

Child abuse prevention: what works?

The effectiveness of home visiting programs for preventing child maltreatment

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The purpose of each paper in the National Child Protection Clearinghouse's *Child Abuse Prevention: What Works?* project is to document research concerning the effectiveness of different types of child maltreatment prevention programs. The *Child Abuse Prevention: What Works?* project is comprised of six individual papers, which are based on research undertaken for the Issues in Child Abuse Prevention Paper no. 24 (Holzer, Higgins, Bromfield, Richardson, & Higgins, 2006). The types of programs detailed in the *Child Abuse Prevention: What Works?* project are: parent education programs; home-visiting programs; personal safety programs; community-focused programs (for example, universal media campaigns); therapeutic programs for children; and family preservation programs.

The following paper discusses the effectiveness of home visiting programs in preventing child maltreatment. The authors begin by providing a brief background to home visiting, followed by a more detailed exploration of the components of an effective home visiting program. For a detailed discussion of the different types of child abuse prevention programs (primary, secondary, and tertiary) and their evaluation, see Issues in Child Abuse Prevention Paper No. 24 (Holzer, Higgins, Bromfield, Richardson, & Higgins, 2006).

The term *primary research* refers to the original collection of data, whereas the term *secondary research* relates to the synthesis and analysis of data that have

already been collected. In the case of secondary research, the data may have been collected by another source and possibly for another purpose (Esterberg, 2002). This publication is based on secondary research. Specifically, this paper represents a systematic review of existing research publications in which the effectiveness of home visiting programs were evaluated. The use of systematic literature reviews (or meta-analyses) to determine the nature and extent of the research evidence base in specific areas are widely used in other Western nations (for example, the Cochran's and Campbell collaborations). For further information on conducting systematic literature reviews see Gough and Elbourne (2002)

Home visiting

Home visiting programs, both in Australia and internationally, are diverse and provide a broad range of interventions designed to improve family functioning and/or alleviate the potential for child maltreatment.

The majority of home visiting programs are early intervention services aimed at supporting prenatal women or mothers with young children (see Black, Kemp & Sampson, 2004 for an evaluation of an Australian program, the Karitane Volunteer Home Visiting Program, which uses an early intervention approach and targets a general - rather than an *at-risk* - population). An early intervention approach reflects a greater awareness of the importance of children's development during the first years of life, the importance of the role of the parents in shaping children's early years, and the subsequent impact of these years on the health and development of the child as s/he ages. With increasing recognition of the importance of early intervention, government policies are moving toward increasing home visiting services as a preventative intervention strategy (Vimpani, Frederico, Barclay, & Davis, 1996).

Home visiting can be defined as 'a mechanism for the delivery of a variety of interventions directed at different outcomes' (Bull, McCormick, Swann, & Mulvihill, 2004, p.1). The interventions may be provided to all mothers and their newborn infants, to parents and children with specific problems, to

disadvantaged families, or to families where children are considered to be *at risk*.

Home visiting can be incorporated into a primary prevention intervention strategy, while also having the capacity to cater for the needs of 'at risk' families at the secondary or tertiary level (Vimpani, Frederico, Barclay, & Davis, 1996). Family preservation programs may use an intensive home visiting component over a shorter time frame and work with families to avoid children being placed into care. The home visiting programs reviewed in this paper work with families over the longer term, such as from birth until the child is two years old, and home visitors see the family regularly throughout this period. Programs that target 'at risk' families focus on areas such as parenting skills, parental attitudes and knowledge, parent-child interactions, and strengthening social connectedness. While preventing child abuse is not the focus of many of these services, they may contribute indirectly to reducing incidents of child maltreatment by ameliorating the risk factors associated with the occurrence of child maltreatment. In addition, home visitors may be able to identify families at a heightened risk for child maltreatment and refer them for additional services (Scott, 2005).

A national audit of child abuse prevention programs in Australia, conducted by Vimpani, Frederico, Barclay, and Davis (1996), found that a home visiting component was incorporated into one quarter of all child abuse prevention programs (Tomison & Poole, 2000). The majority of the home visiting services were delivered by non-professional volunteers who relied on back-up support by professionals. However, in Australia, there have been very few evaluations of the effects of home visiting as a preventative strategy for child abuse and neglect, and very little systematic research into the effects of home visiting on reducing the risk of child maltreatment (Tomison & Poole, 2000; Vimpani, Frederico, Barclay, & Davis, 1996).

In a 1996 review of child abuse prevention programs in Australia, one quarter incorporated a home visiting component.

Method

Home visiting programs emphasise maternal and child wellbeing, and aim to achieve these outcomes by providing health, social, and parenting support (Tomison, 1998). In order to determine the effectiveness of home visiting programs in achieving these ends, a systematic literature search was conducted to retrieve home visiting program evaluations.

Home visiting program evaluations were included in the present study if they met all of the following inclusion criteria:

- evaluated a program designed to prevent or treat some aspect of child maltreatment;
- evaluated the *impact* or *outcome* of a particular home visiting program or programs;
- were methodologically rigorous (that is, included a control/ comparison group or measured impact or outcome variables pre- and post-program); and
- were conducted from 1990 onwards.

The databases searched in order to retrieve published evaluations were: ERIC (Educational Resources Information Centre); AF&SA (Australian Family and Society Abstracts); PsychINFO; Australian Education Index; Child Abuse, Child Welfare, and Adoption; and Sociological Abstracts. The search terms used were: 'home visiting' and 'child abuse'. In total, 318 articles were retrieved. However, only fourteen articles concerning home visiting program evaluations met the inclusion criteria for the present study, four of which were meta-analyses.

Do home visiting programs work?

Home visiting programs have the advantage of bringing services into the home rather than requiring families to seek out services within the community. What makes home visiting different from other preventative intervention strategies is that they allow home visitors an opportunity to observe the environment in which families live, identify and tailor services to meet the needs of families, and build relationships in ways that may not be

possible with other forms of preventative strategies (Gomby, Culross, & Behrman, 1999).

Most evaluations of home visiting programs reported some degree of effectiveness. The results of the evaluations included:

- fewer incidents of child maltreatment (where this outcome was directly measured);
- enhanced parental knowledge and parenting skills;
- improvements in children's cognitive and social development; and
- increased linking of parents to health care and other services (see Tables 1-11).

The following ten home visiting programs were evaluated:

- Community Child Health Nurse home visiting program for newborns (Australia, see Table 5);
- The Comprehensive Child Development Program (USA, see Table 9);
- The Cottage Community Care Pilot Project (Australia, see Table 13);
- The Head Start program (USA, see Table 10);
- Healthy Families America (USA, see Table 3);
- The Healthy Start Program (USA, see Table 2 & 4);
- The Home Instruction Program for Preschool Youngsters (USA, see Table 1);
- The Nurse Home Visitation Program (USA, see Table 6, 7 & 8);
- Parents as Teachers (USA, see Table 11); and
- The Teen Parents and Babies Program (USA, see Table 12).

The programs aimed to improve parenting competence and enhance child development. Programs provided parents with education regarding child development and parenting techniques, as well as practical assistance such as linking families to services and social supports. Two programs also aimed to improve circumstances for mothers as well as children, for example by encouraging mothers to defer future pregnancies and return to further education. Interventions were generally directed at low-income families, young mothers and families considered 'at risk' for child maltreatment. Eight programs explicitly aimed to prevent child maltreatment. Two programs

addressed this issue indirectly through improving parenting skills and welfare, which in turn was expected to enhance the welfare of the children.

Of the programs reviewed in this study, none was successful in achieving positive results in relation to *all* program aims. One program (the Nurse Home Visitation Program) was successful in reducing the prevalence of child maltreatment and improving mothers' and children's measurement outcomes on health, wellbeing and behavioural variables. A further three programs were successful in improving parenting skills and had some success in reducing incidents of child maltreatment. Two programs, (which were not designed to reduce child maltreatment) had some success in improving parenting knowledge and skills, and two programs were not effective at all. In a further two programs the evaluations lacked the necessary methodological rigor to determine whether the programs were effective or not.

Evidence regarding the effectiveness of home visiting programs is mixed. Home visiting programs generally meet their operational aims, but not necessarily their underlying goals. That is, home visiting programs have rarely been found to be effective in preventing child maltreatment.

Was the evidence base credible?

In general, the favourable results of a plethora of home visiting evaluations in Australia, Europe and the USA have led to widespread acceptance of claims that home visiting prevention strategies are effective in reducing the potential for child abuse. However the positive results derived from these evaluations were based on a range of research designs, some of which do not give reliable results. Most program evaluations did not utilise randomly assigned control or comparison groups, which provide the strongest and most reliable evidence of a program's effectiveness. Many home visiting programs used less rigorous evaluation methods, such as self-reporting, or comparisons between the participant group and those that withdrew from the program. Thus the positive findings drawn from these program evaluations may not be borne out if the programs were subject to more rigorous evaluation methods (Chaffin, 2004; Gomby, Culross, & Behrman, 1999).

In this study, the ten program evaluations that were reviewed used the following research designs:

- randomised control groups (The Community Child Health Nurse home visiting program for newborns, the Nurse Home Visitation Program, the Healthy Start Program and Parents as Teachers);
- non-randomised control or comparison groups (The Comprehensive Child Development Program, the Home Instruction Program for Preschool Youngsters, the Cottage Community Care Pilot Project and the Teen Parents and Babies program,); and
- pre and post-test comparisons only (Healthy Families America and Head Start).

Of these designs, the evaluation comprising only a pre and post-test comparison of participant data presents the most significant methodological problems. In the absence of a control or comparison group, it is not possible to determine whether the positive findings were a direct result of the program, or whether they would have occurred over time (for example, due to the development of greater insight and maturity or changing circumstances of the participants).

Another significant methodological issue is whether the program evaluations used appropriate outcome measures that enabled researchers to test the effectiveness of the program. For example, the evaluations of the Community Child Health Nurse home visiting program for newborns and the Head Start program used inadequate outcome measures. The evaluation of the Community Child Health Nurse home visiting program for newborns - a program which aims to reduce risk factors for, and incidents of, child maltreatment – did not assess the program’s impact on the incidence of neglect, an area that evaluations of other programs have indicated show some positive impact. Similarly the evaluation of the Head Start program – a program designed to reduce parents’ potential for child abuse – did not contain any child health or wellbeing measures, or measures of child abuse potential such as Milner’s Child Abuse Potential Inventory (Milner, 1994). Thus, researchers are unable to determine whether these programs achieved

more favourable outcomes for children by reducing the occurrence of child maltreatment.

Most home visiting programs are not evaluated using rigorous evaluation methods, so their effectiveness in preventing child maltreatment is unclear.

Many of the studies also had mixed findings in relation to the outcome variables measured. For example, the evaluation of the Head Start program used both quantitative and qualitative evaluation criteria, and only the qualitative data (home visitor reports) indicated an improvement in parenting skills. While this may be the case, it is also possible that home visitors' expectations of improvements may have influenced their beliefs that improvements in parenting skills had taken place.

It may also be difficult to replicate the success of a home visiting program in one community to another geographical area or sub-population, such as applying aspects of successful programs in the USA to an Australian context. Where positive findings were found in one area (such as improvements in infant health) or sub-population, they were not consistently replicated in similar areas or populations in subsequent or similar studies. Further, findings from evaluations of home visiting models indicate inconsistent results, even when their target population and goals were similar. Thus, the findings from one program model cannot be generalised to another (Gomby, Culross, & Behrman, 1999).

Inconsistent findings across programs indicate that the findings from one program model cannot be generalised to another.

What makes a good home visiting program?

The content and style of delivery of home visiting programs are designed to meet specific goals relevant to each program's specific aims and target population. Home visiting programs also differ in how often families are visited, how long they receive the service and the qualifications of staff who implement the service. Home visiting can be a stand-alone intervention, or a component of a broader intervention program that incorporates a range of

strategies directed at meeting the program's goals (Bull, McCormick, Swann, & Mulvihill, 2004; Vimpani, Frederico, Barclay, & Davis, 1996).

The key features of successful programs included:

- programs that targeted an 'at risk' population;
- programs where services were delivered by more highly trained and qualified home visitors;
- programs where home visitors were experienced in dealing with the complex needs of many 'at risk' clients;
- programs of long enough duration to impact upon parenting or risk factors that contribute to child maltreatment;
- programs that matched program designs to the needs of the client group; and
- programs that focussed on improving both maternal and child outcomes.

A successful home visiting program: The Nurse Home Visitation Program (USA)

The Nurse Home Visitation Program (NHVP) was designed to improve maternal health-related behaviours during and after pregnancy (Olds, Henderson, Chamberlin, & Tatelbaum, 1986a). The program targeted families from socioeconomically disadvantaged communities and assisted mothers to develop responsive, engaged and sensitive care giving in the early years of their child's life (for a detailed description, see Tables 6, 7 & 8).

Targeting an 'at risk' population

Programs that targeted families that were 'at risk' of child maltreatment and/or were most socioeconomically disadvantaged, were more likely to have positive results than those that targeted a universal population.

Programs that targeted an 'at risk' population showed some positive results in improving parenting skills and reducing incidents of child maltreatment.

However the programs that showed positive outcomes for 'at risk' populations were not administered to a universal population, so it is

unknown whether a universal population would also have positive outcomes if they received the same services.

This finding suggests that in a climate of limited financial resources, targeting home-visiting services toward 'at risk' families would enable funds to be channelled into programs for populations who will benefit the most, rather than allocating funds to a broader section of the public who may not benefit from the service, and who may be more able to independently access services within the community.

Programs that targeted families who were most 'at risk' of child maltreatment, and /or most socioeconomically disadvantaged were more likely to have positive results.

Who should deliver home visiting programs?

One of the main issues debated by researchers is whether the positive results of some home visiting programs and not others are due to the use of either professionally trained nurses or 'paraprofessionals' (visitors with no professional qualifications but specific training related to their home visiting role) (Gomby, Culross, & Behrman, 1999). Of the above studies, only the Nurse Home Visitation Program in the USA used qualified nurses to conduct home visits. Programs employing paraprofessionals, such as high school graduates or mothers with specific training in their home visiting responsibilities, tended to be less effective. Olds, Robinson, O'Brien, Luckey, Pettitt, Henderson, Ng, Korfmacher, Hiatt and Talmi (2002) argued that the failure of the other programs to meet their intended aims is their use of paraprofessionals, rather than trained nurses, to deliver the home visiting services. When Olds and colleagues trialled the Nurse Home Visitation Program in a subsequent Denver study using both nurses and paraprofessionals they found that families who were visited by nurses had more positive results than those visited by paraprofessionals (Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds et al., 2002). Other researchers argue that the relationship between the home visitor and the parent is more central than the education level of the visitor, and that well supported, resourced and trained paraprofessionals can be equally as effective as nurses (Gomby,

Culross, & Behrman, 1999). However this assertion has not been empirically tested.

Available evidence suggests that home visiting programs that use professionally-trained visitors are more effective than those with paraprofessional home visitors (such as trained volunteers).

Home visitor experience in addressing program goals with clients

That the Healthy Start Program in the USA did not achieve more positive results may be attributed to an incompatibility between the clients on the one hand, and the services the paraprofessional home visitors were expected to deliver on the other. The home visitors were required to 'build trust' with their clients and provide advice on parenting and other issues. At the same time visitors were expected to identify and address the complex issues 'at risk' families often face such as substance abuse, domestic violence and mental illness - issues that home visitors felt the least competent to address. On the basis of the evidence available it appears that highly trained and experienced home visitors are required to best serve families with multiple and complex needs (Gomby, Culross, & Behrman, 1999).

The more complex the client's needs, the more highly trained home visitors need to be to effect change and achieve positive results.

Appropriate program duration

As effective programs often work with clients who have multiple and complex needs, it is important that the program be of long enough duration to impact on the factors that contribute to child maltreatment. The significance of program duration is evidenced by the success of programs that have included home visiting in both the antenatal *and* postnatal periods. This finding highlights the importance of strategies to ensure client participation for the duration of the program, such as matching parental needs to program design and home visitor skills.

Programs need to be of long enough duration to impact upon parenting or risk factors that contribute to child maltreatment.

Matching the program design to the client group

Another important finding from these evaluations was the importance of matching the program's design and implementation with the program's goals and target population in order for the program to achieve positive results. The Healthy Start Program, for example, was designed to reduce child maltreatment by targeting an 'at risk' population (Gomby, Culross, & Behrman, 1999). The program used paraprofessionals to deliver an 'empowerment' intervention approach, which relied on clients to identify their own risk factors and needs accurately in order to receive appropriate assistance. The program had only minimal success in achieving its desired goals. This finding raises questions as to whether the program's expectations of families challenged by multiple and complex issues were too high, and whether the families may have been better served by a formal assessment of their needs to identify and target appropriate interventions, a finding also reached by other researchers working with families with complex needs (DePanfilis & Wilson, 1996).

In order for a program to achieve positive results, the design and implementation needs to be matched to the program's goals and target population.

Improving maternal and child outcomes

Home visiting programs were also more likely to be successful where the focus was on improving both maternal and child wellbeing. Home visiting programs that attempted to improve the mothers' life chances as well as reduce the risk of child maltreatment showed improvements for both mothers and children.

The most successful home visiting programs aimed to improve the wellbeing of both mothers and children.

What other issues need to be considered when implementing home visiting programs?

Results also highlight the importance of careful consideration of the program's design and implementation, carefully matched to the goals of the program and the program's target population. Given that many programs do not seem to have the capacity to meet the needs of clients with complex issues, programs may have to re-skill workers and focus on known risk factors when targeting 'at risk' families (Chaffin, 2004). Further research is necessary in order to identify which changes actually reduce the risk of maltreatment so that programs can focus their interventions accordingly.

Program managers should adopt strategies that reduce the risk of maltreatment and re-skill workers, if necessary, so they can implement these strategies.

Conclusion

The purpose of this paper was to investigate evaluations of home visiting programs and examine their effectiveness in preventing child maltreatment. Although no one program is effective in preventing all incidents of child maltreatment, attributes of effective home visiting programs were highlighted.

The most successful programs were those in which home visitors were highly trained and well qualified, such as nurses, rather than paraprofessionals. Results indicated that home visitors need to have the necessary skills, experience and training to address the complex issues that many socioeconomically disadvantaged and 'at risk' families face (such as, mental health issues, substance abuse and domestic violence). In addition, home visiting programs that addressed improving mothers' life chances as well as reducing the risk of child maltreatment, showed improvements for both mothers and their children. The most convincing evidence of the potential for home visiting programs to reduce child maltreatment was obtained from the Nurse Home Visitation Program evaluation. Finally, home visiting programs were also more likely to be successful when targeted towards an 'at-risk'

client group. Nonetheless, home visiting programs should be seen as part of a comprehensive approach to child maltreatment prevention that includes primary, secondary and tertiary interventions to ensure that all client groups are serviced appropriately (for a detailed discussion see Holzer, Higgins, Bromfield, Richardson, & Higgins 2006).

In conclusion, it was shown that home visiting programs can be effective in ameliorating risk factors for child maltreatment (for example, by addressing poor family functioning). However there is limited evidence to suggest that home visiting assists in preventing child maltreatment.

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