk factors are associated with increased likelihood of either victimisation or perpetration of child maltreatment, while protective factors enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.

The literature relating to risk and protective factors for child maltreatment is extensive and difficult to interpret, particularly due to inconsistent use of definitions for CAN and CSA and often the lack of clear specification of the age group to which they apply.

There is a need to exercise caution in the interpretation of risk and protective factors. While certain risk factors may exist among families where child abuse occurs, this does not mean that their presence necessarily leads to maltreatment, just as the presence of protective factors does not guarantee that children will be kept safe. Furthermore, certain risk and protective factors may not present in all social and cultural contexts and their potential extent of influence may vary across different environments and situations. There is a complex web of interactions at play.

In the report, we document the most commonly identified risk and protective factors, viewed through the four domains of a socio-ecological model, namely the: child/individual; family/relationships; community and societal.

Delivery mechanisms

We identified a classification of different types of delivery mechanisms that have been used to support the implementation of primary prevention initiatives in this field, as follows:

- **Universal delivery mechanisms:**
  - **Media-based public awareness programmes** – aim to spread messages among the general population using channels such as television, radio, printed materials and the Internet.

- **School-based violence prevention programmes** – typically delivered universally to children in a classroom-setting.
- **Interventions to prevent abusive head trauma** – preventive responses largely take the form of educating new parents about the dangers of shaking their child.
- **Changing social norms** – aim to prevent child maltreatment by changing beliefs and attitudes in society to how we view child abuse. May include measures such as changes to legislation.
- **Reducing the availability of alcohol** – for example, by regulating alcohol sales (e.g. controlling the times at which alcohol can be sold) and increasing prices (e.g. by implementing minimum prices for alcohol or increased taxation).
- **Community interventions** – which aim to enhance community capacity to prevent child maltreatment by expanding formal and informal resources and establishing a context that promotes collective responsibility for more positive child development.
- **Enhanced health care services –** health settings such as primary care and paediatric services present opportunities to identify families at increased risk of maltreatment and to provide them with appropriate support, advice and referral.
- **Preventing exposure to intimate partner violence** – parental intimate partner violence is a key risk factor for child maltreatment and witnessing violence between parents can have long-term impacts on children's well-being.
- **Reducing poverty** – such initiatives seek to prevent child maltreatment through addressing socio-economic drivers of risk.

- **Selective delivery mechanisms:**
  - **Home-visiting programmes** – generally provide parenting, health and social support to new mothers in their own homes, typically via specially trained nurses.
  - **Parenting programmes** – aim to improve parents' knowledge of child development, increase their parenting skills and strengthen parent-child relationships.
  - **Multicomponent preschool programmes** – generally provide preschool education for young children alongside services such as parenting programmes and family support.
  - **Support and mutual aid groups for parents** - aim to strengthen family support networks by providing opportunities for parents to meet and interact with peers in the community.

Examples of effective CAN and CSA primary prevention programmes

Having considered the generic delivery mechanisms that are available, we identified specific programmes that have been subject to robust evaluation and shown the highest levels of evidence of effectiveness within this field. Most of these programmes have been evaluated through Randomised Controlled Trials (RCTs), considered to be the gold standard of evidenced based research. A few programmes have been evaluated through other research methods still considered to be relatively robust, partly due to the fact that they are using a valid control group for comparison.

While our interpretation of the term 'child maltreatment' includes both CAN and CSA, the focus here was primarily on CAN interventions as there was a lack of high quality evaluation and evidence demonstrating the effectiveness of primary prevention programmes in reducing CSA.

- We presented a summary assessment of key aspects of the following 12 primary prevention programmes in relation to CAN within pre-school populations:

Universal

1. **The safe environment for every kid (SEEK)** model, implemented in the US targeted at children between 0-5 years.
2. **Triple P (Positive Parenting Programme),** developed in Australia and implemented across multiple countries (including NZ); targeting children between 0-16 years.
3. **Abusive head trauma education programme** in New York State (and similar programmes across multiple countries including NZ); targets parents of infants.
4. **The Coping with Crying programme** which targets parents of infants in the UK.
5. **Parents as Teachers (0–3 years**), initiated in the USA, and then implemented in other countries, including NZ.

Selective

6. **Early Start,** based in Christchurch, NZ and targets families with children less than five years.
7. **Nurse-family partnership (NFP),** implemented in the US and targeting children between 0-2 years.
8. **Chicago Child Parent Centres,** implemented in Chicago, US, targeting children between 3-9 years.
9. **Healthy Families America, in New York,** targeting families with children between 0–5 years.
10. **Child FIRST, USA,** targeting families with children between 0–5 years.
11. **Early Head Start and Head Start,** implemented across US and targets children up to age three (early head start) and up to age five (head start), and also pregnant woman.
12. **Parent-Child Interaction Therapy,** targeting children between 2-7 years. Originating from the US, PCIT has spread to multiple countries around the world, including New Zealand.

- We documented more detailed case studies of the three primary prevention programmes targeting a reduction of CAN within pre-school populations that showed the strongest evidence of effectiveness, namely:
  - Safe Environment for Every Kid (SEEK), US;
  - Early Start, based in Christchurch, NZ; and
  - Chicago Child Parent Centres, US.

- We provided an overview assessment of five New Zealand based programmes (three of which address CSA) which show some evidence effectiveness demonstrated through less robust evaluation, namely:

Universal programmes	1.	**We Can Keep Safe**, implemented in Auckland, targeted at children between 3-5 years.
	2.	**Right2BSafe** (Phase 2), implemented in the Hauraki/Coromandel regions, targeted at caregivers and other adults who have contact with children.
	3.	**KidPower**, available across New Zealand, targeted at children 4-12 years.
	4.	**All about Me (AaM),** a programme no longer available in NZ, funded by ACC and NZ Police (2007) directed at children attending early childhood education centres and their parents.
Selective programmes	5.	**Family help trust**, implemented in Christchurch, targets pregnant mothers and children under the age of 6 months.

Assessing the extent of the evidence - what can we learn for New Zealand?

Limitations of the literature

The literature within the field of primary prevention of CAN and CSA is vast and dense. Definitions are often applied inconsistently which makes interpretation difficult and sometimes leads to conflicting findings. In general, the evidence in this field is fairly low in both validity and reliability. It suffers from weak research and evaluation designs and there is a lack of good impact data, making cost-benefit analysis challenging (and thus evidence of cost-effectiveness is virtually non-existent). In particular, in relation to the CSA programmes for pre-school aged children, many evaluation studies are relatively old and were conducted using pre-schoolers from the United States as participants. The ability to generalise learnings to the New Zealand context is constrained, given the paucity of robust evaluations conducted on New Zealand initiatives, particularly in relation to culturally-specific programmes.

What approaches look most promising?

- **Effective delivery mechanisms -** We provided an overview of evidence supporting different types of delivery mechanism for primary prevention initiatives in this field. The highest degree of evidence was found for **school based programmes**, **home visiting programmes** and **effective parenting programmes** as having an impact on risk factors for child maltreatment. No type of mechanism was viewed to have proven effectiveness for actually reducing child maltreatment (WHO, 2013).
- **Effectiveness of specific initiatives –** From the summary of findings from meta-reviews of studies of specific programmes we reported the following conclusions:

Evidence relating to CAN interventions targeted at pre-schoolers	Three programmes provided strong evidence of enduring preventive effects: ➢ A nurse **home visiting service** from pregnancy to age 2 (Nurse Family Partnership) ➢ A high quality **pre-school education programme** for children aged 3-4 (Child Parent Centres) ➢ A post-natal **home-visiting** and **effective parenting service** (Parent Education Programme for Teen Mothers High risk)
Evidence relating to CAN interventions targeted at children of all ages (including pre-schoolers)	Four programmes were found to be promising in preventing actual child maltreatment: ➢ **home-visiting programme** ➢ **parent education programme** ➢ **abusive head trauma prevention programme** ➢ **multi-component interventions** Two programmes were found to be effective in reducing risk factors for child maltreatment. ➢ **home visiting programmes** ➢ **parent education programmes**

What works? Common features of effective interventions

We collated themes from the literature as to the features and characteristics of successful programmes, covering areas such as: duration and format; training/core competencies of staff; and content of programmes. Again, there was some blurring of definitions to which these applied, in particular with a blurred boundary as to which were relevant for either CAN, CSA or both. The categories of programmes covered were:

- Features of effective CAN/CSA primary prevention programmes for young children;
- Characteristics of effective parenting primary prevention programmes for parents of young children;
- Features of successful whānau violence prevention and intervention programmes taken from the Kaupapa Māori wellbeing framework; and
- Guidelines for dealing with sexual abuse in a Māori context.

Some further insights from the literature

- **Theoretical and cultural perspectives:**
  - Interventions should be positioned within an appropriate theoretical framework.
  - Incorporating key Māori concepts and values is imperative.
  - Initiatives require a sound theoretical base that focusses on risk and protective factors.
- **The target population for primary prevention:**
  - The earlier intervention occurs, the greater the potential benefits.
  - Programmes should identify and address barriers to participation.
- **Approach and scope of coverage:**

  - Interventions should be comprehensive and address several ecological domains and perspectives.
  - There is value in adopting a strengths-based intervention approach that focuses on increasing resilience.
- **Supporting sustainable change:**
  - It is important to ensure strong organisational leadership and alignment.
  - There are a number of features that support sustainability of service innovations (identified within the report).
- **Implementation:**
  - Core competencies and training of staff must be considered.
  - Research and evaluation of initiatives should be established from the start.

Summary reflections

While a range of interventions has been shown effective in reducing or potentially preventing the impact of risk factors for maltreatment of young children, high-quality evaluation studies examining the actual impacts of interventions on maltreatment outcomes are relatively sparse. In relation to child sexual abuse specifically, evaluations are currently of insufficient quantity and quality to make strong assertions about the overall efficacy of prevention programmes for pre-schoolers.

As such, we have reflected that there are no clear, 'silver-bullet' solutions which the ACC Violence portfolio will be able to pick up and implement with confidence. Rather there is a 'smorgasbord' of initiatives that appear promising, known features of programmes that increase the likelihood of success and some key contextual learnings about the New Zealand environment that will need to be pieced together in a coherent way that makes sense in a Kiwi context.

The process of determining the nature and scale of potential primary prevention interventions within this field requires a careful sifting of the evidence base and consideration of feasible options, with advice from key stakeholders within the sector. A range of perspectives, including public health, social work and early childhood education, will need to be incorporated to shape an appropriate way forward. Furthermore, on-going monitoring and robust evaluation of initiatives will be essential to assessing effectiveness and to building the knowledge base, relevant to the New Zealand context, within this field.

1. Introduction

1.1 Context

1.1.1 The role of ACC in prevention of violence

The remit of the Accident Compensation Corporation (ACC) violence portfolio encompasses prevention of child abuse and neglect, family violence, sexual violence and intentional harm.

The ACC Violence Prevention Strategy describes a key focus on 0-25 year olds and highlights the need to align prevention efforts over the course of the child's development. The brief recognises the importance of supporting very young children and their families during the key stages of their early development, such as in the early stages after birth (when a new born, crying baby can place parents/caregivers under emotional, psychological and physical strain) and in early childhood (when young children start developing knowledge about their bodies and what is private to them and to others).

In New Zealand much of the primary prevention work in relation to child violence, particularly in relation to child sexual abuse, has taken place in secondary school settings. Comparatively, there is very limited availability and reach of primary prevention programmes aimed at reducing child abuse and neglect (CAN) including child sexual abuse (CSA) for 0-5 year olds. ACC is in the process of considering options for potential primary prevention initiatives aimed at reducing CAN and CSA of pre-school children.

1.1.2 Key definitions

Definitions of key terms used within this report are provided below.

Child maltreatment: *"Child maltreatment, sometimes referred to as* ***child abuse and neglect (CAN)****, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation."* (WHO, n.d.).

Child sexual abuse: Involving a child or young person in sexual activities, touching them in a sexual way, using a child for sexual gratification, or involving and/or exposing them to sexually explicit material. Children under the age of 16 years cannot give consent to sexual activities (ACC, 12th May, 2016).

Child neglect: Defined as failure to meet a child's essential needs through inadequate parenting and lack of parental/caregiver responsibility. Neglect is about what parents and caregivers don't do. We all understand that parents are not able to meet all their child's needs all the time, but it is persistent neglect of a child's need which results in some form of harm. Neglect can include physical neglect, neglectful supervision, emotional neglect, medical neglect and educational neglect (Ministry of Women's Affairs, 2013).

1.2 Scope

1.2.1 Purpose of this report

Sapere Research Group was commissioned to complete a literature review summarising the evidence in relation to what works for the primary prevention of CAN and CSA with a focus on children aged 0-5 and the adults around them.

The review addresses the following research questions:

1. What are the risk and protective factors for CAN and CSA within a socio-ecological framework?
2. What are the various delivery models for CAN & CSA prevention interventions?
3. What are some examples of effective CAN and CSA prevention, locally and internationally (including funding approaches, delivery models and core competencies for professionals providing the interventions)?
4. What is the extent of evidence for effective CAN and CSA prevention?

ACC were particularly interested in prevention programmes that can have a wide reach and are scalable for wide implementation. Furthermore, they advised that consideration should be given to the Vulnerable Children's Act and Children's Action Plan given that any future initiatives in this area will need to work in alignment with these initiatives.

1.2.2 Clarifying our interpretation of scope for the review

Appendix 1 provides an overview of some relevant theoretical concepts that have informed our interpretation of scope and our approach to analysis and presentation of the evidence:

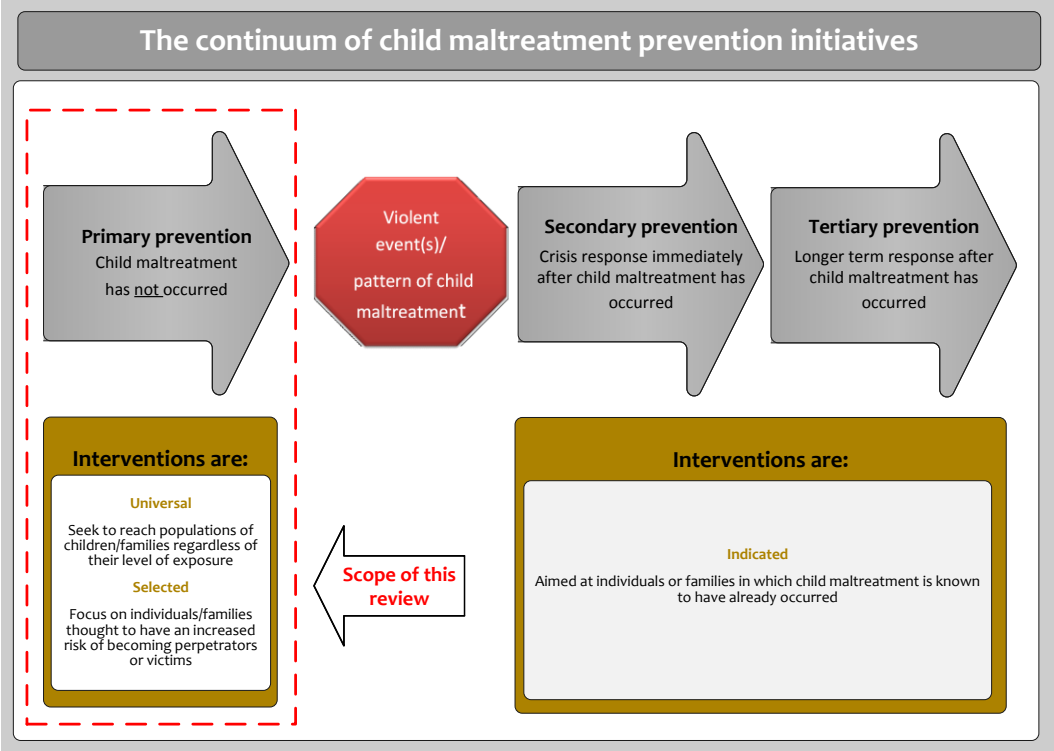
- We have **applied the socio-ecological model as a lens** through which to contextualise our analysis of evidence presented in this literature review. In particular, risk and protective factors are categorised in relation to each of the four domains.
- We have **adopted the public health prevention model** to determine how we make the distinction between primary, secondary and tertiary prevention interventions. ACC asked us to **focus on primary prevention programmes** i.e. initiatives that are implemented to prevent the occurrence of child maltreatment.
- Given that focus, we have limited our consideration to **programmes using either a universal or a selective approach**[1]:
  - Universal approaches: seek to reach populations of children/families *regardless of their level of risk exposure* (i.e. a 'general population' target group); and
  - Selective approaches: focus on individuals/families that are thought to have an *increased level of risk exposure to CAN or CSA.*

[1] A third type of method is 'indicated approaches' which are interventions provided to families in which child maltreatment has already occurred. These are not relevant to the scope of this review, as we are focused on primary prevention programmes only.

- For the purposes of identifying relevant programmes internationally, we have focused on pre-school years (as opposed to under 5 years of age as school start ages differ internationally).

The focus of our scope is illustrated in Figure 1 below.

Figure 1: Levels of prevention showing the scope for our review



Source: Adapted from Ministry of Women's Affairs (2013)

1.3 Approach

The timeframes and resourcing for this project were very tight, with the team from Sapere completing the majority of research and reporting over one-week (at a total of 14 working days).

We undertook a rapid review of the published and non-published primary and secondary literature in this field from New Zealand and other English speaking countries literature. We completed searches of various subject databases using a set of standardised terms. In addition Google Scholar was used to source referenced articles identified through bibliographies of relevant publications. We also scanned a range of websites from relevant organisations. Publications reviewed included journals and periodicals, books, reports by major research institutions or governments, conference proceedings and 'grey literature' documents (such as academic dissertations and other unpublished reports).

Following our desk research, we undertook a small number of telephone interviews with some stakeholders from the sector to help validate and contextualise our findings.

The full details of the search strategy are documented in Appendix 2 provided on page 76.

2. Risk and protective factors

2.1 Introduction

2.1.1 Why address risk and protective factors?

Risk factors are associated with increased likelihood of either victimisation or perpetration of child maltreatment, while protective factors enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk (Point Research, 2014).

Understanding the risk and protective factors for child maltreatment is important for developing effective primary prevention programmes for vulnerable families, to ensure that key design features of interventions (such as the identification of the target population or the most appropriate delivery mechanism) can be tailored to maximise effectiveness.

2.1.2 Some important context and caveats

There is a need to exercise caution in the interpretation and use of information presented in this section, as per the caveats outlined below.

Factors are not a definitive statement of cause and effect

While certain risk factors may exist among families where child abuse and neglect occurs, this does not mean that the presence of all or any of these factors necessarily leads to child abuse and neglect, just as the presence of protective factors does not guarantee that children will be kept safe (Goldman, et al., 2003). It is important also to emphasize that children are the victims and are never to blame for maltreatment. Moreover, cases of child abuse and neglect can also occur in families that experience none of the commonly associated risk factors.

Furthermore, certain risk and protective factors may not present in all social and cultural contexts. Also, their potential extent of influence may vary across different environments and situations, and different risk factors may also have a larger impact on certain types of abuse and neglect.

There are complex relationships between risk factors

There is a complex web of factors, and some may be associated with different types of violence and abuse (Wilkins, et al., 2014). Research has shown that there is no one simple answer in explaining the interplay between the factors that can result in either resilience or continuing risk (Ronan, et al., 2009).

There is evidence that the cumulative effects of exposure to multiple risks strongly influence negative child outcomes and maltreatment (Begle, Dumas, & Hanson, 2010 cited in Ronan, 2009). For instance, in a longitudinal study that followed mother-child dyads over the first 16 years of the child's life, researchers reported that at age 1, 4 and 16 the best predictor of child maltreatment, above and beyond any individual risk factors, was the cumulative level of risk exposure (based on the number of exposure to different ecological risk factors) (MacKenzie et al., 2011 cited in Ronan, 2009).

Māori perspectives in relation to whānau violence

For Māori, colonisation has a multifaceted relationship with violence. It is essential that the importance of the impact of colonisation is understood and recognised as context to consideration of whānau violence today (Dobbs, 2014).

The following example (adapted from analysis completed by ACC (Carne, 2014)) describes how the impact of colonialism has shaped societal structures and attitudes to sexual violence within Māori:

> Pre-colonial Māori society was based on a system of communal protection and care, established and maintained through whakapapa. In traditional Māori society, children were considered to be the lifeblood of generations gone and those to come, and whakapapa links were considered to be maintained through and by them. Acts of violence and/or abuse against wāhine or tamariki were viewed as transgressions upon the whole whānau or hapū (sub-tribe) and were regarded as repugnant.
>
> Traditionally whānau included three or four generations living together. The whānau was where initial teaching and socialisation occurred and older generations were guides to younger generations. Traditional Māori societies were bound by a code of responsibility to maintaining well-being of the whānau or hapū. Any behaviour, such as sexual abuse or violence, which diminished the position of the wider grouping was seen as a serious transgression of socially accepted norms and was dealt with by whānau, hapū and iwi collectively.
>
> One of the most damaging effects of colonisation was the destruction of the whānau. Colonisation facilitated a restructuring of familial roles within whānau Māori, based on the Western European paradigm of the 'nuclear family'. This was normalised as a civil social practice through 'proper' Christian marriages which led to the separation of tangata whenua from wider whānau. The erosion of relational linkages within whānau has had a flow on effect, with many whānau abrogating their traditional responsibilities in regard to, and methods of addressing sexual violence, including the imposition of sanctions against perpetrators. The minimised response of whānau has facilitated on-going expressions of sexual violence.

Limitations of the literature

The literature relating to risk and protective factors for child maltreatment is extensive and difficult to interpret, for the reasons outlined below:

- **Inconsistent use of definitions for CAN and CSA**
  A large number of reports do not clearly specify interpretation of terms, particularly in relation to whether specified risk factors are predictive of CAN or CSA or both.
  - ***Our approach:*** We have summarised risk factors identified as being predictive of 'child maltreatment' generally which may or may not include child sexual abuse (depending on how the researcher has interpreted the definition, which is often not clearly stated). We have also identified separate risk factors identified as being predictive of increased likelihood of child sexual abuse.
- **Age groups not clearly specified**
  The age-group of children to which factors apply is often not clearly specified. The 0-5 age group is part of the wider population, and as such, many or all of the factors may be

relevant. We did not identify any useful references that considered risk or protective factors specifically relating to children aged 0-5 years.

- ***Our approach:*** We have summarised risk factors identified from more general references (where the 0-5 age group is not separated) and within those, highlighted the factors that have obvious relevance for the 0-5 group (e.g. crying baby). We have also presented some data relating to prevalence of CAN in New Zealand in children aged 0-4.

- **Lack of clarity on nature of predictive value**
  Sometimes it not clearly stated whether particular factors are predictive of increased risk of *victimisation* or *perpetration* of abuse. Many references refer, for example to 'increased likelihood of child maltreatment'. There are some references that attempt to make this separation between evidence relating to either victimisation or perpetration but they are rarely related specifically to children.[2]

  - ***Our approach:*** We have placed the child at the centre of this analysis and focussed on identifying risk factors associated with increased likelihood of children becoming victims of abuse. Across the family, community and society levels, this can be interpreted as, for example, there being an increased risk of a parent being more likely to be a perpetrator. Given the lack of clear evidence and the inter-relation between different factors, we have not assessed factors that increase the likelihood of children becoming perpetrators of abuse in later life. Furthermore, we note that a number of risk factors may be represented across more than one domain in the literature; we have positioned each risk factor only once within the most logical domain.

- **Limited information (and some conflicting findings) about comparative effect size of risk factors**
  Very few studies have been identified that consider the comparative effect size of risk factors. While at a high level, there is a strong degree of coherence about risk factors reported in the literature (many of the same risk factors are identified across a range of different secondary sources) there are some conflicting findings when we attempt to go down to the level of detail reported in the primary level research, the results of which may be very specific to time and place.

  - ***Our approach:*** We have reported the conclusions of one meta-analysis conducted in 2005 that compares the relative effect size of different risk factors. We have not attempted to align this to our collation of risk factors presented in the tables below, given the lack of consistency in use of terms etc.

2.1.3 Use of secondary reference sources

It is beyond the scope of this review and resources available to attempt to dissect the vast range of literature. As such, we have not provided detailed itemised evidence of all of these

---

[2] We note that in 2014 ACC commissioned a review of evidence related specifically to sexual violence (Point Research, 2014). While this is useful as a general reference and informs understanding of risk factors for CSA there is very limited reference specifically to children aged 0-5 years.

risk factors, or to discuss the extent to which specific risk factors relate to different forms of child maltreatment. We have focussed on some key secondary references (the main sources are identified below) and have collated the risk factors most commonly mentioned into a single framework.

2.2 Risk factors for child maltreatment

The main secondary sources used to inform our collation of risk factors relating to CAN are:

- The Australian Institute for Family Studies Resource Sheet, entitled *"Risk and protective factors for child abuse and neglect"* (Lamont & Price-Robertson, 2013), with primary sources identified as: Brown, Cohen, Johnson, & Salzinger (1998); Stith et al. (2009); US Department of Health and Human Services (2011).
- The World Health Organisation Media Centre Factsheet (WHO, 2014).
- Reports from the New Zealand Government relating to the White Paper for Vulnerable Children, Volume ii. (New Zealand Government, 2012; New Zealand Government, 2012; Mardani, 2010)
- Child Welfare Information Gateway, US Department of Health and Human Services (Child Welfare Information Gateway, 2004).

2.2.1 The child/individual level

Risk factors for <u>child maltreatment</u> (in children of all ages)

In Table 1 below we have identified risk factors identified within the literature as being associated with children of all ages becoming victims of abuse. As noted above, these factors are relevant to children of all ages, though we have highlighted those most relevant to the 0-5 age group. Furthermore, the definition of 'child maltreatment' is not consistent across sources.

Table 1: Child/individual level – risk factors for child maltreatment

Relevant to children of all ages	Most relevant to children under age five
Health and well-being of chid	
➢ Has high needs (a child for instance is mentally or physically disabled or has chronic illness) ➢ Has physical features, such as facial abnormalities that the parent has an aversion to	➢ Born prematurely ➢ Low birth weight ➢ Being under four years old[3]

[3] The other age group of children for which risk of maltreatment increases is during adolescence.

Relevant to children of all ages	Most relevant to children under age five
Behavioural issues	
➢ Personality or temperament traits that are perceived by the parent as problematic (e.g. aggressive behaviour) ➢ Attention deficits	➢ Persistent crying - cannot be easily soothed or comforted
Parental viewpoint of child	
➢ Being unwanted or failing to fulfil the expectations or wishes of parents (e.g. sex, appearance, temperament or congenital abnormalities)	
Other factors	
➢ Exposure to parental/intimate partner violence ➢ Are a child from a multiple birth	

The New Zealand context - child maltreatment of young children

Age

In New Zealand, younger children have a higher risk of intentional death than older children. On average one child is killed every 5 weeks; most of these children are under five and the largest group is less than a year old (Child Matters, 2016). Ninety percent of all child deaths are perpetrated by someone the child knew. As children reach adolescence (from age 11 onwards) they are at a higher risk of physical punishment than younger children (Centre for Social Research and Evaluation, 2008).

Ethnicity

As noted in the introduction, the causes of whānau violence are acknowledged as complex; the impact of colonisation needs to be considered in relation to whānau violence (Dobbs & Eruera, 2014). Furthermore, it is important to exercise caution when examining statistics related to child maltreatment and ethnicity. In particular, rates of child deaths by maltreatment in a small country like New Zealand can be substantially impacted by small changes.

Generally, Māori are over-represented in family violence statistics as both victims and perpetrators. Also, Māori children are considerably over-represented in child maltreatment statistics when compared to other children in Aotearoa. As part of reporting against the United Nations convention against torture (Ministry of Justice, 2012) the following data were published:

- In 2011/12, there were 6,750 substantiated cases of child abuse for children aged zero to four years old, equivalent to 215 cases per 10,000 children of that age:

  - The rate for Māori children remains consistently higher than the rate for Pacific and other children. In 2011/12, there were 3,618 substantiated cases of child abuse of Māori children aged zero to four years, equivalent to almost 400 cases per 10,000 Māori children in this age group;
  - This rate is 1.9 times higher than the rate for Pacific children and 3.1 times higher than the rate for other children in this age group.
- The number of children zero to four years of age who are hospitalised for intentional injuries fluctuates from year to year:
  - The total number decreased from 107 in 2010/11 to 63 in 2011/12;
  - Intentional injury hospitalisation rates for Māori were 1.5 times higher on average than Pacific children, and four times higher than the rate for other children aged zero to four years from 2006/07 to 2011/12.

2.2.2 The relationship level

The presence of the following risk factors amongst parents or wider family relationships increases the risk of perpetration of child maltreatment by someone in the family. However, it is important to note that many of these can also be risk factors for the adult being a victim of abuse. Again, it is important to note that the risk factors may also relate to CSA (if it has been included in the definition of child maltreatment applied by the author). However, some of the risk factors may not be relevant to sexual abuse, for example, CSA is less related to low income than other forms of child maltreatment but more likely to be associated with other family problems, for example, parental alcoholism, parental rejection, and parental marital conflict (Bolen, 1999, cited in Point Research, 2014).

Also, it is important to highlight that parental substance abuse is noted as being a particularly strong risk factor for child maltreatment. Data from the US have implicated parental substance abuse as a documented or suspected factor in 79 percent of all cases in which a child was removed from the home because of maltreatment. In Australia, 33 percent of substantiated cases of maltreatment involved parents who had significant problems with substance abuse generally and 31 percent involved alcohol abuse more specifically. Generally, substance abuse problems tend to co-occur with other difficulties (Dawe et al., 2008 cited in Ronan, 2009)

Table 2: Parental and family risk factors for child maltreatment

Parents	Wider family relationships
Parenting style	
➢ Difficulty bonding with a new-born e.g. as a result of difficult pregnancy or birth complications (particularly relevant in the under age 5 group of children) ➢ Poor parent-child interaction, lack of parent-child attachment, lack of nurturing and failure to bond ➢ Lacking awareness of child development or having unrealistic expectations that prevent them understanding the child's needs and behaviours (e.g. interpreting the child's perceived misbehaviour as intentional, rather than as a stage in its development) ➢ Low warmth/harsh parenting style ➢ Use of corporal punishment	
Family structure	
➢ Large family size (e.g. with other siblings who are demanding of parental attention; including multiple birth children) ➢ Family breakdown – such as problems with a marriage or intimate relationship – that results in child or adult mental ill-health, unhappiness, loneliness, tension or disputes over custody ➢ Teenage/young parent(s)/single parent ➢ Non-biological parent in the home ➢ Parents experienced change of family structure (e.g. divorce) themselves before the age of 15 ➢ Dominance and control of the relationship by the male	➢ Family breakdown or violence between other family members ➢ A breakdown of support in child rearing from the extended family ➢ Frequent changes in household members
Parental health and well-being	
➢ Physical health problems ➢ Parental disability (physical/cognitive/emotional) ➢ Mental health problems ➢ Cognitive impairment and/or low problem-solving skills ➢ Personal history of child abuse and neglect ➢ Low self-esteem/ feelings of insecurity ➢ Poor prenatal and postnatal care ➢ Parental substance abuse (e.g. misusing alcohol or drugs, including during pregnancy)	➢ Physical, developmental or mental health problems of a family member

Parents	Wider family relationships
Other behaviours of parent	
➢ Involvement in criminal behaviour ➢ Involvement in gangs[4] ➢ Parental conflict or violence ➢ Rigid gender roles	
Socio-economic factors	
➢ Experiencing financial difficulties. ➢ Low level of parental education ➢ Parental unemployment	➢ Discrimination against the family because of ethnicity, religion, sexual orientation, lifestyle etc.

2.2.3 Risk factors at the community and societal level

It is important to highlight that not all community/societal factors may be present or make sense within particular cultural or international settings.

Table 3: Community and societal risk factors for perpetration of CAN and CSA

Community	Societal
Socio-economic factors	
➢ High levels of socio-economic disadvantage ➢ High levels of unemployment ➢ Lack of or inadequate housing (including over-crowding) ➢ Living in a transient or unsafe neighbourhood (may also reduce children's resilience after abuse)	➢ Social and economic policies that lead to poor living standards, or to socio-economic inequality or instability
Access to support and social services	
➢ Lack of access to social support, including child care and social services, to support families and institutions and to meet specialised needs ➢ Lack of access to adequately resourced schools ➢ Weak community sanctions against sexual violence (e.g. police viewed negatively by the community or seen to be unwilling to intervene)	➢ Health and education policies that lead to poor living standards, or to socio-economic inequality or instability

[4] Children of gang involved parents are at greater risk of child abuse, neglect, witnessing violence between their parents (Superu, 2015).

Community	Societal
Damaging social and cultural norms	
➢ Tolerance of violence within the community ➢ Exposure to gender and social inequality in the community or to racism and/or other forms of discrimination ➢ The easy availability of alcohol and drugs	➢ Social and cultural norms that promote or glorify violence towards others (including those that promote physical punishment, demand rigid gender roles, or diminish the status of the child in parent–child relationships) as depicted in the media, in popular music and in video games ➢ Social and cultural norms that demand rigid gender roles ➢ Social and cultural norms that diminish the status of the child in families
Other	
➢ Social isolation ➢ Stressful life events that impact on the community e.g. earthquakes.	➢ Inadequate system level responses (e.g. justice system including legislation, police etc.) leading to inadequate policies and programmes to prevent child maltreatment, child pornography, child prostitution and child labour

2.3 Assessing the relative size of effect for risk factors for child maltreatment

In this section we present the findings from a series of meta-analyses identifying the relative strength of various risk factors for child physical abuse and neglect (Stith, et al., 2009). Data from 155 studies examining 39 different risk factors were included in the review. Analysis of effect sizes for these studies led to the conclusions presented in Table 4 below. It is important to highlight that this review related to children of all ages and also did not include child sexual abuse within the scope.

Table 4: Relative effect sizes from evidence relating to risk factors for child physical abuse and neglect (Stith, et al., 2009).

Effect size				
	Large	Moderate	Small	Insignificant
Risk factors for child physical abuse				
Parent–child interaction		Parent perceives child as problem Unplanned pregnancy Parent–child relationships	Parenting behaviours	Stress over parenting
Parent characteristics independent of	Anger/hyper-reactivity	Anxiety Psychopathology Depression	Personal stress Social support Alcohol abuse	Parent health problems Approval of corporal

Effect size				
the child		Self-esteem Poor relationship with own parents Experienced childhood abuse Criminal behaviours	Unemployment Coping skills Single parenthood Parent age Drug abuse Parent gender	punishment
Child characteristics, excluding parents		Child social competence Child externalizing behaviours	Child internalizing behaviours	Child gender Neonatal problems Child disability Child age
Family factors	Family conflict Lack of family cohesion	Spousal violence	Marital dissatisfaction Family size Socio-economic status	Non-biological parent in home
Risk factors for neglect				
Parent–child interaction/ report of child behaviour	Parent–child relationships Parent perceives child as problem		Parenting behaviours Stress over parenting	
Parent characteristics independent of the child	Personal stress Anger/hyper-reactivity Self-esteem	Psychopathology Unemployment Depression	Social support Parent experienced childhood abuse Parent age Single parenthood	
Child characteristics, excluding parents		Child social competence Child externalizing behaviours	Child internalizing behaviours	Child gender Child age
Family factors		Family size	Socio-economic status	

2.4 Risk factors specifically relating to child sexual abuse

Some, but not all, of the factors identified above as being associated with child maltreatment are also relevant to increased likelihood of child sexual abuse. For example, low socioeconomic background tends not to emerge from these types of studies as a salient risk factor for sexual abuse (Ronan, et al., 2009).

2.4.1 CSA risk factors (for children of all ages)

We found fewer sources of literature with clear information about risk factors for CSA and there was less coherence in conclusions. Those that we did find tended to relate to the individual and relationship domains, rather than to community or societal factors.

The following information has been compiled from a range of different sources and references are identified in relation to each factor.

The child/individual level

- **Gender:** For children across all age groups, more girls than boys are the victims of sexual abuse. An international survey conducted in 2007 found that, in New Zealand (where nearly 3000 women were questioned about unwanted sexual contact before they were aged 15) one in four girls are sexually abused before the age of 15, the highest rate of any country examined (Fanslow, et al., 2007). According to Help Auckland, statistics today suggest that as many as 1 out of 3 girls may be sexually abused before they turn 16 years old. Most of this abuse (90 percent) is likely to be done by someone the child knows and 70 percent will involve genital contact. In comparison, 1 in 7 boys may be sexually abused before turning 16 years old (HELP, 2016). As reported in the New Zealand Crime and Safety Survey 2014 24 percent of women and 6 percent of men have experienced one or more sexual offences at some point during their lives (Ministry of Justice, 2015).[5]
- **Age:** Children are most vulnerable to sexual abuse during their pre-pubertal years (Asawa, et. al., 2008 cited in Ronan 2009); in New Zealand the median age of onset for sexual abuse is nine years old (Fanslow, et al., 2007).
- **Ethnicity:** As noted above in relation to risk factors for child maltreatment, Māori children are considerably over-represented in child maltreatment statistics when compared to other children in Aotearoa. For child sexual abuse, the survey conducted in 2007 mentioned above (Fanslow, et al., 2007) showed that Māori girls suffer roughly twice as much sexual abuse as European girls – 30.5 percent of Māori compared with 17 percent of Europeans in Auckland, and 35.1 percent of Māori compared with 20.7 percent of Europeans in the northern Waikato.
- **Disability:** International research demonstrates that children (and adults) with disabilities have a much greater risk of being sexually violated (McPhillips, et al., 2002). Factors contributing to this may include:
  - Being more likely to be living in poverty
  - Having few options to alter their living arrangements
  - Not having access to outside assistance
  - Having close living and work environments with male supervisors/carers
  - Having a higher likelihood of not being believed
  - Lack of access to information about sexuality or sex education
  - Being objectified as a result of not viewing them as owning their own bodies due to their need for assistance to do certain tasks
  - Being less physically capable of resisting and more isolated from support
- **Other types of victimisation:** Children who experience other forms of victimisation are more likely to be the target of sexual abuse and children who witness/are the victim of other crimes are significantly more likely to be sexually abused (U.S. Department of Health and Human Services, 2010).

[5] It is possible that for pre-schoolers the gender of the child may be less relevant, but we could not find a source of data relating to this.

The relationship level

- **Family structure** (This is often cited as being one of the most important risk factors in child sexual abuse) (U.S. Department of Health and Human Services, 2010):
  - Children who live with two married biological parents are at a low risk for abuse. The risk increases where children live with step-parents or a single parent, and further for children living with foster parents or in other care settings.
  - One early study found that girls from stepfather families were five times more vulnerable to the risk of sexual abuse than girls in intact families, and that a girl was also at higher risk if she had ever lived without her mother, or if her mother had substantially less education than her father, or if her mother was particularly punitive about sexual matters.
  - Children living without either parent (foster children) are 10 times more likely to be sexually abused than children that live with both biological parents.
  - Children who live with a single parent that has a live-in partner are at the highest risk; they are 20 times more likely to be victims of child sexual abuse than children living with both biological parents.
- **Parenting style and behaviours:** The following factors are identified in the literature (Fergusson, et al., 1996):
  - Low parental attachment;
  - Overprotective parents;
  - Parents with alcohol problems; and
  - Marital conflict.

2.4.2 Sexual development in pre-school children

The information provided in Figure 2 is taken from a leaflet published for the Christchurch Schools Toolkit for Safer Children (Methodist Mission, 2009). While it has a focus on *behaviours* exhibited by children (rather than risk factors that make the likelihood of CSA more likely) it provides a useful insight into the fact that behaviours considered to be 'outside healthy and safe' parameters may be exhibited by very young children.

Figure 2: Christchurch Schools Toolkit for Safer Children – created & compiled by the Methodist Mission (2009)

2.5 Protective factors

In the same way that there are factors that increase the susceptibility of children and families to child maltreatment, there are also factors that may offer a protective effect. There has been very little systematic research on these protective and they are not well understood (New Zealand Government, 2012). We did not identify any useful references that considered protective factors specifically relating to children aged 0-5 years. The most common protective factors identified in research that may assist in reducing the incidence of child maltreatment and increasing resilience of children are outlined in Table 5 below.

Table 5: Protective factors that may assist in reducing likelihood of child maltreatment (relevant to children of all ages)

Ecological level	Protective factors
Child/ individual factors	➢ Good health/ history of adequate development ➢ Above average intelligence ➢ Positive peer relationships ➢ Strong, positive social networks ➢ Hobbies/interests ➢ High self-esteem and independence ➢ Secure attachment with parent(s) ➢ Strong social skills ➢ Positive disposition/easy temperament
Parental/family factors	**Parent** ➢ Positive parent-child relationship, secure attachment with child ➢ Supportive family environment and stable family relationships ➢ Sound parental coping skills and resilience ➢ High levels of strong paternal care ➢ Awareness of stages in child development ➢ Having household rules and parental monitoring of the child ➢ Parental employment ➢ High level of parental education ➢ Mothers having participated in a school-based sexual abuse prevention programme (related to reduced incidence of CSA) (Point Research, 2014).
	Family ➢ Extended family networks ➢ Concrete support for parents ➢ Strong family expectations of pro-social behaviour ➢ Faith/ religious participation
Community	➢ Strong, positive social networks ➢ Stable and adequate housing ➢ Well-resourced schools available in neighbourhood ➢ Access to health and social services ➢ Supportive adults outside the family who serve as role models or mentors ➢ Communities that support parents/ take responsibility for preventing abuse.
Society	➢ Promotes strong culture and gender identities, and nonviolent social norms ➢ Facilitates preventative education - school-based programmes aimed at preventing child maltreatment.

Protective factors for Māori child maltreatment

There is a large body of literature focused on identifying and describing factors which contribute to Māori health and wellbeing generally. Many of these studies highlight the importance of secure cultural identity and cultural connections.

There is a strong emphasis on Māori whānau ora – whereby the aim is for Māori families to achieve their maximum health and wellbeing, in the broadest sense. Whānau plays a central role in the wellbeing of Māori individually and collectively as a principal source of strength, support, security and identity. A stable whānau provides a platform of protection for Māori children, and is a key protective factor in the prevention and intervention of Māori child maltreatment (New Zealand Government, 2012).

In line with kaupapa Māori principles, strengths-based (as opposed to deficit-based) approaches are recommended which tend to focus on individual and whānau strengths, their potential, empowerment and right to self-determination. This also connects with concepts of resilience which, from a Māori point of view, can include cultural identity from whakapapa whānau support, to practising the concepts of aroha and manaaki, and karakia. It can involve, but is not limited to, "self-identification (i.e. through knowing one's whakapapa), participation in marae activities, involvement with whānau (extended family), access to one's tūrangawaewae, relationships with other Māori, and the use of Māori language, concepts and customs" (Carne, 2014).

3. Delivery mechanisms for primary prevention programmes

There are a variety of delivery mechanisms that have been used to support the implementation of primary prevention initiatives in relation to CAN and CSA. In this section we provide a brief overview of the generic types of delivery mechanisms that may be employed and review the extent of evidence to support their relative effectiveness, before we move on to consider some specific examples of primary prevention initiatives later in the report.

It is important to highlight that the mechanisms described below do not relate only to pre-school populations but may also be used in interventions involving older children. Furthermore, the material presented in this chapter (which has been sourced primarily from WHO, 2013) does not differentiate between what works in relation to reducing CAN or CSA specifically, though the scope of the study included CSA in the definition of child maltreatment.

3.1 Classification of delivery mechanisms

There are two key approaches used for primary prevention programmes[6]:

- Universal approaches, which seek to reach populations of children/families *regardless of their level of risk exposure* (i.e. a 'general population' target group); and
- Selective approaches, which focus on individuals/families that are thought to have an *increased level of risk exposure to CAN or CSA*.

3.1.1 Universal delivery mechanisms

We outline below the main types of delivery mechanisms used for programmes that seek to reduce CAN and CSA (WHO, 2013):

- **Media-based public awareness programmes** – aim to spread messages among the general population using channels such as television, radio, printed materials and the Internet. They can be used for a variety of purposes, including raising awareness of child abuse, promoting positive parenting practices, changing social norms regarding the acceptance of abusive behaviour and encouraging the reporting of maltreatment.
- **School-based violence prevention programmes** – typically delivered universally to children in a classroom-setting. The general aim is to educate children about abuse; teach them to recognize potentially harmful situations; distinguish between appropriate and inappropriate touching and teach them strategies for saying "no" to unwanted approaches; and encourage disclosure of abuse to trusted adults.

---

6 A third type of method is 'indicated approaches' which are interventions provided to families in which child maltreatment has already occurred. These are not relevant to the scope of this review, as we are focused on primary prevention programmes only.

- **Interventions to prevent abusive head trauma** – abusive head trauma is a severe form of child abuse that can result in serious brain, neck and spinal injury. It is often referred to as the "shaken baby" or "shaken infant" syndrome. Preventive responses largely take the form of educating new parents about the dangers of shaking their child.
- **Changing social norms** – aim to prevent child maltreatment by changing beliefs and attitudes in society to how we view child abuse. Social norms programmes often include mass media campaigns but may extend beyond this to include measures such as changes to legislation.
- **Reducing the availability of alcohol** – many acts of violence towards children occur when perpetrators have been drinking alcohol and studies show that greater alcohol availability in communities is associated with increased child maltreatment. Availability can be reduced by regulating alcohol sales (e.g. controlling the times at which alcohol can be sold) and increasing prices (e.g. by implementing minimum prices for alcohol or increased taxation).
- **Community interventions** – community interventions aim to enhance community capacity to prevent child maltreatment by expanding formal and informal resources and establishing a normative cultural context that promotes collective responsibility for more positive child development.
- **Enhanced health care services –** health settings such as primary care and paediatric services present opportunities to identify families at increased risk of maltreatment and to provide them with appropriate support, advice and referral.
- **Preventing exposure to intimate partner violence** – parental intimate partner violence is a key risk factor for child maltreatment and witnessing violence between parents can have long-term impacts on children's well-being.
- **Reducing poverty** – such initiatives seek to prevent child maltreatment through addressing socio-economic drivers of risk, though there is a shortage of evaluated interventions of this reducing poverty to prevent child maltreatment.

3.1.2 Selective delivery mechanisms

Examples of selective delivery mechanisms include (WHO, 2013):

- **Home-visiting programmes** – generally provide parenting, health and social support to new mothers in their own homes, typically via specially trained nurses. The delivery and content of home-visiting programmes can vary widely.
- **Parenting programmes** – aim to improve parents' knowledge of child development, increase their parenting skills and strengthen parent-child relationships. They are often delivered through group sessions and can be implemented both universally and to high-risk groups.
- **Multicomponent preschool programmes** – generally provide preschool education for young children alongside services such as parenting programmes and family support. They can be universal but often target families living in deprived communities.
- **Support and mutual aid groups for parents** - aim to strengthen family support networks by providing opportunities for parents to meet and interact with peers in the community. In addition to developing parents' social connections, they can also provide: peer support; help with family problem solving; and activities to strengthen parenting, coping and communication skills.

3.2 Effectiveness of delivery models

In terms of the question of whether universal or selective approaches are more effective, many researchers have advocated for universal models, while others argue that selective prevention models, focusing on a clearly defined 'at risk' population, are the most effective in preventing child maltreatment (Child Welfare Information Gateway, 2011).[7] As a general point, there is limited consensus within the evidence as to what types of delivery mechanisms are the most effective.

In the following tables, we have summarised conclusions as to the extent of the evidence base overall for each individual type of delivery mechanism, in terms of both reducing risk factors associated with child maltreatment and direct evidence of reducing child maltreatment outcomes, from a meta-review (WHO, 2013). As noted above, this material does not differentiate between what works in relation to reducing CAN or CSA specifically, though the scope of the study included CSA in the definition of child maltreatment.

[7] We consider the relative pros and cons of universal and selective approaches further in the final section of this report, where we also address the question as to whether a mixed approach might be beneficial.

Table 6: Strength of evidence for the impact of different delivery mechanisms used for universal programme (adapted from WHO, 2013)[8]

Delivery mechanism	Summary of conclusions from review of evidence	Evidence for impact on:	
		Risk factors for child maltreatment	Child maltreatment outcomes
School-based programmes	Many studies have evaluated the impact of school-based programmes; few studies are methodologically sound.	●	△
Media-based public awareness programmes	Few studies have examined the effectiveness of mass media programmes in reducing child maltreatment, and findings from studies have been mixed.	△	○
Prevent abusive head trauma	Few studies have examined the impacts of such interventions, although they are relatively wide spread.	○	○
Changing social norms	Very few programmes have been assessed or subjected to rigorous evaluation.	△	△
Reducing the availability of alcohol	Few studies have measured the effects of reducing alcohol availability on child maltreatment.	○	△
Reducing poverty	Shortage of evaluated interventions; available studies have focused on the impacts of welfare reforms and have reported somewhat conflicting results.	△	△
Community interventions	A large body of empirical research suggests that intervention at the neighbourhood level is likely to prevent child maltreatment within families. Most promising components are social capital development and community coordination of individualised services (Daro & Dodge, 2009).	○	△
Preventing child exposure to intimate partner violence	US evidence suggests school-based programmes can prevent partner violence. Other programmes that show some promise include empowerment/participatory approaches to addressing gender equality, broader strategies aiming to change social/cultural gender norms and interventions that help reduce access to/harmful use of, alcohol.	△	△
Enhanced paediatric care	Some evidence that enhanced paediatric care can be instrumental in reducing child maltreatment. Evaluation study of SEEK programme in the U.S found it reduced child maltreatment (measured through involvement in child protection services, medical problems relating to possible neglect and self-reported child assault by parents).	○	○

[8] **Key:**
● Considered effective or supported by at least two well-designed studies or a systematic review
○ Considered to be promising or supported by one well-designed study
△ Considered to have insufficient, weak, or mixed evidence supporting the delivery mechanism

Table 7: Strength of evidence for the impact of different delivery mechanisms used for selective programmes (adapted from WHO, 2013)[9]

Delivery mechanism	Summary of conclusions from review of evidence	Evidence for impact on:	
		Risk factors for child maltreatment	Child maltreatment outcomes
Home-visiting programmes	Evidence suggests that these can be effective in reducing risk factors but their impacts specifically on child maltreatment are less clear. However, the Nurse Family Partnership programme from the US and the Early start programme from NZ have been subjected to well-designed evaluation and are shown to be effective in reducing child maltreatment.	●	○
Parenting programmes	Reviews have generally concluded that while they can reduce risk factors for child maltreatment, the evidence for their effectiveness in reducing actual maltreatment remains limited, due to few studies measuring actual maltreatment outcomes.	●	○
Multicomponent preschool programmes	Although evidence for the effectiveness of multicomponent preschool programmes is mixed, some positive effects have been reported.	○	○
Support and mutual aid groups for parents	Few studies have evaluated the impact of support groups in preventing child maltreatment, while those examining their impacts on risk factors have reported mixed results (some programme evaluations have nevertheless reported benefits).	△	△

[9] **Key:**

● Considered effective or supported by at least two well-designed studies or a systematic review
○ Considered to be promising or supported by one well-designed study
△ Considered to have insufficient, weak, or mixed evidence supporting the delivery mechanism

4. Evidence for primary prevention of CAN and CSA in pre-schoolers

In this section we document key findings reported in the evidence base in relation to primary prevention initiatives that seek to reduce child maltreatment in pre-school children. We have:

- Identified programmes showing **high levels of evidence of effectiveness from robust evaluation studies**, providing:
  - **a summary of examples of effective programmes** - an assessment of key aspects of 12 specific universal and selective primary prevention programmes in relation to CAN within pre-school populations; and
  - **three documented case studies** – of primary prevention programmes targeting a reduction of CAN within pre-school populations that show strongest evidence of effectiveness.
- Summarised the **key conclusions from three meta-review studies** addressing the relative effectiveness of different interventions relating to primary prevention initiatives for CAN and CSA.
- Provided an overview assessment of **five New Zealand based programmes** (three of which address CSA) which show some evidence of effectiveness demonstrated through less robust evaluation.

It is important to note that while our interpretation of the term 'child maltreatment' includes both CAN and CSA (as per the WHO definition provided in section 1.1.2 on page 13), the focus of evidence covered in this section relates primarily to interventions related to reducing measures related to CAN and not to CSA. This is because there is a lack of high quality evaluation and evidence demonstrating the effectiveness of primary prevention programmes in reducing CSA (see section 4.2 below for further information on this).

4.1 Programmes with the strongest evidence of effectiveness

4.1.1 Examples of effective programmes that seek to reduce CAN

In Appendix 4 on page 81, we have reported on 12 examples of effective primary prevention programmes (five universal and seven selective approaches) that seek to reduce CAN and that are either solely or partly targeted at pre-schoolers.

Selection of initiatives

The programmes selected for inclusion are all considered within the review literature to be 'evidence-based', as they have been subject to robust evaluations that show reductions in some outcome measures related to child maltreatment. Most of these programmes have been evaluated through Randomised Controlled Trials (RCTs), considered to be the gold standard of evidence based research. A few programmes have been evaluated through other research

methods still considered to be relatively robust, partly due to the fact that they are using a valid control group for comparison.

With regard to assessing the statistical significance of findings, it is important to consider the detail of each study; in our summary table, we have listed the main conclusions drawn from the evidence provided. Where a particular initiative has been deemed to be 'effective', it does not mean than *all* outcome variables were statistically significant (for instance, significant effects on outcome levels that were observed after one month, may not have been sustained six months later).

However, in terms of exclusions, there are other widely cited programmes within this field, such as Parent-Child interaction therapy and SafeCare, which have been proven (through RCTs) to reduce reoccurrence of child maltreatment. Given that our focus is primary prevention (i.e. on programmes that seek to prevent child maltreatment before it occurs) these initiatives have also been excluded from the list (Chaffin, et al., 2004). Many programmes, such as Incredible Years, specifically target children with behavioural problems. Even though these programmes have a potential to contribute to the reduction of child maltreatment the evidence base is generally lacking and as such, these programmes are not included in Appendix 4.

The 12 programmes we have described are:

Universal

1. **The safe environment for every kid (SEEK)** model, implemented in the US; targeted at children between 0-5 years.
2. **Triple P (Positive Parenting Programme),** developed in Australia and implemented across multiple countries (including NZ); targeting children between 0-16 years.
3. **Abusive head trauma education programme** in New York State (and similar programmes across multiple countries including NZ); targets parents of infants.
4. **The Coping with Crying programme** which targets parents of infants in the UK.
5. **Parents as Teachers (0–3 years**), initiated in the USA, and then implemented in other countries, including NZ.

Selective

6. **Early Start,** based in Christchurch, NZ and targets families with children less than five years.
7. **Nurse-family partnership (NFP),** implemented in the US and targeting children between 0-2 years.
8. **Chicago Child Parent Centres,** implemented in Chicago, US, targeting children between 3-9 years.
9. **Healthy Families America,** in New York, targeting families with children between 0–5 years.
10. **Child FIRST,** USA, targeting families with children between 0–5 years.
11. **Early Head Start and Head Start,** implemented across US and targets children up to age three (early head start) and up to age five (head start), and also pregnant women.
12. **Parent-Child Interaction Therapy,** targeting children between 2-7 years. Originating from the US, PCIT has spread to multiple countries around the world, including New Zealand.

4.1.2 Case studies of effective prevention programmes

In this section we have documented three case studies of primary prevention programmes targeting a reduction of CAN within pre-school populations that show strongest evidence of effectiveness.

We recognise that none of these initiatives address CSA but we could not identify CSA initiatives for pre-schoolers that showed a similar level of robust evaluation and evidence of effectiveness.

The Safe Environment for Every Kid (SEEK) Model - USA

Overview

The universal SEEK-model was developed in the US to fill the gap in child maltreatment prevention efforts. SEEK is located within the Center for Families within the Department of Pediatrics at the University of Maryland School of Medicine. The Center for Families is focused on child maltreatment, including prevention, diagnosis and treatment, as well as advocacy (Chaffin, et al., 2004; Superu, 2014).

The model offers a practical approach to the identification and management of targeted risk factors for child maltreatment for families with children aged 0-5, integrated into paediatric primary care. The main objective of SEEK is essentially to help practitioners identify and help address targeted risk factors for child maltreatment in families with young children. In this way, the model aims to strengthen families and support parents to promote children's health, development, and safety – and ultimately – help prevent CAN and CSA. SEEK is funded by the Maryland Department of Human Resources, the United States Centers for Disease Control and Prevention, the United States Department of Health and Human Services, Administration on Children and Families, the Doris Duke Charitable Foundation and The Maryland Technology Development Corporation (University of Maryland Medical Center, 2016).

Incorporating preventive measures into the regular check-ups provided to children – often in the presence of their parent(s) – offers a powerful tool in the prevention of child maltreatment. Firstly, many children have multiple check-ups, especially during the first five years. Secondly, there has long been an understanding that health professionals should not only focus the attention on the child, but also on the family environment. The paediatrician therefore has a great opportunity to establish a relationship with both the child as well as the parents (Dubowitz, 2014).

The core components of the SEEK model include:

- **Health Professional Training:** The training involves developing an ability to briefly assess and help address targeted psychosocial problems (e.g. maternal depression) by applying motivational interviewing techniques, identification and utilisation of parents' strengths and resources, etc. (Universtiy of Maryland, 2015).
- **SEEK Parent Questionnaire:** The idea behind the questionnaire is to offer a practical and efficient way to systematically screen for the targeted population. The questionnaire is a single-page document that poses questions related to multiple maltreatment risk factors, including parental depression, substance abuse, social support, intimate partner violence (IPV), major parental stress and food insecurity. To help address the potential issue of disclosure, the PQ is developed with an empathic tone and clearly states that

every parent is asked to answer the set of questions. The PQ can also be completed online, prior to the visit, and exists in several languages (Dubowitz, 2014; Dubowitz & Leventhal, 2014).

- **Collaboration with mental health professional/social worker:** Ideally, a mental health professional or a social worker is available to assist with family assessments and referrals to community resources (Universtiy of Maryland, 2015).
- **Parent hand-outs:** These hand-outs are relatively brief and simple, and provide basic information including national hotlines and websites of organisations directed at parents (Universtiy of Maryland, 2015).

Evidence supporting SEEK

Two large randomized controlled trials (RCTs) have evaluated the SEEK-model (Universtiy of Maryland, 2015). Both involved mothers with children aged between 0-5. The first evaluation incorporated paediatric inner-city clinics serving a low decile population in Baltimore. The study involved 558 families (Dubowitz, et al., 2009) (mother and child), split between control and treatment groups and took place between June 2002 and November 2005. Measurement of child maltreatment involved number of Child Protective Services (CPS) reports, instances of possible medical neglect documented in their medical record (e.g. delay of immunisation) and instances of severe physical assault reported by parents (University of Maryland, 2015).

The second evaluation took place in 18 suburban private paediatric practices serving a relatively low-risk, middle-income population, from June 2006 through January 2009 (Dubowitz, et al., 2009). A total of 18 paediatric practices were assigned to treatment and control groups and 1119 mothers were recruited to complete assessments at the start of the evaluation, and then after 6 and 12 months. Maltreatment was assessed in three ways: maternal self-report, children's medical records, and CPS reports (Dubowitz, et al., 2009; Dubowitz., et al., 2012).

Both evaluations concluded that SEEK offers a promising and practical enhancement of paediatric primary care in the prevention against maltreatment and that assessing psychosocial problems did not, on average, require additional time for the paediatricians. In the study of the high risk population, there was significantly less child abuse and neglect in SEEK families. For example, there were 30% fewer CPS reports in the SEEK group compared to controls; for every 17 families receiving the SEEK model, one reported instance of CM was prevented. Within the second study, involving relatively low risk families, fewer SEEK mothers reported minor physical assaults and psychological aggression toward their children and there were relatively few instances of maltreatment in the medical records and few reports to CPS (SEEK, 2016).

Next steps

Today, there is much interest in implementing the SEEK model across the US and also internationally. There has also been interest in implementing SEEK in other settings, for example, in hospitals during inpatient admissions and Emergency Department attendances and also within social work and/or mental health services (SEEK, 2016).

Early Start - Christchurch, NZ

Overview

The Christchurch based Early Start programme is a home-visitation programme which aims to reduce child maltreatment and provides services to the most disadvantaged 15 percent of the population: families or whānau with new-born babies in difficult social and family circumstances that may put at risk the health and wellbeing of their children.[10] Initially funded by the Health Funding Agency, Community Funding Agency and the Christchurch City Council, Early Start enrolled as a pilot programme in 1995, influenced by the Hawaiian Healthy Start home-visitation programme (Superu, 2014). Today, Early Start is receiving funding from the Ministry of Social Development, Canterbury DHB, and the Department of Child, Youth and Family, and is contracted to work with between 250 and 275 families.

The programme targets families who are facing severe social, economic or emotional challenges and comprises a system of home based family support and visitation provided by trained family support workers. On top of having a relevant tertiary degree (e.g. nursing, social work, early childhood education, teaching or other related fields), the family support worker is also expected to show interpersonal skills, and an awareness of cultural issues. The family support worker receives a five-hour training session and visits families to achieve the following goals, varying by each family's needs: improve child health, reduce child abuse, improve parenting skills, support parental physical and mental health, encourage family economic well-being, and encourage positive partnerships such as reduce partner violence (Fergusson, 2005).

Programme delivery of Early Start includes (Fergusson, 2005):

- **Client assessment:** This involves an assessment of the needs of the family, carried out by the family support worker. The needs assessment is split between four levels:
  - Level 1. High need: One–two hours home visitation per week.
  - Level 2. Moderate need: Up to one-hour home visitation per fortnight.
  - Level 3. Low need: Up to one-hour home visitation per month.
  - Level 4. Graduate: Up to one-hour contact (phone/home visitation) per three months.
    All families enter the programme at Level 1 and, depending on progress, change level. Individual families participate for up to five years.
- **Individual family plans:** To address the individual needs of every family, two family plans are prepared for every client family. One Family Support Plan (FSP) and one Individual Family Plan (IFP). The FSP is developed by the family support worker along with other Early Start staff to address general issues, such as child health, along with family-specific issues, such as child neglect. The Individual Family Plan is developed by both the family and family support worker and focuses on family goals for the next three months. Full-time family support workers usually carry a caseload of 10 to 20 families.

[10] Early start is a part of a wider Family Start network, with 32 sites across NZ (Early Start, 2016)

- **Collaborative approach:** Drawing on the issues covered in the family plans, the Family support worker applies a collaborative problem-solving model based around principles involving; an understanding of cultural perspectives, assisting clients to seek and generate their own solutions and acting as an interpreter for new material, ideas or suggestions.

Originally, Early Start did not contain a systematic parenting component to their programme, and instead relied on the skills and abilities of individual family social workers to fulfil this function. This limitation has since been addressed by incorporating the following structured parenting programmes into Early Start:

- Partners in Parenting Education (PIPE) for those aged zero to three
- Incredible Years Toddler for those aged 12 to 18 months
- Triple P Level 4 for the three-to-five-year-olds
- Getting Ready for School for the four-to-five-year-olds (Superu, 2014).

Evidence supporting Early Start (Ministry of Social Development, 2012)

The Early Start programme has good evidence of effectiveness, and is cited internationally as an evidence-based programme. Early Start has been subject to one RCT. In this trial, the outcomes for 220 families receiving the programme were compared with the outcomes for a control group of 223 families not receiving the programme. Both groups have been followed up over a nine year period to determine the extent to which children and families receiving Early Start gained benefits when compared with the control group families.

Post-intervention results indicate that the intervention group, when compared to the control group, had significantly longer duration of early childhood education, greater scores for positive and non-punitive parenting attitudes and a smaller percentage of parental reports of the use of severe physical assault. At a nine-year follow-up point the intervention group had significantly fewer internalising or externalising behaviour problems; a higher overall parenting score; a smaller percentage of visits to the hospital for accident or injury; a smaller percentage of parent-reported harsh punishment; a lower score for physical punishment; better scores on the strengths and difficulties questionnaire; fewer severe physical assaults by a parent; and a smaller percentage of agency contacts for physical child abuse.

There was no evidence to suggest Early Start had benefits for a range of parental and family outcomes, including maternal depression, parental substance use, family violence, family economic circumstances, family stress and adversity. Furthermore, the nine-year follow up study concluded that the lack of benefit of Early Start for parental and family outcomes highlights the importance of developing better links and integration between home visiting services such as Early Start and a wide range of other family related services. These services include: family planning and contraceptive advice; adult mental health services; educational and career support; family budgeting services; and family relationship services.

In a comparison study of Early Start and a similar, but less effective, Australian programme (Family Care) carried out by Ronan, 2009, the authors suggest that Early Start achieved better outcomes because of its better staff training, higher level of intensity and duration, and attention to measuring the reliability of the programme. In turn, Early Start has been compared to the well cited and effective Nurse Family Partnership (NFP) programme in the US (see Table 13 on page 81) where they've been recognised to share common features that may help explain their effectiveness in reducing child maltreatment. Both use well-trained,

tertiary-level practitioners and carry out an intensive programme of home visits aimed at at-risk mothers and families. Based on a social learning model (whereby learning is viewed as a cognitive process that takes place in a social context and can occur purely through observation or direct instruction), the programme goals of Early Start are also similar to those in NFP.

Early Start precedes and is part of the wider national Family Start network which has 32 sites across New Zealand offering intensive home visiting service to vulnerable families. Family Start, launched in 1998 as a new programme designed to help families has not yet been subject to a robust evaluation (Ministry of Social Development, 2005; Sowry, 1998).[11] In 2009 the Minister for Social Development and Employment commissioned an independent review of the Family Start and Early Start intervention programmes. This review concluded that there was strong evidence for Early Start producing positive results for children and improving outcomes for New Zealand's most at-risk families. The evidence for the effectiveness of Family Start, however, was rather less convincing. Recommendations were made for potential areas of improvement, including provider and workforce development; working more closely with individual providers; developing and implementing a national evaluation framework; and ensuring that the programmes reach the families most in need (Superu, 2015).

Finally, the nine-year follow up study emphasises that while Early Start has undergone substantial changes in both client referral methods and programme content, the weight of the evidence suggests the findings of the randomised trial are likely to apply to the present day Early Start service.

Next steps

Currently Early Start employs between 17-20 fulltime Family Support Workers/Whānau Awhina and there are currently 70 families waiting to access the Early Start service. The current rate of entry suggests that it will most likely take 3-5 months before those families waiting are enrolled in the Early Start Programme. This suggests that additional funding is needed in order to meet the demand of the Christchurch population.

[11] A review of Family Start from 2009 suggests that there has been uneven implementation and that a relatively non-specific programme specification under the initial model has resulted in a range of ineffective parenting programmes being used under the Family Start banner.

The Chicago Child Parent Center (CPC) programme

Overview

The Chicago Child Parent Center (CPC) programme is a selective early intervention programme that provides comprehensive educational and family-support services to economically disadvantaged children from preschool to early elementary school. The CPC programme was established in 1967 through funding from Title I of the landmark Elementary and Secondary Education Act of 1965. It is the second oldest (after Head Start) federally funded preschool programme in the U. S. and is the oldest extended early childhood intervention. Initially implemented in four sites and later expanded to 25, the programme is designed to serve families in high-poverty neighbourhoods that are not being served by other early childhood programmes (Human Capital Research Collaborative, 2016).

The overall goal of the programme is to promote children's academic success and to facilitate parent involvement in children's education. Although there is some variation in curricula across sites the CPCs universally emphasize the development of language, literacy and numeracy through active learning. Participating children also receive health services, including initial medical screenings, along with free or reduced-price meals (Mersky, et al., 2011).

One of the distinguishing strengths of the CPC model, particularly in regard to its potential impacts on child maltreatment, is the programme's emphasis on family involvement. When the Chicago Longitudinal Study (CLS) participants attended the programme in the early 1980s, parents were asked to visit their child's school at least one half-day per week, facilitating parent–child interactions, parent and child attachment to school, and mutual parental support. Parents were also eligible to engage in vocational and educational training opportunities regularly available at the CPCs. In addition, upon enrolment, all families received at least one visit from a school-community liaison, who continued to provide support as needed to help connect families with local resources. Today, the Child-Parent Centers use the Creative Curriculum. The Creative Curriculum for Preschool is an award-winning curriculum for preschool success. It enables children to develop confidence, creativity, and lifelong critical thinking skills, and is based on 38 objectives for development and learning (Chicago Public Schools, 2016).

CPC requires 2.5 hours of parent involvement weekly. Parents sign a School-Home agreement at the time of registration agreeing to participate at least 2.5 hours each week. These hours can be a combination of both in school parent activities or at home activities. The key personnel, referred to as the "The Collaborative Team" consists of the Head Teacher (HT), Parent Resource Teacher (PRT), and School Community Representative (SCR). The Collaborative Team works together to ensure the needs of all students, families and teachers are met to promote the success of each child in the CPC. The centers are also supported through the mandatory participation of parents (Promising Practices Network, 2008).

Evidence supporting Chicago CPC

Although the Chicago CPC programme is not specifically stating that it is aiming to reduce child maltreatment, it is targeting many risk factors associated with child maltreatment – recognising that the causes of child maltreatment are a function of family, child, and community characteristics (consistent with the socio-ecological framework) (Reynolds,

2003).

Much of the research on the CPC model comes from federally funded CLS. The CLS follows a cohort of more than 1,500 children who grew up in high-poverty neighbourhoods in Chicago and attended public Kindergarten programmes in the Chicago Public Schools from 1985-1986.[12] Children in the study were at risk for poor outcomes because they faced social disadvantages including neighbourhood poverty, family low-income status, and other family economic adversities (Human Capital Research Collaborative, 2016).

Important to note is that the Chicago CPC programme has not been subject to any RCTs – but quasi-experimental research methods. In spite of this, the programme has been marked as "promising", see for instance the National Institute of Justice (National Institute of Justice, 2012). Furthermore, the promising practices network has given the programme a "proven" rating, due to the fact that the sample sizes for the analyses have been adequate, and as the researchers have been using rigorous empirical methods.

Today, the study is in its 20th year of operation. Besides investigating the short- and long-term effects of early childhood intervention, the study traces the scholastic and social development of participating children and the contributions of family and school practices to children's behaviour.

Overall, the CPC preschool programme has shown effectiveness at improving a range of child and adolescent outcomes, with the largest benefits found for participation in the preschool programme, and fewer (but still statistically significant) benefits found for school-age participation (Promising Practices Network, 2008).[13]

At age 17 of the programme participants, 1,408 of the original sample of 1,539 children were followed up and court petitions for child maltreatment and child protective service records were examined. The students participating in the preschool intervention group had significantly lower rates of court petitions (5.0%) compared with the treatment as usual group (10.5%) and the extended programme participants also had significantly lower rates (3.6%) compared with the treatment as usual group (6.9%). Similar findings were reported from child protective service records. Out-of-home placements were also significantly reduced for CPC participants compared with nonparticipants (Washington State Institute for Public Policy, July 2008).

Amongst the more general findings, students previously enrolled in the CPC study have been found to have a 29% higher graduation rate from high school, a 41% reduction in enrolment in special education, a 33% lower rate of juvenile arrest, a 42% lower rate of arrest for a violent offense, when compared to the comparison group (Orr, 2012).

Researchers have suggested that CPC might have been more successful than other similar programmes, like Head Start in the U.S, as it encourages parental involvement (Kautz, et al.,

---

[12] The methodological issues inherent in this longitudinal project have been addressed extensively. The principle threats to the validity of findings are selection bias into the programme and non-random attrition from the sample. Selection bias due to the quasi-experimental design of the study has been extensively investigated. Selection bias into the preschool intervention appears to be small and have been found to not affect estimates of programme impact (University of Minnesota, n.d.).

[13] Some CLS participants attended both the preschool and school-aged programme for four to six years, whereas other children participated for only one to three years in the preschool programme (Nelson & Caplan, 2014).

2014).

Next steps

The Chicago CPCs are currently being expanded in the Midwest, funded by the U.S. Department of Education's Investing in Innovation (i3) Fund. Through a partnership of 11 education and non-profit agencies in Illinois, Minnesota, and Wisconsin, the University of Minnesota is working to implement, research, and sustain the CPC model in high-need schools. The aim is to validate and assess generalizability of the CPC model to a broad array of social contexts. The University of Minnesota has also established two funds to further sustain implementation and research of CPCs (Human Capital Research Collaborative, 2015; Chicago Public Schools, 2016).

4.2 Key conclusions from review articles

We identified a number of review articles and meta-analyses that take a view of the level of effectiveness and the strength of findings reported in the literature across a range of primary prevention programmes.

4.2.1 Meta-review of CAN prevention interventions for pre-schoolers (excluding CSA interventions)

Reynolds, et al., 2009 reviewed empirical evidence from studies reporting on whether early childhood primary prevention programmes can reduce rates of child abuse and neglect. The authors identified 14 programmes from literature published between 1990 and 2007 that are aimed at prevention of child maltreatment for children from birth to five years. Out of these, five programmes showed significant reductions in rates of child maltreatment but only two programmes provided substantiated evidence of long-term preventive effects. These were the Chicago Child-Parent Center programme (see the case study outlined on page 43) and the Nurse–Family Partnership programme (see Table 13 on page 81). Common characteristics of these programmes include implementation by professional staff, relatively high dosage and intensity, and comprehensiveness of scope.

4.2.2 Meta-review of CAN prevention interventions for children of all ages (including pre-schoolers)

McLanahan & Butchart, 2009, sought to synthesize evidence from systematic and comprehensive reviews on the effectiveness of universal and selective child maltreatment prevention interventions.

The majority of the extensive review paper focuses on programmes targeted at reducing CAN in children using the following different types of intervention: home visiting, parent education, abusive head trauma prevention, multi-component interventions, media-based interventions and support/mutual aid groups. Four of these – home-visiting, parent education, abusive head trauma prevention and multi-component interventions – were found to be promising in preventing actual child abuse and neglect; home-visiting and parent education also seemed effective in reducing risk factors for child maltreatment. However, the

researchers emphasised that the conclusions should be interpreted with caution due to the methodological shortcomings of the reviews and outcome evaluation studies they draw on.[14]

4.2.3 Meta-review of CSA primary prevention programmes for pre-schoolers

As we have noted above, there is a scarcity of high quality evidence relating to the effectiveness of primary prevention programmes in reducing child sexual abuse, particularly in relation to programmes directed at pre-schoolers. In this section, we have summarised the conclusions of a recent Australian Royal Commission review, relating to primary prevention initiatives that seek to reduce CSA within pre-school populations (Pitts, 2015). We note that the scope selected interventions does not include any of the initiatives in NZ outlined in section 4.3 below, given that these did not meet the threshold for rigorous evaluation applied by the researchers. Furthermore, we recognise that none of the studies reported on seem to focus on strengthening protective factors, when primary prevention generally has a greater focus on promoting protective factors rather than identifying and reducing risk. (We will consider this issue further in the final section of this report.)

Table 8: Knowledge of sexual abuse – review of evidence for CSA programmes for pre-schoolers

Conclusion	Evidence
Pre-intervention (baseline) knowledge of concepts related to sexual abuse	
Baseline knowledge among pre-schoolers is low.	A pilot study (Zhang et al, 2013, cited in Pitts, 2015) of 136 Chinese pre-schoolers aged three to five years found that only 16 per cent would report 'secret' touching to an adult, and almost 35 per cent of pre-school children believed that all adults were allowed to touch their private parts (Walsh & Brandon, 2012, cited in Pitts, 2015).
Baseline knowledge among parents is low.	Parents report their own prevention education to be 'woefully inadequate' (Walsh & Brandon, 2012, cited in Pitts, 2015).
	Parents underestimate their child's vulnerability to being a victim of sexual assault (Wurtele, 1998, cited in Pitts, 2015).
Parents are less likely to discuss abuse related issues with pre-schoolers than older children.	A study of 212 Australian mothers found that fewer than one in four had discussed issues related to abuse from known and trusted adults with their children. When discussions did occur, they were more likely to be directed towards children aged 5–12 years than pre-schoolers (Walsh, 2012, cited in Pitts 2015).

[14] The report also included a chapter by David Finkelhor examining initiatives to prevent child sexual abuse which focusses on two primary strategies. Firstly, the review considers offender management approaches, which are not within the scope of this review, as they are secondary prevention measures. Next, Finkelhor addresses school-based educational programmes, again not really within scope given our interest in programmes addressing pre-school children. He concluded that the school-based educational programmes do achieve some of their goals (such as teaching children such skills as how to identify dangerous situations and to help children not to blame themselves) but that on the whole, studies are inconclusive about whether education programmes reduce victimization.

Conclusion	Evidence
Post-intervention knowledge of concepts related to sexual abuse	
Programmes appear effective at increasing knowledge of pre-schoolers about CSA and increasing skills-based knowledge on what to do in potentially abusive situations.	A study of 123 Latino pre-schoolers found that 10 hours of psycho-education focused on teaching children and their parents concepts related to general as well as personal safety was effective at increasing pre-schoolers' awareness of inappropriate[15] touch requests and discerning good from bad touches. The programme was effective also at increasing children's knowledge about what to say and do, who to tell and what to report following an inappropriate touch request (Kenny, 2012, cited in Pitts 2015).
The content and framing of training (what is delivered) influences how much pre-schoolers learn.	Pre-schoolers learn more when the focus of instruction is on behavioural skills rather than interpreting one's feelings (Wurtele, 1998, cited in Pitts 2015).
	Pre-schoolers learn more when explicit rather than abstract concepts are taught (Conte 1985, cited in Pitts 2015).
Approaches involving teachers and parents are more effective.	Pre-schoolers learn more when both teachers and parents act as instructors (Wurtele, 1989, cited in Pitts 2015).
Retention of knowledge over time	
In general, knowledge gains among pre-school aged children are maintained over time.	Studies employing short follow-up periods report that pre-schoolers are able to detect inappropriate touch requests one month after follow up, and retain the behavioural skills relating to what to do if confronted by an inappropriate touch request (Wurtele, 1990, cited in Pitts 2015).
	Behavioural skills training (which teaches children it is inappropriate for adults to touch their private parts and how to respond) tends to result in longer retention of knowledge than feelings-based training, which focuses on teaching children to distinguish between what feels good and what feels bad (Wurtele, 1990, cited in Pitts 2015).
	Similar results are seen when follow-up periods of up to five months are used suggesting young children are able to retain information related to sexual abuse prevention (Wurtele, 1990, cited in Pitts 2015).

[15] Appropriate touch requests are verbal signals to children from parents, doctors and nurses to touch the child's private parts in a non-sexual way (for example, for medical or hygiene reasons). Inappropriate touch requests are verbal and nonverbal signals from adults to touch or look at the child's private parts, or for the child to touch or look at the adult's private parts (Pitts, 2015).

Table 9: Outcome measure 2: Adverse effects – review of evidence for CSA programmes for pre-schoolers

Conclusion	Evidence
We found no evidence to support criticisms of prevention programmes (e.g. potential introduction of new concepts of guilt and anxiety).	Of five studies that included the measurement of adverse effects of training such as fear and anxiety, none detected adverse effects of training (Pitts, 2015)
Parents, children and pre-school teachers rate child sexual abuse training positively.	Parents and children rate child sexual abuse training positively (Wurtele, 1990, cited in Pitts 2015).
	Pre-school teachers rate child sexual abuse training positively (Wurtele, 1989, cited in Pitts 2015).

Table 10: Other outcome measures for which there was no evidence available – review of evidence for CSA programmes for pre-schoolers

Conclusion	Comments
Outcome measure 3: Protective behaviours	
It is not known how effective prevention programmes are at increasing the use of protective behaviours among young children as such studies have not been conducted.	Children's self-protective skills are measured using simulated abduction/abuse situations. These methods have been used in studies with older children as participants but ethical concerns have prohibited their use with young children.
Outcome measure 4: Disclosures of CSA	
Evaluations of prevention programmes for pre-schoolers have not generally included measures for disclosure or actual rates of abuse.[16]	One study using a small sample (n=43) of three to five year olds found that a six to eight week programme incorporating child, parent and teacher training had no effect on reports of abuse at post-test, eight weeks after commencement of the programme. However, given the very small sample and the relatively short follow-up period, it is unlikely that effects of training on rates of disclosure would be able to be demonstrated statistically (Hill & Jason, 1987, cited in Pitts, 2015).
Outcome measure 5: Cost effectiveness	
There has been limited (or no) study of cost-effectiveness in this field	According to Pitts (2015) the cost effectiveness of prevention programmes for pre-schoolers has not been studied (Pitts, 2015).

[16] We note that primary prevention programmes focus on the prevention of abuse prior to it occurring and as such, programmes may be unlikely to include measures or mechanisms for disclosure. However, there is a blurred boundary here given that primary prevention programmes (and the knowledge conveyed) may prompt disclosures of abuse that has already occurred.

Conclusion	Comments
	One study that reported on the cost of a prevention programme for pre-schoolers estimated a cost per participant of approximately US$350 (with a delivery cost per group of 10 children and 10 adults estimated to be US$7,000) (Kenny et al., 2012, cited in Pitts 2015).

4.3 New Zealand programmes with some evidence of effectiveness from less robust evaluations

Appendix 5 on page 88 lists five additional examples of New Zealand based primary prevention programmes. These have been subject to less robust evaluation methods and as such, the findings should be interpreted with some caution. However, they have been selected for consideration as they have shown some indications of being effective in reducing child maltreatment; as such, they may provide relevant learnings to inform the development of new or extension of existing primary prevention programmes within New Zealand.

It is important to note that the table does not cover a full list of all available initiatives in New Zealand, nor does it list all evaluated initiatives within the country. We note that our initial focus was on initiatives that had been subject to robust evaluation; these were examples that came to light during our review of the literature as potentially being of interest despite the lower quality of evaluation methodology.[17]

The New Zealand based programmes included are:

Universal programmes

1. **We Can Keep Safe**, implemented in Auckland, targeted at children between 3-5 years.
2. **Right2BSafe** (Phase 2), implemented in the Hauraki/Coromandel regions, targeted at caregivers and other adults who have contact with children.
3. **KidPower**, available across New Zealand, targeted at children 4-12 years.
4. **All about Me (AaM),** a programme no longer available in NZ, funded by ACC and NZ Police (2007) directed at children attending early childhood education centres and their parents.

Selective programmes

5. **Family help trust**, implemented in Christchurch, targets pregnant mothers and children under the age of 6 months.

[17] As noted above, the Incredible Years programme, which specifically target children with behavioural problems, has not been included as the evidence base is lacking.

5. What can we learn from the evidence for New Zealand?

5.1 Limitations of the literature

The literature within the field of primary prevention of CAN and CSA is vast and dense. Definitions are often applied inconsistently which makes interpretation difficult and sometimes leads to conflicting findings. The many limitations of the evidence base examined in this literature review make it difficult to draw clear conclusions and to assess which findings are likely to be relevant for the New Zealand context.

5.1.1 Validity and reliability of the evidence base

Validity refers to how well a research study measures what it intends to measure, where reliability is the degree to which an assessment tool produces stable and consistent results. These are key concepts that inform the ability to draw and generalise robust conclusions from evidence. Across the board, the evidence in this field is fairly low in both validity and reliability, though we have identified some initiatives that have been evaluated to a high standard.

Some key limitations of the evidence base for evaluation of CAN and CSA primary prevention initiatives (and in particular from the New Zealand based studies to date) that contribute to this conclusion include (Superu, 2014):

- weak research and evaluation designs (e.g. lack of control groups);
- a lack of clear definition, understanding and focus on maltreatment outcomes:
  - limited measurement of actual outcomes of interventions;
  - a wide range of programmes with differing but over-lapping purposes and desired outcomes leading to challenges of comparing different programme outcomes
  - a lack of follow-up studies;
- lack of programme replication, especially in different cultural contexts;
- the need for independent evaluations;
- lack of good impact data, making cost-benefit analysis challenging (and thus evidence of cost-effectiveness is virtually non-existent).

Some specific problems relating to evaluations of CSA primary prevention programmes for pre-school aged children include (Pitts, 2015):

- inconsistent reporting affecting the reliability and validity of psychometric assessment instruments;
- failure to account statistically for the similarity of children within individual pre-schools which may over-estimate the effect of the prevention programme, and limited use of sub-group analyses; and
- the majority of outcome measures used in evaluation studies relate to child or parent knowledge about child sexual abuse and prevention. Concrete, behavioural outcome measures such as disclosure of child sexual abuse or reductions in rates of abuse are

rarely used. Thus, it is not clear from the literature whether knowledge about child sexual abuse and its prevention translates to higher rates of disclosure or lower rates of abuse.

5.1.2 Relevance of the evidence to the NZ context

Issues relating to validity and reliability go alongside concerns about the ability to generalise learnings to the New Zealand context. The key limitation is the paucity of robust evaluations conducted on New Zealand initiatives, particularly in relation to culturally-specific programmes. In particular, in relation to the CSA programmes for pre-school aged children, many evaluation studies are relatively old and were conducted using pre-schoolers from the United States as participants (Pitts, 2015).

5.2 What approaches look most promising?

5.2.1 Universal versus selective approaches

It is not possible from the review of the evidence to say whether universal or selective approaches are more effective. We found evidence for examples of both approaches that showed proven effectiveness but success depends largely on what the initiatives involve, and how they are implemented and evaluated. The choice between universalism and selectivism is commonly faced in public policy; the following table outlines some of the key factors to consider when weighing up options. We know that 'scale-ability' is a key issue for ACC in terms of maximising the potential reach of initiatives to be implemented. Universal approaches, by definition, are likely to have a wider reach but, as highlighted below, this needs to be balanced against ensuring best value for money, with universal approaches having the potential to spread resources too thinly to achieve effect.

Furthermore, in Appendix 6, we have provided a brief overview of the relatively new, yet growing body of research around the use of predictive risk modelling (PRM), that could be applied as a potential method of identifying children and families at risk of experiencing child maltreatment. If ACC decides to go down a route incorporating a selective approach to primary prevention, it would be worthwhile considering this potential and indeed, keeping up to speed with developments within PRM.

Table 11: Advantages and disadvantages of universal approaches (New Zealand Government, 2012)

Advantages of universal approaches	Disadvantages of universal approaches
Greater public backing for the legitimacy of the taxpayer investment, enabling quality provision (as more people may gain benefit).	High base cost (as in the cost of providing the service to all when the benefits are disproportionately for a sub-group).
Increased take-up owing to wider information dissemination (universal access ensures that many people are aware of and spread knowledge of the service).	Limited resources are spread thinly over a large number of recipients (rather than heavily weighted to need). This can result in wasteful 'overdosing' of average to good families with more service than required, while offering insufficient dosage, compromising effectiveness, for high-needs, high-risk families.

Advantages of universal approaches	Disadvantages of universal approaches
Less perceived stigma associated with access (this is for everyone, not just 'some other people').	'Middle class capture' where service capacity is predominantly taken up by parents who are dedicated to doing the best for their children (and will do so with or without access to these services). Meanwhile truly needy families reject the service, perceiving it as not being designed for, or sensitive to, them and their needs.
Avoiding false positive and negative targeting issues (e.g. inappropriately identifying or missing a client).	

5.2.2 What initiatives are most effective?

Effective delivery mechanisms

In section 3.2, we provided an overview of evidence supporting different types of delivery mechanism for primary prevention initiatives in this field. In the European Report on Preventing Child Maltreatment (WHO, 2013) (noting that the scope covered children of all ages) the highest degree of evidence was found for **school based programmes**, **home visiting programmes** and **effective parenting programmes** as having an impact on risk factors for child maltreatment. No type of mechanism was viewed to have proven effectiveness for actually reducing child maltreatment.

We note that in terms of 'scale-ability', the mass media approach offers potential for a wide reach of messaging across the population. The review concluded that there was some, but limited evidence, to suggest effectiveness of this.[18] From experience of working within the New Zealand sector, stakeholders we spoke with emphasised the importance of getting the right messaging and ensuring that any media approaches are universal and not discriminatory. They need to resonate with a wide population.

Effectiveness of initiatives

In the summary of findings from meta-reviews of studies of specific programmes, reported in section 4.2 and in our examples of promising New Zealand based programmes, we identified the following:

[18] We note the Right2BSafe mass media programme in East Waikato (Hauraki/Thames area) provides an example of a promising New Zealand based initiative. Though evidence has not been provided from an RCT level evaluation of the initiative, findings from a small sample of in-depth interviews with parents and children and during programme observations at four early childhood centres, led to some promising findings around message absorption and understanding.

Evidence relating to CAN interventions targeted at pre-schoolers	Three programmes provided strong evidence of enduring preventive effects: ➢ A nurse **home visiting service** from pregnancy to age 2 (Nurse Family Partnership) ➢ A high quality **pre-school education programme** for children aged 3-4 (Child Parent Centres) ➢ A post-natal **home-visiting** and **effective parenting service** (Parent Education Programme for Teen Mothers High risk)
Evidence relating to CAN interventions targeted at children of all ages (including pre-schoolers)	Four types of programmes were found to be promising in preventing actual child maltreatment: ➢ **home-visiting programmes** ➢ **parent education programmes** ➢ **abusive head trauma prevention programmes** ➢ **multi-component interventions** Two programmes were found to be effective in reducing risk factors for child maltreatment. ➢ **home visiting programmes** ➢ **parent education programmes**
Promising New Zealand based initiatives	The five examples from New Zealand were: ➢ An **early childhood education centre's child sexual abuse programme aimed** at 3-5 year olds (We Can Keep Safe, based in Auckland) ➢ A **mass media campaign** to raise awareness about child sexual abuse (not specific to 0-5) (Right2BSafe, Phase 2, Hauraki/Coromandel regions) ➢ **Family workshops** aimed at helping children protect themselves from violence (aimed at children between 4-12 years) (KidPower, available across New Zealand) ➢ **All about Me (AaM),** a programme previously available in NZ, funded by ACC and NZ Police (2007) directed at children attending early childhood education centres and their parents ➢ A long-term home-based **parenting programme** designed for pregnant women and their families who are considered ultra-high-risk for child abuse and family dysfunction (targets pregnant mothers and children under the age of 6 months) (Family Help Trust, Christchurch)

In terms of 'scale-ability' we note that the home-visiting approach of initiative is relatively resource intensive and would be extremely costly to implement on a wide scale. That said, there may be options to build around existing frameworks within New Zealand. There may be potential to build on and leverage off some of the health related system approaches, including Plunket visits following birth, the B4 School checks or the Tamariki well-child framework.

Depending on the approach adopted, early childhood education programmes have the potential to be scaled-up to provide wide coverage. The method of visiting teachers providing training to children over a series of days, shown to be highly effective, would be relatively resource intensive; a possible alternative approach would be the development of a

resource-pack, with information such as the pamphlet we showed in Figure 2: Christchurch Schools Toolkit for Safer Children.

Some researchers have concluded that a comprehensive approach to tackling CAN and CSA is most effective and that multi-dimensional programmes incorporating a range of delivery mechanisms in a variety of settings are likely to be most successful (Landers, 2013).

Also, we recognised earlier in the report that none of the studies that had been robustly evaluated seemed to focus on strengthening protective factors, when primary prevention generally has a greater focus on promoting protective factors rather than identifying and reducing risk. In a review article (Ellenbogen, et al., 2014) the authors concluded that high quality early childhood education has the potential of promoting resilience in families through promoting growth in areas of social, emotional and cognitive development that are particularly affected by child maltreatment.

5.2.3 What works? Common features of effective interventions

Across the literature, a range of features and characteristics of successful programmes were identified. Again, there was some blurring of definitions to which these applied, in particular with a blurred boundary as to which were relevant for CAN, CSA or both.

In the following tables, we have collated some of the key themes, with key secondary sources and primary references indicated within the text.

Features of effective CAN/CSA primary prevention programmes for young children

Duration and format:

- There is a positive correlation between the length and number of sessions and the knowledge gained, with the ideal programme length being anything up to an hour over a course of four to five sessions (Woodley & Metzger, 2012).

Ensuring cultural appropriateness:

- Programmes that do not take cultural and family norms into account may be ineffective as concepts taught may be confusing - particularly if they contradict what the child has learned at home. Using proverbs, metaphors, humour and stories, as well as appropriate common and formal language, adopted from a specific culture can assist.

Involvement:

- Include children as active participants in the learning process (Barron & Topping, 2009).
- Active parental involvement is considered one of the key components to programme effectiveness and in particular to successful medium- to long-term outcomes, particularly with regards to parents' ability to recognise and react to potentially unsafe situations and reinforcing knowledge and skills (Babatsikos, 2010).

Training/core competencies of staff:

- Learning outcomes are better if programmes are conducted by well-trained, qualified staff, for instance teachers, specialised workers or specialised facilitators (Woodley & Metzger, 2012).

Teaching techniques:

- Interventions which utilise cognitive-behavioural methods are most effective. For instance, the use of role play and interactive puppet shows is considered more effective than video-or lecture based programmes (Woodley & Metzger, 2012).

- Combine a range of techniques including (Davis & Gidycz, 2000; Barron & Topping, 2009):

  Active techniques:

  - Skills practice/rehearsal or role-play, provide children a safe, non-threatening environment in which they may practice recognizing possible danger signals of abusive situations and how to respond.
  - Shaping and reinforcement are behavioural learning techniques that are typically used along with skills practice/rehearsal or role-play techniques. (In child sexual abuse prevention programmes specifically, shaping involves rewarding or encouraging (i.e., reinforcing) a child's response to a situation when it is appropriate, with the goal of eventually getting the child to act out the desired response).
  - Discussion between presenter(s) and children.

  Passive techniques:

  - Modelling, in which the presenters act out a situation and demonstrate how to respond. Sometimes, this is presented in the form of a play or a puppet show.
  - Films, comic books or children's books about child sexual abuse prevention.

Repetition and practice:

- Teach important concepts multiple times and provide many opportunities to practice skills (Sarno & Wurtele, 1997 cited in Point Research, 2014).

Content of CAN interventions (may also be relevant to CSA interventions):

- Specific rather than abstract concepts (Sarno & Wurtele, 1997 as cited in Point Research, 2014).
- Concrete rules with little room for confusion, have appropriate visual cues and contain allowances for differences in children's moral development (Barron & Topping, 2009).
- Identifying potential abuse situations (Finkelhor, 2009 cited in Point Research, 2014).).
- Trusting intuition e.g. teaching children to trust their feelings if something is not quite right (Asawa et al., 2008, cited in Point Research, 2014).
- How to tell (and keep telling) an adult when children are concerned about the behaviour of another person (Finkelhor, 2007).
- Identifying sources of support (Asawa et al., 2008, cited in Point Research, 2014).
- Programmes must be able to adequately deal with any disclosures that occur through the delivery of the programmes (Adair 2006; Wolfe et al., 2006 cited in Russell, 2008).

Content for CSA interventions specifically:

- The content of CSA prevention programmes has evolved over the past 25 years (Woodley & Metzger, 2012). For instance:
  - Teaching children the correct terms for genitalia is a relatively recent development.
  - Instead of teaching children the difference between 'good' and 'bad' touch, programmes should use terms such as 'okay' and 'not okay' touch, so that children won't grow up thinking that all sexual touches are bad and that eventually, when they are consenting adults, they may experience 'good' sexual touching.
- Reducing blame, e.g. children understanding they are not to blame if adults touch them in inappropriate ways (Asawa et al., 2008, cited in Point Research, 2014; Barron & Topping, 2009).
- Secrets e.g. secrets versus surprises, 'good' and 'bad' secrets and secrets to keep and secrets to tell (Asawa et al., 2008, cited in Point Research, 2014; Barron & Topping, 2009).

Characteristics of effective parenting primary prevention programmes for parents of young children (Superu, 2014)

Staffing/infrastructure:

- suitably qualified and trained staff
- professional supervision
- support and ongoing training
- record-keeping/data collection
- processes to maintain programme integrity/fidelity
- community outreach and good networks with other agencies
- limited caseloads, especially with home-visiting

Design and delivery:

- detailed programme logic with specified goals or outcomes
- structured curriculum and planned sessions with programme/manual documentation
- cultural competence (diverse staff ethnicity matched to client group)
- responsiveness to cultural concepts and practices
- specified target population and recruitment process with strategies to engage and retain participants
- initial assessment or screening
- appropriate programme dose and duration
- individualised plans and onward referral where appropriate (e.g., health services)
- intensive/comprehensive programmes with home-visiting component
- modelling of skills and opportunity to practise skills

Content:

- child behaviour focus and developmentally appropriate
- managing children's behaviour and providing a predictable environment
- positive parenting strategies and non-punitive problem solving
- parent-child interactions
- strategies to help parents and children regulate emotions
- children's health, development and safety
- parental and family wellbeing and life-course (ongoing needs)

Outcomes:

- ongoing monitoring and evaluation – quality improvement process

The following information, relating to features of successful whānau violence prevention and intervention programmes is taken from the Kaupapa Māori wellbeing framework (Dobbs & Eruera, 2014). While this is not specific to CAN or CSA programmes, we felt it was useful context, given the importance of ensuring cultural appropriateness of programmes within New Zealand.

Extract from - the Kaupapa Māori wellbeing framework: the basis for whānau violence prevention and intervention (Dobbs & Eruera, 2014)

Successful programmes are likely to have:

- Māori population based responses that complement the work of Māori and other community-based intervention services. These should be grounded in te reo me ona tikanga (Māori language and culture) and underpinned by Māori values and beliefs, Māori cultural paradigms and frameworks.
- Government agencies working in close collaboration with iwi organisations to facilitate the implementation of Māori whānau violence prevention initiatives that meet the needs, priorities and aspirations of iwi.
- Funding sufficient to (a) engage leaders and staff who have the nationally and locally recognised skills to ensure successful implementation of violence prevention initiatives, and (b) to allow for local consultation and subsequent responsiveness in planned activities and projects.
- Support for capacity building opportunities for both prevention and intervention staff, including opportunities for networking, advocacy, and training.
- Māori violence prevention initiatives that are funded for research and evaluation in a way that builds local knowledge within a Māori worldview.

The following guidelines for dealing with sexual abuse in a Māori context were formed as a result of semi-structured interviews with approximately 120 people who represented whānau. Although they would typically be applied to therapeutic approaches for victims of sexual abuse (rather than primary prevention initiatives) they provide additional useful context to inform important concepts in relation to sexual abuse. Essentially, a kaupapa Māori approach is different in terms of philosophy, basic concepts and methods than interventions founded on mainstream approaches. It is a strengths-based approach which aims at restoring mana and building resilience of both the individual and whānau. It starts at a point of establishing safety, building trust and relationships and establishing boundaries through use of tikanga, karakia and whānaungatanga. Therapy takes a variety of forms depending on the needs and desires of the survivor (self-determination) but includes de-colonisation and other cultural information.

Guidelines for dealing with sexual abuse in a Māori context (Joyce and Erai, 1992, cited in Carne, 2014)

The following three concepts were considered to be critical when dealing with sexual abuse in a Māori context:

The role of colonisation

- Māori face the challenge of developing healing models based within traditional values but relevant in contemporary society.
- The system and bureaucratic structures which have evolved from colonialist beliefs are often damaging for Māori.
- The need to recognise Māori methods and beliefs as being equally valid in Aotearoa society, as criteria for decision making.

The role of whānau, hapū and iwi in healing

- If sexual abuse healing concentrates on the victim alone it could further isolate the victim from their family members, or even help to perpetuate the 'victim blaming' ethos evident in our society.
- Many respondents felt it was pointless to try and heal an individual and then return them to a 'sick' environment.
- The strength of Māori society lies in the whānau-hapū-iwi system.
- Healing of sexual abuse involves the safety and personal healing of the victim/s as well as initiating a process aimed at ensuring the perpetrator does not abuse again.
- The process of healing the whānau is the most effective form of prevention – it means that re-abuse is less likely.

Te Oranga – healing the whole person

- All parts making up a person need to be dealt with.
- This type of holistic healing requires special skills and knowledge, such as karakia which may be made available to Māori and whānau in their healing process.

5.3 Some further insights from the literature

5.3.1 Theoretical and cultural perspectives

Interventions should be positioned within an appropriate theoretical framework

To maximize the effects of prevention and care, WHO recommends that interventions are delivered as part of a public health approach (WHO, 2014): however, the focus on a public health perspective has been criticised as treating sexual violence as something akin to influenza (Carmody 2013 cited in Point Research, 2014).

The key point is that a sound policy development process should be employed, involving stages of: problem definition and understanding; identification and assessment of potential interventions; design and implementation; monitoring, evaluation and review.

Incorporating key Māori concepts and values is imperative

In the paper on the application of the Kaupapa Māori wellbeing framework to whānau violence prevention and intervention referenced earlier (Dobbs & Eruera, 2014), it is stated that 'Western approaches have not curbed the epidemic of whānau violence. Multi-level approaches to whānau violence prevention and intervention are more likely to achieve the best results'.

Culturally responsive initiatives and programmes that restore and strengthen whānau and communities should be considered as well as the individual based interventions of mainstream for Māori whānau. Kaupapa Māori conceptual frameworks, for example the Mauri Ora framework, advocate for the development of Māori models that change the way whānau violence is understood and managed (Dobbs & Eruera, 2014).

Furthermore, the guidance highlights that it is essential that primary prevention initiatives recognise and understand the difference between whānau and family. The use of cultural imperatives, for example, whakapapa, tikanga, wairua, tapu, mauri, and mana, are viewed to have the potential to inform wellbeing in whānau relationships, to transform behaviours and to provide alternatives to violence. Using these imperatives can guide transformative practices and inform strategies for whānau violence prevention and whānau wellbeing. They can also be seen as protective factors within whānau, hapū and iwi.

Initiatives require a sound theoretical base that focusses on risk and protective factors

Regardless of the delivery model for the intervention, it is recommended that programmes have a strong grounding in the evidence base and in epidemiological and theoretical knowledge, including consideration of how to impact on known risk and protective factors.

5.3.2 The target population for primary prevention

The earlier intervention occurs, the greater the potential benefits

There is clear evidence that the earlier primary prevention interventions occur in children's lives, the greater the potential for:

- Reducing well-known risk factors associated with multiple negative outcomes (Trentacosta et al., 2008, cited in Ronan, 2009).
- Securing additional benefits to the child (including, for example, brain development, behavioural and social competence, and educational attainment) (McLanahan & Butchart, 2009).
- Securing additional benefits to society (e.g. reduced delinquency and crime) (McLanahan & Butchart, 2009).

In addition, early case recognition coupled with secondary support of child victims and families can help reduce reoccurrence of maltreatments (WHO, 2014).

Programmes should identify and address barriers to participation

There are many barriers, both practical (e.g., lack of transport, time off work) and emotional (e.g. lack of trust in providers, suspicion) that may prevent the family from engaging in primary prevention programmes. Services that identify and address obstacles and

motivational issues are likely to see increased engagement and successful completion rates increase (Curtis et al., 2009, cited in Ronan, 2009). This includes recognising the importance of cultural appropriateness.

5.3.3 Approach and scope of coverage

Interventions should be comprehensive and address several ecological domains and perspectives

Rather than focusing on a single domain (such as the individual) initiatives that deal with several domains of functioning (for example, including the family and community) potentially have a greater influence on achieving better outcomes (Lamont & Price-Robertson, 2013). One key stakeholder working in the field of child sexual abuse highlighted the benefits of adopting a whole-of-system approach to intervention, addressing all environments where young children spend time. There is a need to ensure that all parts of the environment are safe and that there are systems in place to respond appropriately when dangers are identified.

In addition, programmes may target several risk factors in multiple settings, while attending to the linkages between them (Wolfe et al., 2006 cited in Russell, 2008). Multi-sectoral approaches to reducing child maltreatment are also recommended (WHO, 2014).

Given the wide perspectives to be addressed, we note that there is some difficulty with the approach of characterising interventions as being 'effective or ineffective' on the basis of just the outcome of child maltreatment. Impacts on broader measures of child and family well-being are important in their own right and may lead to effects on later outcomes such as crime prevention and educational attainment (Reynolds, et al., 2009).

Value of a strengths-based intervention approach

Research suggests that effective intervention services for vulnerable families should focus not only on reducing negative factors but on promoting protective factors. By building on family strengths, families are better placed to cope with stress, which in turn can lead to a reduced incidence of child abuse and neglect. Promoting protective factors may also help professionals working with families to build more positive relationships with clients (Lamont & Price-Robertson, 2013). For New Zealand, there is strong alignment here with strengths-based Māori approaches.

5.3.4 Supporting sustainable change

Ensure strong organisational leadership and alignment

It is important to promote an organisational culture and climate conducive to the use of evidence supported prevention of child maltreatment programmes, which begins with ensuring a vision that aligns with organisation values and direction and is facilitated by strong leadership. In relation to this general principle, it is also essential to gain initial and ongoing support internally and externally from both staff and a wide variety of stakeholder groups.

Features that support sustainability of service innovations

The following features are shown to promote sustainability of new, innovative services (U.S. Department of Health & Human Services, 2008):

- Positioning the initiative as a permanent, routine development rather than as a pilot or temporary service to be delivered on a fixed-term basis only[19];
- Attracting and retaining qualified staff who are supportive of and receptive to the use of innovative services;
- Achieving strong external support for continuing a programme; and
- Securing permanent rather than short-term funding streams.

5.3.5 Implementation

Core competencies and training of staff

Although the literature acknowledges that programmes delivered by well-trained, qualified teachers and staff have been linked to better outcomes (Shonkoff and Phillips, 2000, cited in Russell, 2008), there is little detail provided about the core competencies or training requirements. However, there is a consensus that the educator's skill, or use of self[20], is the most important element of successful violence prevention programme delivery (Dyson & Fox, 2006 cited in Russell, 2008). Further, there is an identified need for specialised and accredited training programmes (Carmona, 2005; Ellis, 2004 cited in Russell, 2008).

Research and evaluation

Any intervention will need a robust research and evaluation framework:

- An evaluation strategy should be integrated from programme's inception (Mulroney 2003; Davies et al., 2003 Hassel and Hanna 2007 cited in Russell, 2008).
- Programmes should have clear goals and systematically document their results relative to their goals (Nation et al., 2003; Hanna and Hassel 2007 cited in Russell, 2008).
- It will be important to facilitate innovation – different evaluation processes may be required at different times in the 'life cycle' of a new initiative to ensure that innovation is not stifled.

5.4 Some final reflections

We have presented an overview of key learnings from a vast range of literature relating to the primary prevention of CAN and CSA.

---

19 We note that this recommendation needs to be balanced with the need to test approaches and evaluate effectiveness of innovative initiatives within a New Zealand context.

20 'Use of self' is a term used in social work practice relating to the combining of knowledge, values, and skills gained in social work education with aspects of one's personal self, including personality traits, belief systems, life experiences, and cultural heritage (Walters, 2008).

While a range of interventions has been shown to be effective in reducing or potentially preventing the impact of risk factors for maltreatment of young children, high-quality evaluation studies examining the actual impacts of interventions on maltreatment outcomes are relatively sparse. In relation to child sexual abuse specifically, evaluations are currently of insufficient quantity and quality to make strong assertions about the overall efficacy of prevention programmes for pre-schoolers.

As such, we have reflected that there are no clear, 'silver-bullet' solutions which the ACC Violence portfolio will be able to pick up and implement with confidence. Rather there is a 'smorgasbord' of initiatives that appear promising. Known features of programmes that increase the likelihood of success and some key contextual learnings about the New Zealand environment will need to be pieced together in a coherent way that makes sense in a Kiwi context.

The process of determining the nature and scale of potential primary prevention interventions within this field requires a careful sifting of the evidence base and consideration of feasible options, with advice from key stakeholders within the sector. A range of perspectives, including public health, social work and early childhood education, will need to be incorporated to shape an appropriate way forward. Furthermore, on-going monitoring and robust evaluation of initiatives will be essential to assessing effectiveness and to building the knowledge base, relevant to the New Zealand context, within this field.

6. References

ACC, 12th May, 2016. *ACC: email correspondence.* s.l., s.n.

Arthur, J., 2013. *Right2BSafe – A report on Phase 2 of the Right2BSafe Campaign for the prevention of Child Sexual Abuse in Hauraki/Coromandel Regions,* s.l.: Ministry of Justice .

Babatsikos, G., 2010. Parents' knowledge, attitudes and practices about preventing child sexual abuse: a literature review. *Child Abuse Review,* 19(2), pp. 107-129.

Barron, K. J. & Topping, I. G., 2009. Child Sexual Abuse Prevention Programs: A Review of Effectiveness. *Review of Educational Research,* 79(1).

Blueprint, n.d.. *Triple P System.* [Online]
Available at: http://www.blueprintsprograms.com/funding/triple-p-system
[Accessed 04 07 2016].

Blueprints, n.d.. *Nurse-Family Partnership.* [Online]
Available at: http://www.blueprintsprograms.com/funding/nurse-family-partnership
[Accessed 04 07 2016].

Bolden-Barrett, V., n.d.. *Qualifications for Head Start Teachers & Assistant Teachers.* [Online]
Available at: http://work.chron.com/qualifications-head-start-teachers-assistant-teachers-27194.html
[Accessed 04 07 2016].

Bolen, R. a. S. M., 1999. Prevalence of child sexual abuse: A corrective metanalysis. *Social Service Review,* Volume 73(3): , pp. p. 281-313. .

Bronfenbrenner, U., Jul 1977. Toward an experimental ecology of human development.. *American Psychologist, Vol 32(7),* pp. 513-531.

Carne, S., 2014. *Healing Approaches for Maori Whanau entitles to Access ACC Sensitive Claims Support,* Wellington: ACC.

Centers for Disease Control and Prevention, 2010. *Preventing shaken baby syndrome: A Guide for Health Departments and Community-Based Organizations,* s.l.: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control..

Centers for Disease Control and Prevention, 2016. *The Social-Ecological Model: A Framework for Prevention.* [Online]
Available at: http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
[Accessed 05 07 2016].

Centre for Social Research and Evaluation, 2008. *Preventing physcial and psychological maltreatment of children in families,* s.l.: s.n.

Chaffin, M. et al., 2004. Parent–Child Interaction Therapy With Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. *Journal of Consulting and Clinical Psychology,* 72(3), pp. 500-510.

Chaffin, M. et al., 2004. Parent–Child Interaction Therapy With Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. *Consulting and Clinical Psychology,* Volume Vol. 72, No. 3, p. 500–510.

Chicago Public Schools, 2016. *About our programs.* [Online]
Available at: http://cps.edu/Schools/EarlyChildhood/Pages/Childparentcenter.aspx
[Accessed 04 07 2016].

Child First, n.d.. *Funding Partners: Overview of Child First Funding.* [Online]
Available at: http://www.childfirst.org/about-us/funding-partners
[Accessed 04 07 2016].

Child First, n.d.. *Replication.* [Online]
Available at: http://www.childfirst.org/our-network/replication
[Accessed 04 07 2016].

Child Matters, 2016. *http://www.childmatters.org.nz/55/learn-about-child-abuse/facts,* s.l.: s.n.

Child Welfare Information Gateway, 2004. *Risk and Protective Factors for Child Abuse and Neglect.* [Online]
Available at: https://www.childwelfare.gov/pubPDFs/riskprotectivefactors.pdf
[Accessed 05 07 2016].

Child Welfare Information Gateway, 2011. *Child Maltreatment Prevention: Past, Present, and Future,* Washington: Child Welfare Information Gateway.

Child Welfare Information Gateway, n.d.. *Framework for prevention of child maltreatment.* [Online]
Available at: https://www.childwelfare.gov/topics/preventing/overview/framework/
[Accessed 05 07 2016].

Coalition for Evidence-Based Policy, n.d.. *Social Programs That Work. Child FIRST - Near Top Tier.* [Online]
Available at: http://evidencebasedprograms.org/1366-2/child-first-near-top-tier
[Accessed 04 07 2016].

Coster, D., Bryson, C. & Purdon, S., 2016. *Evaluation of coping with crying,* s.l.: NSPCC.

Daro, D. & Dodge, K. A., 2009. Creating Community Responsibility for Child Protection: Possibilities and Challenges. *Future Child,* 19(2), pp. 67-93.

Davis, M. K. & Gidycz, C. A., 2000. Child sexual abuse prevention programs: A metaanalysi. *Journal of Clinical Child & Adolescent Psychology ,* Volume 29.

Dias, M., 2005. Preventing abusive head trauma among infants and young children: a hospital-based, parent education program.. *Pediatrics, 2005,,* p. 115:e470− e477.

Dobbs, 2014. *Kaupapa Maori wellbeing framework: the basis for whanau violence prevention intervention,* s.l.: s.n.

Dobbs, T. & Eruera, M., 2014. *Kaupapa Maori wellbeing framework: the basis for whanau violence prevention intervention,* s.l.: s.n.

Dubowitz., H., W.G., L., J.N., S. & L.S., M., 2012. The SEEK model of pediatric primary care: can child maltreatment be prevented in a low-risk population?. *Acad Pediatr.,* 12(4), pp. 259-68.

Dubowitz, H., 2014. The Safe Environment for Every Kid (SEEK) Model:Helping promote children's health, development, and safety. *Child Abuse & Neglect,* Volume 38, pp. 1725-1733.

Dubowitz, H., Feigelman, S., Lane, W. & Kim, J., 2009. Pediatric Primary Care to Help Prevent Child Maltreatment: The Safe Environment for Every Kid (SEEK) Model. 123(3).

Dubowitz, H., Feigelman, S., Lane, W. & Kim, J., 2009. The Safe Environment for Every Kid (SEEK) Model: Helping promote children's health, development, and safety). Pediatric Primary Care to Help Prevent Child Maltreatment: The Safe Environment for Every Kid (SEEK) Model. *Pediatrics,* 123(3).

Dubowitz, H. & Leventhal, J. M., 2014. Pediatric Clinics of North America: Child maltreatment. 61(5).

DuMonta, K. et al., 2008. Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect,* 32(3), p. 295–315.

Early Start, 2016. *Home.* [Online]
Available at: http://www.earlystart.co.nz/
[Accessed 04 07 2016].

Early start, 2016. *Waiting List Status.* [Online]
Available at: http://earlystart.co.nz/waitinglist.html
[Accessed 04 07 2016].

Early Start, n.d.. *About Us - Early Start Team.* [Online]
Available at: http://earlystart.co.nz/staff.html
[Accessed 04 07 2016].

Early Start, n.d.. *About us - Our Background.* [Online]
Available at: http://earlystart.co.nz/background.html
[Accessed 04 07 2016].

Education Review Office , 2008. *The Implementation of All about Me Toku Ahuatanga Whanui,* Wellington: Education Review Office.

Ellenbogen, S., Klein, B. & Wekerle, C., 2014. Early childhood education as a resilience intervention for maltreated children. *Early Child Development and Care,* Volume 184.

Family Help Trust, 2012. *2013 Business Plan.* [Online]
Available at: http://www.familyhelptrust.org.nz/resources/business-plan
[Accessed 04 07 2016].

Family Help Trust, n.d.. *Family Help Trust Sponsors and Supporters.* [Online]
Available at: http://www.familyhelptrust.org.nz/about/sponsors-a-supporters
[Accessed 04 07 2016].

Family Help Trust, n.d.. *The New Start Programme.* [Online]
Available at: http://www.familyhelptrust.org.nz/services/new-start-programme
[Accessed 04 07 2016].

Family Help Trust, n.d.. *The Safer Families Programme.* [Online]
Available at: http://www.familyhelptrust.org.nz/services/safer-families-programme
[Accessed 04 07 2016].

Fanslow, J., Robinson, E., Crengle, S. & Perese, L., 2007 . *Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women.,* s.l.: s.n.

Fanslow, J., Robinson, E., Crengle, S. & Perese, L., 2007. *Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women.,* s.l.: s.n.

Fergusson, D. e. a., 2005. *Early start evaluation report ,* s.l.: Christchurch school of Medicine.

Fergusson, D. M., Horwood, J. & Lynskey, M., 1996. Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse.. *Journal of the American Academy of Child and Adolescent Psychiatry,* Volume 34, pp. 1365 -1374.

Finkelhor, D., 2007. Prevention of sexual abuse through educational programs directed toward children. *Pediatrics,* Volume 120.

Fortson, B. L. et al., 2016. Atlanta: Division of Violence Prevention, National Center for Injury Prevention and Control, National Center for Injury Prevention and Control.

Goldman, J., Salus, M., Wolcott, D., & Kennedy, K., 2003. *What factors contribute to child abuse and neglect? A coordinated response to child abuse and neglect: The foundation for practice,* s.l.: Washington D.C.: Office on Child Abuse and Neglect..

Goldman, J., Salus, M. K., Wolcott, D. & Kennedy, K. Y., 2003. *What factors contribute to child abuse and neglect? A coordinated response to child abuse and neglect: The foundation for practice,* s.l.: Washington D.C.: Office on Child Abuse and Neglect..

Health and Human Services Agency, n.d.. *arent Child Interaction Therapy (PCIT), Home Start.* [Online]
Available at:
http://sandiego.networkofcare.org/mh/services/agency.aspx?pid=ParentChildInteractionTherapyPCITHomeStart_61_2_0
[Accessed 04 07 2016].

Healthy Families America, 2015. *History.* [Online]
Available at: http://www.healthyfamiliesamerica.org/history/
[Accessed 04 07 2016].

HELP, 2016. *Proud Supporters.* [Online]
Available at: http://helpauckland.org.nz/get-involved/proud-supporters
[Accessed 07 04 2016].

HELP, 2016. *Sexual Abuse Statistics.* [Online]
Available at: http://helpauckland.org.nz/get-info/statistics
[Accessed 05 07 2016].

HELP, 2016. *We Can Keep Safe.* [Online]
Available at: http://helpauckland.org.nz/services/we-can-keep-safe/existing-initiatives-preeschool
[Accessed 04 07 2016].

Human Capital Research Collaborative, 2015. *Midwest CPC Expansion.* [Online]
Available at: https://humancapitalrc.org/midwest-cpc/midwest-cpc-expansion
[Accessed 05 07 2016].

Human Capital Research Collaborative, 2016. *About CPC - History of the Child-Parent Centers.* [Online]
Available at: https://www.humancapitalrc.org/midwest-cpc/about-cpc
[Accessed 05 07 2016].

Human Capital Research Collaborative, 2016. *About CPC - History of the Child-Parent Centers.* [Online]
Available at: https://www.humancapitalrc.org/midwest-cpc/about-cpc
[Accessed 05 07 2016].

Kautz, T. et al., 2014. *Fostering and measuring skills: improving cognitive and non-cognitive skills to promote lifetime success,* s.l.: OECD.

Kidpower, Teenpower and Fullpower Trust, 2013. *About Kidpower NZ.* [Online]
Available at: http://www.kidpower.org.nz/about
[Accessed 04 07 2016].

Kidpower, Teenpower and Fullpower Trust, 2013. *Kidpower.* [Online]
Available at: http://www.kidpower.org.nz/kidpower
[Accessed 04 07 2016].

Kidpower, Teenpower and Fullpower Trust, 2013. *Supporters.* [Online]
Available at: http://www.kidpower.org.nz/supporters
[Accessed 04 07 2016].

Kidpower, Teenpower and Fullpower Trust, n.d.. *Kidpower NZ Pilot - Evaluation Report.* [Online]
Available at:
http://www.kidpower.org.nz/content/evaluation_KIDPOWER%20NZ%20Summary2.pdf
[Accessed 04 07 2016].

Lamont, A. & Price-Robertson, R., 2013. *Risk and protective factors for child abuse and neglect.* [Online]
Available at: https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect
[Accessed 05 07 2016].

Landers, C., 2013. *Preventing and Responding to Violence, Abuse, and Neglect in Early Childhood: A Technical Background Document,* New York: Child Protection Section, UNICEF.

MacMillan, H., 2004. *Preventing Child Maltreatment.* [Online]
Available at: http://www.child-encyclopedia.com/maltreatment-child/according-experts/preventing-child-maltreatment
[Accessed 04 07 2016].

Mardani, J., 2010. *Preventing child neglect in New Zealand: A public health assessment of the evidence, current approach, and best practice guidance,* s.l.: Office of the children's commissioner.

McLanahan & Butchart, 2009. *The Future of Children - preventing Child Maltreatment,* s.l.: Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution.

McLanahan & Butchart, 2009. *The future of children: preventing child maltreatment,* s.l.: Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution.

McPhillips, K., Berman, S., Olo-Whaanga, E. & McCully, K., 2002. *Preventing sexual violence: a vision for Auckland/Tamaki Makaurau,* s.l.: ACC and Auckland Sexual Abuse HELP.

Mersky, J. P., Topitzes, J. D. & Reynolds, A. J., 2011. Maltreatment prevention through early childhood intervention: A confirmatory evaluation of the Chicago Child-Parent Center pre-school programme. *Children and Youth Services Review,* 33(8), pp. 1454-1463.

Methodist Mission, 2009. *Child Development - Ages & Stages.* [Online]
Available at: http://toah-nnest.org.nz/images/pdfs/ChildDevelopmentAgeandStages.pdf
[Accessed 05 07 2016].

Ministry of Justice, 2012. *http://www.justice.govt.nz/policy/constitutional-law-and-human-rights/human-rights/international-human-rights-instruments/international-human-rights-instruments-1/convention-against-torture/united-nations-convention-against-torture-and-other-cruel-inhuman,* s.l.: s.n.

Ministry of Justice, 2015. *New Zealand Crime and Safety survey 2014,* s.l.: s.n.

Ministry of Social Development, 2005. *Outcome / impact evaluation of Family Start: Final report.* [Online]
Available at: http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/evaluation/outcome-impact-family-start/
[Accessed 05 07 2016].

Ministry of Social Development, 2012. *Early start - nine year follow up,* s.l.: s.n.

Ministry of Social Development, n.d.. *Predictive Modelling.* [Online]
Available at: http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/predicitve-modelling/
[Accessed 05 07 2016].

Ministry of Women's Affairs, 2013. *Current thinking on primary prevention of vioelence against women,* s.l.: s.n.

National Institute of Justice, 2012. *Program Profile: Child–Parent Center Program (Chicago, Ill.).* [Online]
Available at: https://www.crimesolutions.gov/ProgramDetails.aspx?ID=292
[Accessed 05 07 2016].

Nelson, G. & Caplan, R., 2014. The Prevention of Child Physical Abuse and Neglect: An Update. *Journal of Applied Research on Children: Informing Policy for Journal of Applied Research on Children: Informing Policy for,* 5(1).

New Zealand Family Violence Clearinghouse, 2015. *MSD trials Predictive Risk Modelling.* [Online]
Available at: https://nzfvc.org.nz/news/msd-trials-predictive-risk-modelling
[Accessed 05 07 2016].

New Zealand Government, 2012. *Children's Action Plan: Identifying, Supporting and Protecting Vulnerable Children.,* s.l.: s.n.

New Zealand Government, 2012. *The White Paper for Vulnerable Children, Volume ii. ,* s.l.: s.n.

New Zealand Police, 2007. *Police launch All about Me - Toku Ahuatanga Whanui.* [Online]
Available at: http://www.police.govt.nz/news/release/2927
[Accessed 04 07 2016].

NSPCC, 2016. *Coping with Crying.* [Online]
Available at: https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/coping-with-crying/
[Accessed 04 07 2016].

Olds, D., 2010. The Nurse-Family Partnership. In: R. Haskins & W. S. Barnett, eds. *Investing in Young Children: New Directions in Federal Preschool and Early Childhood Policy.* s.l.:(Brookings and NIEER.

Orr, A., 2012. *Chicago Child Parent Center.* [Online]
Available at: http://centerforeducation.rice.edu/slc/LS/CCPC.html
[Accessed 05 07 2016].

Parents as Teachers, 2007. *Parents as Teachers: A Child Abuse and Neglect Prevention Program.* [Online]
Available at: http://jfs.ohio.gov/OCTF/Parents-as-Teachers-Fact-Sheet.pdf
[Accessed 04 07 2016].

Parents as Teachers, 2011. *Parents as Teachers Logic Model.* [Online]
Available at:
http://www.parentsasteachers.org/images/stories/documents/LogicModel_Web.pdf
[Accessed 04 07 2016].

Parents as Teachers, 2013. *Guide to Funding.* [Online]
Available at:
http://www.parentsasteachers.org/images/stories/documents/GuidetoFunding_2013.pdf
[Accessed 04 07 2016].

PCIT, 2016. *PCIT Around the World.* [Online]
Available at: http://www.pcit.org/pcit-around-the-world.html
[Accessed 04 07 2016].

Pitts, C., 2015. *Child sexual abuse prevention programs for pre-schoolers: A synthesis of current evidence,* Sydney: Royal Commission into Institutional Responses to Child Sexual Abuse.

Point Research Limited, 2012. *An evaluation of the "We Can Keep Safe" personal safety programme.,* s.l.: s.n.

Point Research, 2014. *Sexual violence primary prevention literature review,* s.l.: ACC.

Prinz, R., 2009. Population-based prevention of child maltreatment: the U.S. Triple P System population trial.. *Prevention Science, 10(1),* p. 1−12..

Promising Practices Network, 2008. *Programs that work: Child-Parent Centers.* [Online]
Available at: http://www.promisingpractices.net/program.asp?programid=98
[Accessed 05 07 2016].

Reynolds, A. J., Mathieson, L. C. & Topitzes, J. W., 2009. Do early childhood interventions prevent child maltreatment? A review of research. *Child Maltreat,* p. 14: 182.

Reynolds, A. J. et al., 2011. Age-26 Cost-Benefit Analysis of the Child-Parent Center Early Education Program. *Child Development,* 82(1).

Reynolds, A. R. D., 2003. School–Based Early Intervention and Later Child Maltreatment in the Chicago Longitudinal Study. *Child Developmen,* Volume Vol. 74 Issue 1, pp. p3-26.

Ronan, K., Canoy, D. F. & Burke, K. J., 2009. Child maltreatment: Prevalence, risk, solutions, obstacles. *Australian Psychologist,* 44(3), pp. 195-213.

Sarno, J. A. & Wurtele, S. K., 1997. Effects of a personal safety program on preschoolers' knowledge, skills, and perceptions of child sexual abuse. *Child Maltreatment,* Volume 2.

SEEK, 2016. *Seek Overview.* [Online]
Available at: http://www.seekwellbeing.com/#!seek-overview/w98nk
[Accessed 04 07 2016].

Sowry, R., 1998. *First family start contract signed.* [Online]
Available at: https://www.beehive.govt.nz/release/first-family-start-contract-signed-0
[Accessed 05 07 2016].

Stith, S. M. et al., 2009. Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior,* 14(1), pp. 13-29.

Superu, 2014. *Effective parenting programme vulnerable children,* Wellington: Families Commission.

Superu, 2015. *Improving outcomes for children of gang-involved parents,* s.l.: s.n.

Triple P, n.d.. *Benefits of Triple P.* [Online]
Available at: http://www.triplep.net/glo-en/find-out-about-triple-p/benefits-of-triple-p/
[Accessed 04 07 2016].

Triple P, n.d.. *The world of Triple P.* [Online]
Available at: http://www.triplep.net/glo-en/find-out-about-triple-p/the-world-of-triple-p/
[Accessed 04 07 2016].

Triple P, n.d.. *Train your staff - population approach.* [Online]
Available at: http://www.blueprintsprograms.com/funding/triple-p-system
[Accessed 04 07 2016].

Turner, M., 2006. *Evaluation of Family Help Trust Twelve-Month Outcomes,* Christchurch: Family Help Trust .

U.S Department of Health & Human Services, 2008. *1306.21 Staff qualification requirements.* [Online]
Available at:
https://eclkc.ohs.acf.hhs.gov/hslc/standards/hspps/1306/1306.21%20%20Staff%20qualifi

cation%20re-quirements..htm
[Accessed 04 07 2016].

U.S Department of Health & Human Services, 2014. *Head Start Program Facts Fiscal Year 2014.* [Online]
Available at: https://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets/2014-hs-program-factsheet.html
[Accessed 04 07 2016].

U.S. Department of Health & Human Services, 2008. *Child Maltreatment,* s.l.: s.n.

U.S. Department of Health & Human Services, 2015. *Implementing Healthy Families America.* [Online]
Available at: http://homvee.acf.hhs.gov/Implementation/3/Healthy-Families-America--HFA-/10/2/#ModelImplementation-StaffingRequirements
[Accessed 04 07 2016].

U.S. Department of Health and Human Services, 2010. *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress, Executive Summary.,* Washington DC: U.S. Department of Health and Human Services, Administration for Children and Families.

University of Maryland Medical Center, 2016. *SEEK Project.* [Online]
Available at: http://umm.edu/programs/childrens/services/child-protection/seek-project
[Accessed 04 07 2016].

University of Maryland, 2015. *Seek Overview.* [Online]
Available at: http://safeenveverykid.wix.com/seek#!seek-overview/w98nk
[Accessed 08 06 2016].

University of Minnesota, n.d.. *The Child-Parent Center Program and Study.* [Online]
Available at: http://www.cehd.umn.edu/icd/research/cls/ch2.html
[Accessed 04 07 2016].

Universtiy of Maryland, 2015. *Evaluating the Implementation and Effectiveness of the Safe Environment for Every Kid (SEEK) Model.* [Online]
Available at: http://safeenveverykid.wix.com/seek#!evaluation/ke4ya
[Accessed 08 06 2016].

Universtiy of Maryland, 2015. *The SEEK Model.* [Online]
Available at: http://safeenveverykid.wix.com/seek#!theseekmodel/c1ua6
[Accessed 08 06 2016].

Vaithianathan, R., 2012. *Vulnerable Children: Can administrative data be used to identify children at risk of adverse outcomes?,* s.l.: University of Auckland.

Walters, H. B., 2008. *An Introduction to Use of Self in Field Placement.* [Online]
Available at: http://www.socialworker.com/feature-articles/field-placement/An_Introduction_to_Use_of_Self_in_Field_Placement/
[Accessed 07 05 2016].

Washington State Institute for Public Policy, July 2008. *Evidence based programs to prevent children from entering and remaining in the child welfare system,* s.l.: s.n.

WHO, 2010. *Violence prevention the evidence,* Geneva: WHO Press, World Health Organization.

WHO, 2013. *European report on Preventing Child Maltreatment,* s.l.: WHO Regional Office for Europe.

WHO, 2014. *Child maltreatment.* [Online]
Available at: http://www.who.int/mediacentre/factsheets/fs150/en/
[Accessed 05 07 2016].

WHO, 2014. *Child maltreatment.* [Online]
Available at: http://www.who.int/mediacentre/factsheets/fs150/en/
[Accessed 05 07 2016].

WHO, n.d.. *Child Maltreatment.* [Online]
Available at: http://www.who.int/topics/child_abuse/en/
[Accessed 05 07 2016].

Wilkins, N. et al., 2014. *Connecting the dots:An Overview of the Links Among Multiple Forms of Violence,* s.l.: Centers for Disease Control and Prevention.

Woodley, A. & Metzger, N., 2012. *An evaluation of the "We Can Keep Safe" personal saftey programme,* Auckland: Point Research Limited.

Appendix 1 – Theoretical foundations

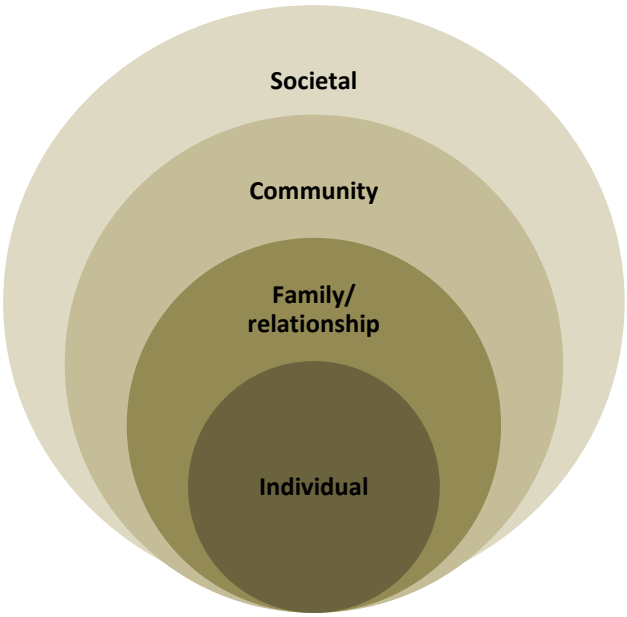
Key theoretical concepts

The socio-ecological framework of family violence

ACC adopts a socio-ecological perspective for the violence portfolio, applying this as a lens for consideration of related policy interventions and prevention programme development.

A socio-ecological model (as illustrated in Figure 3 below) conceptualises violence as the outcome of complex interactions at four levels (Ministry of Women's Affairs, 2013). There are processes of reciprocal interaction that progressively become more complex between children and all levels of environmental influences. This process is affected by relations a child experiences within and between these settings, informal as well as formal.

Figure 3: The socio-ecological model of violence and violence prevention



Source: Adapted from work on the ecological model developed by Bronfenbrenner (Jul 1977) cited in Ministry of Women's Affairs (2013)

Table 12: Definitions for the four domains in the socio-ecological model of violence

Domain	Definition
Individual	The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Prevention strategies at this level are often designed to promote attitudes, beliefs and behaviours that ultimately prevent violence.
Family/ relationship	The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members influence their behaviour and contribute to their range of experience. Prevention strategies at this level include programmes designed to reduce conflict, foster problem solving skills, and promote healthy relationships.
Community	The third level explores the settings (such as schools, workplaces, and neighbourhoods) in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level are typically designed to impact the social and physical environment, for example, by reducing social isolation.
Societal	The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the social policies that help to maintain (or reduce) economic or social inequalities between groups in society.

Source: (Centers for Disease Control and Prevention, 2016)

Classification of the types of prevention programme

Theories and practices used by professionals working within this field have built upon models developed in other disciplines, including public health, education and mental health. Whilst all disciplines have been useful in guiding frameworks and practices, the field of public health is considered the most influential in prevention of child maltreatment.

Programmes for prevention of child maltreatment can be divided into primary, secondary and tertiary prevention intervention models. Models developed from different perspectives lead to varying interpretations and definitions (which means there are inconsistencies in terminology, approaches to analysis of evidence literature and development of different definitions).

We have adopted a public health perspective leading to the following definitions:

- **Primary prevention:** aims to prevent child maltreatment before it ever occurs;
- **Secondary prevention:** refers to the immediate responses after child maltreatment has occurred, to deal with the short-term consequences of violence
- **Tertiary prevention:** seeks to minimise the harm resulting from child maltreatment that has already occurred, with a focus on long term prevention.

In turn, interventions can also be classified as to the target group upon which the programme is focussed upon. They can adopt either a (Child Welfare Information Gateway, n.d.):

1. **Universal approach:** which seeks to reach populations of children/families *regardless of their level of risk exposure* (i.e. a 'general population' target group);
2. **Selective approach** which focuses on individuals/families who are thought to have an *increased level of risk exposure to CAN or CSA*; or an
3. **Indicated approach** which is an intervention aimed at individuals or families in which child maltreatment has already occurred.

Appendix 2 – Search strategy

Search terms used for this review were:

- AB (child abuse OR child neglect) AND KW (prevent* OR program* OR strategy)
- AB (abuse OR neglect) AND KW (prevent* OR program* OR strategy) AND AB (preschool OR (early childhood) OR kindergarten)
- AB (abuse OR neglect) AND KW (prevent* OR program*) AND AB (preschool OR (early childhood) OR kindergarten)
- AB (abuse OR neglect) AND KW (prevent* AND program*) AND AU (preschool OR (early childhood) OR kindergarten)
- SU (abuse OR neglect) AND AB (prevent* AND program*) AND TX (preschool OR early childhood OR kindergarten)
- SU (abuse OR neglect) AND TX (prevent* AND program*) AND TX (preschool OR early childhood OR kindergarten)
- SU (abuse OR neglect) AND AB (prevent* AND program*) AND AB (preschool OR early childhood OR kindergarten)
- SU (child sexual abuse) AND AB (prevent* AND program*) AND AB (preschool OR early childhood OR kindergarten)
- SU (child abuse OR child neglect) AND AB (evaluat* OR assess*) AND AB (prevent* OR program*)
- SU (child abuse OR child neglect) AND AB (evaluat* OR assess*) AND AB prevent*
- SU (child abuse OR child neglect) AND AB (evaluat* OR assess*)
- SU (child abuse OR SU child neglect) AND (AB evaluat* OR AB assess*)
- SU (child abuse OR SU child neglect) AND AB evaluat* AND AB assess*
- SU child abuse AND TX program* AND TX early childhood
- SU child abuse AND TX program* AND TX preschool
- SU child abuse
- preschool AND program* AND prevent* AND abuse
- (early childhood) AND program* AND prevent* AND abuse
- (early childhood) AND program* AND prevent* AND abuse AND (evaluat* or assess*)
- early childhood program* prevent* abuse (evaluat* OR assess*)
- DE (sex crimes - prevention) AND DE (child abuse OR child neglect)
- DE (crime prevention programs) AND DE (human services programs) and DE (child abuse OR child neglect)
- DE (prevention of child abuse)
- DE (child AND sexual AND abuse AND prevention)

* some terms may have been used across different descriptor fields

The search terms were used in the following databases:

- Ebsco Business Source Premier
- Proquest Research Library
- ABI/Inform Global
- Google Scholar
- JSTOR
- PubMed/NCBI
- Science Direct
- Taylor & Francis Online

Key source websites were:

aifs.govt.au	Australian Institute of Family Studies
apo.org.au	Australian Policy Online
australia.cochrane.org	Cochrane Australia
baspcan.org.uk	British Association for the Study & Prevention of Child Abuse & Neglect (UK)
childabuseroyalcommission.gov.au	Royal Commission into Institutional Responses to Child Sexual Abuse (Australia)
childmatters.org.nz	Child Matters
childrensactionplan.govt.nz	Children's Action Plan
childtrends.org	Child Trends (US)
childwelfare.gov	Child Welfare Information Gateway A service of the Children's Bureau, Administration for Children and Families, Department of Health and Human Services (US)
communities.qld.gov.au	Department of Communities, Child Safety and Disability Services, State of Queensland (Australia)
coe.int	Council of Europe (The Lanzarote Convention)
esr.cri.nz	Institute of Environmental Science and Research
justice.govt.nz	Ministry of Justice
kidshealth.org.nz	Kids Health, A joint initiative between the Paediatric Society of New Zealand and Starship Foundation
nzfvc.org.nz	The New Zealand Family Violence Clearinghouse
msd.govt.nz	Ministry of Social Development, including Child, Youth & Family
nationalcac.org	National Children's Advocacy Center (US)
ncjrs.gov	National Criminal Justice Reference Service (US)
nctsn.org	National Child Traumatic Stress Network (US)
nspcc.org.uk	National Society for the Prevention of Cruelty to Children (UK)

oecd.org/els/social/childwellbeing	OECD - Doing better for children
occ.org.nz	Office of the Children's Commissioner
rcfv.com.au	Royal Commission into Family Violence (Australia)
un.org	United Nations, including UNICEF
who.org	World Health Organization

Appendix 3 – Comparative effect sizes for risk factors

Tables extracted from Stith, S. M. et al., 2009. Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior,* 14(1), pp. 13-29.

	d	CI	*r*	Q^w	*k*	*N*
Microsystem: parent–child interaction/parental report of child behavior						
Parent perceives child as problem	.62	.53/.71	.30***	57.68***	25	3317
Unplanned pregnancy	.58	.28/.89	.28***	.31	2	1490
Parent–child relationships	−.55	−.66/−.45	−.27***	117.68***	32	1624
Parent use of corporal punishment	.55	.38/.72	.26***	4.65	7	703
Parenting behaviors	.34	.24/.44	.17***	130.85***	25	2956
Stress over parenting	.15	.00/.30	.07***	51.14***	11	2075
Microsystem: parent characteristics independent of the child						
Anger/hyper-reactivity	.72	.47/.97	.34***	14.25*	9	345
Anxiety	.60	.41/.79	.29***	4.39	8	563
Psychopathology	.59	.48/.69	.28***	62.21***	13	8630
Depression	.55	.45/.67	.27***	46.18***	14	8258
Self-esteem	−.50	−.64/−.36	−.24***	32.92***	11	2485
Poor relationship with own parents	.44	.34/.54	.22***	20.38*	11	2997
Parent experienced childhood abuse	.44	.34/.54	.21***	78.55***	15	3722
Criminal behaviors	.42	.24/.60	.21***	.66	4	1963
Personal stress	.39	.29/.49	.19***	50.74***	22	3114
Social support	−.36	−.45/−.28	−.18***	65.32***	20	10,315
Alcohol abuse	.34	.19/.50	.17***	8.06*	3	654
Unemployment	.30	.19/.42	.15***	29.57***	8	1263
Parent coping and problem-solving skills	−.27	−.52/−.02	−.14*	7.54*	4	303
Single parenthood	.24	.19/.30	.12***	108.23***	22	14,223
Parent age	−.20	−.26/−.14	−.10***	234.05***	31	12,136
Drug abuse	.16	.01/.32	.08*	2.18	3	654
Health problems	.22	−.01/.45	.11	3.17	3	286
Parent gender	.13	−.03/.30	.07***	.10	2	7309
Approval of corporal punishment	.09	−.11/.30	.05	5.65	5	1674
Microsystem: child characteristics, excluding parents						
Child social competence	−.53	−.64/−.42	−.26***	27.46*	14	1527
Child externalizing behaviors	.47	1.39/.54	.23***	135.69***	31	2874
Child internalizing behaviors	.31	.22/.40	.15***	50.62***	23	2282
Child gender	.08	−.04/.19	.04	6.10	13	1702
Prenatal or neonatal problems	.08	−.03/.19	.04	15.34	10	1432
Child disability	.02	−.20/.24	.01	.8	4	325
Child age	−.05	−.14/.04	−.02	12.63	14	3332
Microsystem: family characteristics						
Family conflict	.54	.54/1.15	.39***	16.02*	5	170
Family cohesion	−.68	−.98/−.38	−.32***	3.02	5	183
Spousal violence	.46	.31/.61	.22***	3.82	5	773
Marital satisfaction	−.32	−.47/−.90	−.16***	14.45*	8	840
Family size	.31	.24/.38	.15***	65.53***	23	11,224
Socio-economic status	−.28	−.36/−.20	−.14***	41.45***	16	10,321
Non-biological parent in home	−.05	−.28/.17	−.03	3.25	3	302

*$p<.05$; **$p<.01$; ***$p<.001$.

Note. *d* = *d*-value (numerical representation of the relationship between two risk factors corrected for sample size expressed in standard deviation units); CI = Confidence Interval; *r* = effect size expressed as correlation; Q^w = homogeneity within; *k* = number of effect sizes; *N* = sample size.

	d	CI	r	Q^w	k	N
Microsystem: parent–child interaction/parental report of child behavior						
Parent–child relationships	−1.09	−1.31/−.86	−.48***	58.16***	11	400
Parent perceives child as problem	.91	.46/1.36	.41***	4.91	4	87
Parenting behaviors	.37	.24/.50	.18***	32.54***	8	1016
Stress over parenting	.29	.05/.53	.14**	40.82***	4	307
Microsystem: parent characteristics independent of the child						
Personal stress	.81	.60/1.02	.38***	24.84***	3	386
Anger/hyper-reactivity	.74	.42/1.06	.35***	1.98	3	211
Self-esteem	−.69	−.99/−.38	−.33***	1.98	4	184
Psychopathology	.52	.39/.66	.25***	14.45*	8	7652
Unemployment	.51	.35/.67	.25***	8.69*	4	719
Depression	.42	.32/.53	.21***	15.93*	8	8207
Poor relationship with own parents	.39	.25/.54	.19***	15.40*	7	855
Social support	−.33	−.43/−.24	−.16***	55.11***	13	8582
Parent experienced childhood abuse	.31	.17/.45	.15***	25.21***	6	1417
Parent age	−.25	−.36/−.13	−.12***	19.94*	9	8120
Single parenthood	.16	.03/.28	.08***	13.41	9	7751
Microsystem: child characteristics, excluding parents						
Child social competence	−.62	−.81/−.43	−.30***	10.03	7	584
Child externalizing behaviors	.45	.31/.58	.22***	35.37**	17	956
Child internalizing behaviors	.22	.08/.36	.11***	48.22***	11	922
Child gender	.03	−.17/.22	.01	.28	5	961
Child age	−.02	−.23/.19	−.01	13.49	8	369
Microsystem: family factors						
Family size	.54	.45/.64	.26***	75.19***	12	8546
Socio-economic status	−.39	−.51/−.28	−.19***	36.29***	10	7986

*$p<.05$; **$p<.01$; ***$p<.001$.

Note. d = d-value (numerical representation of the relationship between two risk factors corrected for sample size expressed in standard deviation units); CI = Confidence Interval; r = effect size expressed as correlation; Q^w = homogeneity within; k = number of effect sizes; N = sample size.

Appendix 4 – Evidence for robustly evaluated initiatives

Table 13: Summary of evidence relating to effective and robustly evaluated primary prevention initiatives targeted at pre-school children

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Universal programmes					
The safe environment for every kid (SEEK) model Implemented in the US targeted at children between 0-5 years.	The programme offers a practical approach to the identification and management of targeted risk factors for child maltreatment for families with children aged 0-5, integrated into paediatric primary care (Superu, 2014).	Subject to two RCTs, the programme has shown promising results by reducing maltreatment reports, harsh parenting, and improving immunisation. (Superu, 2014)	Funded by the Office on Child abuse and Neglect US DHHS, the Centre for Disease Control & Prevention, and the Doris Duke Foundation (University of Maryland Medical Center, 2016)	Paediatricians, with training on how to briefly assess and help address targeted psychosocial problems, for instance by applying motivational interviewing techniques (University of Maryland Medical Center, 2016).	There is much interest in implementing the SEEK model across the US as well as internationally. However, some suggest that the evidence is not enough to taking the model to scale (Dubowitz, 2014).
Triple P (Positive Parenting Programme) Developed in Australia and implemented across multiple countries (including NZ); targeting children between 0-16 years (Triple P, n.d.; WHO, 2013).	Triple P is one of the most widely used parenting programmes. It aims to strengthen parents' skills, knowledge and confidence and reduce child problem behaviours, targeting five developmental levels from infancy to adolescence, offering various levels of support ranging from universal media messages to intensive parent training and being delivered in a variety of settings (WHO, 2013).	Most evaluations have focused on child behaviour outcomes rather than child maltreatment. However, one U.S study used a geographical randomisation methodology to estimate the impacts of Triple-P on child maltreatment. Large effect sizes were found for three independently derived population indicators: substantiated child maltreatment, child out-of home placements, and child maltreatment injuries (Prinz, 2009; WHO, 2013).	State and local funding has been used to support many components of Triple P. It has been funded by local school districts when used in schools, by the health sector when offered in hospitals and primary care clinics, by social services in the family resource centre arena and by mental health funding for community mental health clinics (Blueprint, n.d.).	Staff could include family workers, social workers, psychologists, doctors, nurses, school counsellors and teachers. Triple P offers staff training courses depending on the delivery mechanism (Triple P, n.d.).	Triple P is used in 25 countries around the world – in situations ranging from individual healthcare or educational practitioners delivering directly to their own clients, to county, council, state or national governments training workforces to deliver Triple P in tailored or population-based rollouts (Triple P, n.d.).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Abusive head trauma education programme in New York State Similar programmes exist across multiple countries (including NZ) and targets parents of infants.	The intervention was introduced (in 1998) to hospitals providing maternity care in western New York State, providing information to all new parents (including fathers or father-figures wherever possible) on the dangers of shaking their baby and on alternative strategies for dealing with persistent crying (Dias, 2005).	Used randomised telephone interviews with participants and compared results with state wide incidence rates in the control group, Pennsylvania. The programme was associated with a 47% reduction in the incidence of abusive head trauma injuries over the 5.5 year study period (1996 – 2002), with no comparable reduction seen in control group (Dias, 2005).	This research was supported by grants from the New York State (William B. Hoyt Memorial) Trust Fund, the Matthew Eappen Foundation, and WNY health insurers (Blue Cross/Blue Shield of Western New York, Independent Health, and Univera Healthcare) (Dias, 2005).	Administered by trained nurses. The programme provided a 1-hour training session for nurse managers from these hospitals during an annual, regional, perinatal outreach conference, emphasizing the dangers of violent infant shaking, discussing the programme methods, and providing a short set of written instructions to train the nurses on their units (Dias, 2005).	Large potential in being taken up to scale, see for instance Centers for Disease Control and Prevention (2010).
The Coping with Crying programme Targets parents of infants in the UK.	The intervention included showing a psycho-educational film, designed to help all expectant and new parents cope with their babies crying, and to reduce the incidence of non-accidental head injuries (NAHI) in infants in the UK. A pilot study was carried out in 2012, where the film was introduced in 24 hospitals and birthing units across England, Wales, Scotland and Northern Ireland. Each hospital agreed to show it for a period of at least two years. During this time period, over 41,000 parents saw the film (Coster, et al., 2016).	A quasi experimental mixed methods approach was used to evaluate a pilot of the programme. Evidence from the qualitative evaluation and the quantitative survey suggests that, during times of stress, parents were reacting in a positive way to their infant crying and were seeking help when it was necessary. Moreover, the evaluation's findings show that the film is engaging to parents and there is a high degree of recall. There is evidence that it has a positive impact on knowledge, attitudes and behaviour, which suggests that the programme is an effective tool in educating parents about crying and non-accidental head injury (Coster, et al., 2016).	The film was created and funded by NSPCC (leading children's charity in the UK) (NSPCC, 2016).	Venues where the film was shown included children's centres, clinics, hospitals and at the parent's home. It was shown by midwives, health visitors and children's centre staff, as well as other professionals or volunteers working in health or children's services (Coster, et al., 2016).	Large potential in being taken up to scale. The authors undertaking the evaluation recommend the programme to be shown at routine appointments, in order to reach as many parents as possible (Coster, et al., 2016).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Parents as Teachers (PAT) (0–3 years) Initiated in the USA, and then implemented in other countries, including NZ	PAT is a parent education, family support and school readiness programme for parents from pregnancy until kindergarten (Superu, 2014). The four goals are: (1) increase parent knowledge of early childhood development and improve parenting practices, (2) provide early detection of developmental delays and health issues, (3) Prevent child abuse and neglect and (4) increase children's school readiness and school success (Parents as Teachers, 2011). PAT is a universal model as it serves all families regardless of their risk levels, but can also serve as a secondary prevention programme at times. Examples include programmes specifically for adolescent parents, families living in poverty, and young military families living in stressful situations (Parents as Teachers, 2007).	PAT is regarded as an evidence based programme and has been shown to result in improvements in child development outcomes. Some research provides support in reducing child maltreatment. Potential abuse includes number of injuries and ingestions treated. In one RCT in an urban community, children at age three were more likely to be fully immunized and less likely to be treated for injury in the previous year. Furthermore, PAT families had fewer documented cases of abuse and neglect in comparison to the state average, based on the "Second Wave" study which examined 400 families enrolled in 37 diverse school districts across Missouri (Parents as Teachers, 2007).	Programmes offering Parents as Teachers services are supported by a wide range of funding sources including state, local and federal government agencies, private foundations and corporate supporters (Parents as Teachers, 2013).	Initial training and ongoing professional development build parent educators' core competencies in the following areas: (1) family support and parenting education, (2) child and family development, (3) human diversity within family systems, (4) health, safety, and nutrition and (5) relationships between families and communities (Parents as Teachers, 2011).	Supports hundreds of thousands of families in all 50 states as well as many other countries. In New Zealand, the Parents as First Teachers (PAFT) programme is based on the US PAT (Superu, 2014).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Selective programmes					
Early Start Based in Christchurch, NZ and targets families with children under five years.	The New Zealand Early Start programme is aimed at vulnerable Christchurch families caring for children under five years of age. Risk factors evident in families involved with Early Start include domestic, family or intimate partner violence and parental substance abuse (Superu, 2014).	Early Start has been subject to one RCT, where the treatment group, when compared to the control group, showed smaller percentage of parental reports of the use of severe physical assault. At the nine-year follow up, the treatment group had a smaller percentage of visits to the hospital for accident or injury; a smaller percentage of parent-reported harsh punishment; a lower score for physical punishment; and a smaller percentage of agency contacts for physical child abuse, among others (Superu, 2014).	Funded by the Ministry of Social Development, Canterbury DHB, and the Department of Child, Youth and Family (Early Start, n.d.).	Early Start employs between 17-20 fulltime Family Support Workers/Whanau Awhina. All the clinical staff at Early Start have professional qualifications with backgrounds in either nursing, social work, early childhood education, teaching or other related fields (Early Start, n.d.).	Currently there are 70 families waiting to access the Early Start service and they are funded to provide services to a maximum of 201 families. The current rate of entry shows that it will most likely take 3-5 months before those families waiting are enrolled in the Early Start Programme (Early start, 2016). There is no publicly available information of plans for programme expansion.
Nurse-family partnership (NFP) Implemented in the US and targeting children between 0-2 years.	The target group is vulnerable first-time mothers, such as adolescents, single parents, those of low socioeconomic status or those with little education. Individual parents are visited in the home during the antenatal and postnatal periods by nurses (Superu, 2014).	The NFP programme has been evaluated in three RCTs since its inception in the 1980s. Results include significantly fewer visits to the hospital emergency department, less restriction and punishment of children and a larger number of appropriate play materials, fewer hazards in the home and less avoidable punishment than those in the control group (Superu, 2014; MacMillan, 2004).	NFP can be supported by federal funding streams aimed at promoting healthy development of young children. Many states have allocated general funds to support NFP based on the strong evidence of outcomes and cost/benefit achieved through the model. In addition, the Affordable Care Act made an historic investment in home visiting, allocating $1.5 billion to support states in implementing evidence-based home visiting programmes (Blueprints, n.d.).	Staff comprise specially trained nurses, who receive three training sessions which covers: the history of the programme, the research evidence to support its efficacy, the theoretical and clinical foundations of the programme, the principles of forming effective therapeutic relationships with family members, solution focused therapies, understanding women's stages of readiness for change, issues related to ethnic and racial diversity, the prenatal content, safety issues related to home visiting, the programme protocols and record keeping system (Blueprints, n.d.).	By 2010, the NFP was serving over 20,000 families, and was then likely to grow substantially with the support of health care reform (Olds, 2010). A range of such programmes has been developed following on from the success of the NFP programme developed by David Olds in the US – one example being Early Start in Christchurch (Superu, 2014).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Chicago Child Parent Centres Implemented in Chicago, US, targeting children between 3-9 years (WHO, 2013).	Targets low-income families. It provides preschool education, parent programmes, outreach services and ongoing family support when children enter formal schooling. Preschool education develops children's physical, social, emotional and cognitive skills, including literacy, numeracy and communication, to prepare them for school (WHO, 2013).	A long-term evaluation using a quasi-experimental design found that participating children had lower lifetime rates of child maltreatment (by age 17) measured by court petitions and referrals to child protection services (WHO, 2013). Other long-term effects (measured when the participating children were 24 years) include lower rates of arrest for felonies, lower rates of serious crimes punishable by imprisonment (>1year) compared to the control group (WHO, 2010).	Government-funded (Reynolds, et al., 2011)	Staff includes a team of head teacher, parent resource teacher and a school community representative that aligns and coordinates services and education for students and their families (Chicago Public Schools, 2016).	Established in 1967, the programme has provided comprehensive child and family services from ages 3 to 9 in 25 schools in high-poverty neighbourhoods in the US (Reynolds, et al., 2011).
Healthy Families America – New York (HFNY) Targeting families with children between 0–5 years.	HFA is an intensive parenting programme for parents deemed at risk of child maltreatment. It is delivered by paraprofessionals and involves home visits from pregnancy through to the child's fifth birthday or enrolment in kindergarten or preschool programmes. Home visits focus on promoting healthy behaviours, child development, coping with stress, parenting skills and parental self-sufficiency.	Evaluations of the programme have been undertaken in several sites, with varied results. In New York, for example, mothers in the intervention group reported committing one-quarter as many acts of serious abuse at age 2 as control mothers. There was also evidence of less harsh parenting, and minor physical aggression. Among women who were "psychologically vulnerable," HFNY mothers were one-quarter as likely to report engaging in serious abuse and neglect as control mothers (WHO, 2013; DuMonta, et al., 2008).	Several sources. It was originally funded by Ronald McDonald House Charities (Healthy Families America, 2015).	HFA has four primary staff positions: (1) family support - conduct home visits with families; (2) parent survey - conduct family and child assessments and sometimes screen families for enrolment; (3) supervisors - provide administrative, clinical and reflective supervision to family support and parent survey staff; and (4) programme managers who oversee programme operations, funding, quality assurance, and evaluation. HFA National Office requires that family support and parent survey staff have minimum of a high school diploma. HFA core training is a mandatory four-day seminar delivered by nationally certified HFA trainers (U.S. Department of Health & Human Services, 2015).	HFA has more than 600 affiliated sites across 39 states, the District of Columbia, American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, the U.S. Virgin Islands, and in Canada. (U.S. Department of Health & Human Services, 2015).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Child FIRST (0-5 years) USA	Child FIRST (Child and Family Interagency, Resource, Support, and Training) is a comprehensive, home-based, therapeutic intervention targeting multi-risk young children and families. It was developed to prevent or diminish serious emotional disturbance, developmental and learning disabilities, and abuse and neglect. It is delivered by a professional to individual parents in their homes in 24 weekly sessions (Superu, 2014).	In a recent RCT, Child First mothers had less parenting stress at the six-month follow-up, lower psychopathology symptoms at the 12-month follow-up, and less protective service involvement at three years post-baseline relative to usual care mothers. Families were more connected to services and children showed fewer externalising and language problems (Superu, 2014). Furthermore, Child FIRST families were 33% less likely than control group families to be involved with child protective services for possible child maltreatment during the three years (Coalition for Evidence-Based Policy, n.d.).	Funded through a variety of public and private funding sources (Child First, n.d.).	Child First staff work in teams of a licensed Master's level, Mental Health/Developmental Clinician and a Bachelor's level Care Coordinator. Both must have substantial experience with very young children and with ethnically diverse, challenged families. The Clinician's work with the parent and young child focuses on their relationship, while the Care Coordinator's work focuses on connecting the family with community-based services and supports. Staff must be multi-lingual, reflecting the ethnic composition of the community (Superu, 2014).	Currently, Child First has 15 affiliate programme sites, with 14 implementing agencies, and a total of 40 Child First clinical teams. There is current capacity to serve 1,000 children and their families per year. Child First champions and advocates are working to increase capacity at the affiliate sites (Child First, n.d.). Child First has recently been subject to national replication; with inquiries from over 25 states (Child First, n.d.).
Early Head Start and Head Start (EHS) Implemented across US and targets children up to age three (early head start) and up to age five (head start), and also pregnant women (Fortson, et al., 2016).	This community-based programme targets vulnerable families, aiming to improve the health of pregnant women, encourage child development, provide family support through home-visiting or community center sessions and provide early childhood and parent education (Superu, 2014).	A randomized trial of an Early Head Start programme in the United States found that compared with parents in the control group, participating parents were less likely to report spanking their child in the previous week (WHO, 2010).	The Congress of the United States authorizes the amount of federal spending for Head Start each year (U.S Department of Health & Human Services, 2014).	Head Start teachers' have an associate, bachelor's or advanced degree in early childhood education (ECE). Head Start teachers often major in ECE or child development, with coursework in such areas as early literacy, learning assessment, typical and atypical development, elementary science and math, and expressive arts. Coursework also might include family development, psychology, children's literature, and health and physical development (Bolden-Barrett, n.d.; U.S Department of Health & Human Services, 2008).	Since Head Start was established in 1965, the programme has served more than 32 million children, birth to age 5, and their families. In 2014, Head Start was funded to serve nearly one million children and pregnant women in centres, family homes, and in family child care homes in urban, suburban, and rural communities throughout the nation (U.S Department of Health & Human Services, 2014).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Parent-Child Interaction Therapy (PCIT) Targeting children between 2-7 years. Originating from the US, PCIT has spread to multiple countries around the world, including New Zealand	PCIT is a programme that specifically targets the relationship between parents and their children. Therapists coach parents while they interact with their children, teaching caregivers strategies that will promote positive behaviours in children who have disruptive or externalizing behaviour problem. The intervention is delivered by a professional to individual parent-child dyads in a health setting or at home. (Superu, 2014)	It has been evaluated for families with children aged up to six years at risk of maltreatment or with a history of maltreatment. It has good evidence of effectiveness in reducing child maltreatment and associated risk factors. Participants in PCIT have been shown to have short-term gains in reduced externalising of problems by children, reduced behaviour intensity and reduced stress. A second study found that post-programme, the standard 12-session PCIT group had significantly better results than a waitlist control in children's behaviour problems and intensity, and internalising and externalising behaviour, and in parents' stress, verbalisations and sensitivity. (Superu, 2014)	Funded through a variety of sources including County Funding, Donations, Federal Funding, Grants, Independent Fund Raising, Private Funding, State Funding, United Way Certified Funded, and Workforce Investment Act (Health and Human Services Agency, n.d.).	Staff consists of therapists (Superu, 2014).	Originating from the US, PCIT has spread to multiple countries around the world, including New Zealand (PCIT, 2016). There is no publicly available information of plans for programme expansion.

Appendix 5 – Examples of NZ programmes

Table 14: Examples of child maltreatment primary prevention programmes in New Zealand, with some evidence of effectiveness but subject to less robust evaluation

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Universal programmes					
We Can Keep Safe Based in Auckland. Aimed at children between three to five years.	A proactive child personal safety programme intended to reduce the sexual abuse of children. Prior to the commencement of the programme, parents are invited to a preliminary meeting (Parents' Evening), where the programme is discussed in detail by the educator and where parents have an opportunity to ask questions and have them answered. In addition, parents are encouraged to attend each session. The programme itself consists of five, 45 minute sessions delivered by a specialist educator. Drama, music, movement, storytelling and puppetry are the main methods of delivery, which are augmented by resources such as a resource book (aimed at both parents and children), handouts and take-home activities. The programme is held in early childhood education centres and aims to encourage safe affirming messages about: body awareness, touching and feeling, telling	Evaluation undertaken by Point Research Limited who collected data via 17-20 in depth interviews with parents and children and during programme observations at four early childhood centres within the wider Auckland area during February to May 2011. The evaluation found that after the programme, most of the children could: distinguish between "OK" and "not OK" touches and articulate how these touches would make them feel; articulate strategies for action if someone touched them in a way they didn't like or made them scared or worried; identify at least one trusted adult who they could tell about touching they didn't like; understand that telling a grown up would help keep them safe; identify and use the correct anatomical or widely accepted terms for their genital areas e.g. penis and bottom, and just under half used the words vagina or vulva; articulate the three touching rules e.g. It is okay for you to touch your own penis/vulva/bottom, It is not okay for	Delivered by the Auckland HELP Foundation, which is funded through a number of local businesses, organisations and individuals. Receives no governmental funding (HELP, 2016; HELP, 2016).	The programme is delivered by a specialist educator. No in-depth information of whether staff training is provided (Point Research Limited, 2012).	Delivered in preschools around Auckland to more than 600 children a year. No information on plans of expanding the programme outside of Auckland (Point Research Limited, 2012).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
	and keeping safe in many areas of our lives. It aims to teach this in a fun, age appropriate manner that encourages consistent messages at home and in the classroom (Point Research Limited, 2012).	you to touch someone else's penis/vulva/bottom and it is not okay for someone else to touch your penis/vulva bottom; distinguish between secrets and surprises. Most indicated that they would tell their mum when given a scenario involving a `secret'. These changes were largely sustained at one, six and twelve months, although there is some evidence that this knowledge may start to decrease around one year following the programme (Point Research Limited, 2012).			
Right2BSafe, Phase 2. Hauraki/Coromandel regions Aimed at caregivers and other adults who have contact with children	A campaign to raise awareness about child sexual abuse. The promotion of the campaign included distribution of posters and magnets featuring the champions, regular articles in the areas newspaper and on local radio stations, the placement of billboards of the champions outside major towns in the area, workshops with social service agencies and networks, as well as involving both councils in Thames-Coromandel and Hauraki districts (Arthur, 2013).	An evaluation of phase 2 of the campaign shows success in raising local awareness of child sexual abuse. Almost three-quarters of those members of the public approached in the street surveys in Waihi and Thames were aware of the project, and of these participants half were using, or knew someone who was using at least one strategy to help prevent child sexual abuse. The most frequently identified source of knowledge about the campaign across all the groups surveyed was the newspaper articles that also featured a champion's poster (Arthur, 2013).	Funded by the Ministry of Justice and CAPS Hauraki (Arthur, 2013).	The champions were invited to attend training by Miriam Cessa from Rape Prevention Education in April 2013 to help them deal with any disclosures of sexual abuse they might experience in their role (Arthur, 2013)..	No information on uptake of the campaign beyond the Hauraki/Coromandel regions (Arthur, 2013).
KidPower Available across New Zealand Aims at children between 4-12 years.	Parent and Child workshops where children learn age-appropriate skills that they can use to feel safer and more confident dealing with people. Parents also learn how to continue practicing and	An evaluation was undertaken by Evaluation & Auditing Services Ltd in 2004. It is based on data collected from 845 Children and 32 teachers. Key findings include: the programme is successful in increasing	Funded by a number of sponsors and donors, including governmental bodies such as the Ministry of	Staff training includes two courses: introductory level and comprehensive. This includes teaching	More than 39,500 people have practiced safety skills with the New Zealand Centre since 1993 and

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
	reinforcing these skills. The primary objective is to help children protect themselves from violence (Kidpower, Teenpower and Fullpower Trust, n.d.).	students' confidence and reducing their anxiety; three months following the training, teachers agree that the training has helped the students deal with personal safety issues; three months after the training, children reported that they felt safer as a result of the training (Kidpower, Teenpower and Fullpower Trust, n.d.).	Justice and Auckland Council (Kidpower, Teenpower and Fullpower Trust, 2013).	teachers, childcare providers, counsellors, and other professionals, direct applications of People Safety skills relevant to their own specific work situation (Kidpower, Teenpower and Fullpower Trust, 2013).	hundreds of thousands more have received training for educators, social service agency staff, law enforcement officials, and parents and from our educational resources. Many schools, colleges, the Institute of Technology, outdoor pursuit centers, clubs and community groups etc. contract regularly with the Kidpower Teenpower Fullpower Trust. The instructors travel to bring services to all parts of New Zealand (Kidpower, Teenpower and Fullpower Trust, 2013).
All about Me (AaM) Directed at children attending early childhood education centres, and their parents.	The programme, All about Me, aims to teach young children skills to help keep themselves safe from emotional, physical and sexual abuse, neglect and family violence. The module consists of a	All about Me has been evaluated by the Education Review Office (ERO). As a part of the evaluation, a mixed method approach was used with four key elements: a survey of the services attending training up to April	Partly funded by ACC and the New Zealand Police (New Zealand Police, 2007)	From 6 March 2007 to 30 June 2008, Child Protection Studies delivered training workshops in 44 areas	The programme is no longer available (New Zealand Police, 2007).

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
	teaching guide, materials for parents and resources for children (Education Review Office , 2008).	2008, case studies of services implementing AaM, information from police education officers, and observation of training workshops. The majority of centres responding to ERO's survey believe that there have been increases in various kinds of behaviour relating to the intended learning outcomes of the programme. Centres had most often observed increases in: children saying positive things about themselves, being confident, using correct names for body parts, and taking a more active role in self-help and self-care (Education Review Office , 2008).		to approximately 2000 teachers from 650 centres. The service managers attend a full-day workshop and their staff usually attend a half-day session. The half-day session is intended to provide an overview of issues related to child protection and also an introduction to the AaM resource, whilst the full day workshop is more comprehensive and gives the managers an opportunity to explore the programme and resources in more detail. The full day course also covers steps in introducing the programme to the centre and ways to support staff and engage parents (Education Review Office , 2008).	

Programme	Delivery mechanism	Evidence base	Funding	Core competencies/ training of staff	Scale/plans for programme expansion
Selective programmes					
Family help trust Based in Christchurch Targets pregnant mothers and children under the age of 6 months (Family Help Trust, n.d.; Family Help Trust, n.d.).	Family Help Trust is a long-term home-based early intervention child protection programme designed for pregnant women and their families who are considered ultra-high-risk for child abuse and family dysfunction. When evaluated, Family Help Trust consisted of two services, Safer Families – a programme for high-risk pregnant women with multiple-risk histories, and New Start – a programme which specialises in similar clients with a history of offending For families to be accepted into Family Help Trust, they must show high scores on a series of risk factors (Turner, 2006).	An evaluation from 2006, using data collected from 55 participating families, shows that the programme has potential to make significant improvements in crucial child abuse prevention areas (Turner, 2006).	Funded/sponsored by a number of organisations (Family Help Trust, n.d.).	Family Help Trust use only qualified Social Workers as case managers (Turner, 2006).	Currently no information on expanding beyond Christchurch, however included in their business plan from 2013 is to work with other governmental departments and agencies to expand and promote delivery of services to children at high risk of violence (Family Help Trust, 2012).

Appendix 6 – Risk prediction modelling

Risk prediction modelling – identifying high risk populations for selective interventions

There is a relatively new, yet growing body of research around the use of predictive risk modelling (PRM) that could be applied as a potential method of identifying children and families at risk of experiencing child maltreatment (Vaithianathan, 2012).

Predictive risk modelling (PRM) uses an automated risk scoring tool which harvests data from a variety of sources. It uses historical correlations and patterns to generate a risk score for the occurrence of an adverse event through the use of an algorithm applied over a large administrative data set. PRM is a commonly used tool within the health sector, for instance in predicting the probability of readmissions. Preventative initiatives (such as intensive self-management support for people with chronic disease) can be put in place to reduce the risk of recurring hospital admissions (Vaithianathan, 2012).

Researchers from Auckland University have proposed that the same risk prediction methodology and tools that have been successfully used within the healthcare arena could be applied with equal benefit in other areas of social policy (Vaithianathan, 2012).

Applying PRM techniques to the area of child maltreatment would enable scarce child protection and early intervention preventive resources to be targeted strategically at high-risk populations. Furthermore, appropriate programmes of varying intensity can be tailored to meet the differing requirements of children and caregivers at all levels of risk. The authors have developed a core model which predicts the risk of maltreatment and a separate model which predicts each child's risk of having a substantiated finding of neglect, emotional abuse and/or physical/sexual abuse by age 5 and behavioural problems by age 7. In practice, if a child is found to have a high risk score, a targeted response would be implemented with the aim of preventing child maltreatment (Vaithianathan, 2012; New Zealand Family Violence Clearinghouse, 2015).

Many ethical and practical concerns have been raised about the potential use of PRM, including those associated with: the individualised conception of risk; the stigmatisation of people identified as having high risk scores; the stigmatisation of groups such as Māori and people receiving benefits; the variable quality of the administrative data the model is based on; concerns as to the model's predictive ability; questions about resource allocation; questions about the actions and obligations of agencies in relation to high risk scores; privacy and the use of data without consent; and potential impacts on people's interactions with services and government agencies (New Zealand Family Violence Clearinghouse, 2015).

However, it can be argued that these concerns may be mitigated considerably by appropriate implementation strategies or, indeed, may plausibly be outweighed by the potential benefits of using the tool of PRM in designing and implementing primary prevention programmes for such vulnerable populations (Ministry of Social Development, n.d.).