A population approach to the prevention of child maltreatment

Rationale and implications for research, policy and practice

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Abuse and neglect of children in the home marks the extreme end of a continuum of family conditions undermining child wellbeing. Taking this into account, the prevention of child maltreatment rightfully is focused on optimising the conditions—across the entire population—that promote healthy family relationships and support child development. Here we outline how a population approach to evidence-based parenting support can contribute to the prevention of child maltreatment by reducing the family-related risk factors associated not only with abuse and neglect but also with a broader array of adverse childhood outcomes. We present evidence about the scale of child maltreatment, how the current siloed approaches miss opportunities to reach the necessary audiences, and how the challenges to achieving this can be overcome.

Population approach in the current context

Definition of population approach for child maltreatment prevention

There is general agreement that the prevention of child maltreatment at a minimum involves tackling known risk factors that expose children and young people to harmful familial environments including maltreatment by caregivers/adults. There is less agreement about how to best accomplish this. We argue that successful prevention of child maltreatment necessitates the adoption of a population approach, as has occurred with other major health issues such as tobacco-related cancers, road accidents/fatalities, dental carries and STDs/HIV. Population

approaches have to address a range of issues, from high-frequency issues (such as less-than-optimal parenting) through to relatively common risk factors that drive demand for services/statutory responses, including low-frequency but highly serious problems (where a blend of universal and targeted strategies may be needed—as outlined later). The overwhelming demands on statutory child protection services, and the complications of intersecting systems for responding to young children at risk in the context of family law disputes, increase the need for addressing the primary drivers of maltreatment across the population, before the problems become intractable or harder to remediate. Targeted services, including statutory child protection services, reach only a small proportion of the population and typically quite late in the trajectory of family dysfunction associated with serious maltreatment (Herrenkohl, Higgins, Merrick, & Leeb, 2015; Higgins, 2015).

By "population approach" we mean, first, that the overarching goal is to reduce the *prevalence* of child maltreatment and associated indicators at a population level (not just within suspected "high risk" groups/locations) and, second, that prevention efforts, especially those pertaining to parenting need, be designed and implemented for *community-wide impact*. Such an approach would rely heavily on providing supports that are non-stigmatising, drawing on specialised services where necessary, and emphasising local networks and existing sources of support accessible to the majority of families (Child Family Community Australia [CFCA], 2014).

Public health focused interventions to address adverse family environments and the conditions that undermine parental confidence and competence can reach a much greater number of children and their families, and so widen the net for positive preventive effects (Mullan & Higgins, 2014). Although there is a substantial body of research that points to the extensive risk factors for child maltreatment that relate to parenting skills and the quality of the broader family environment (CFCA, 2017), the evidence base shows that strategies to enhance parenting knowledge and skills effectively reduce the severity of risk factors for child maltreatment (Daro & Benedetti, 2014; Prinz, 2016). Rather than assume parenting is an innate characteristic, it should be framed as a learnable skill set that varies across the population and can be supported, strengthened and enhanced regardless of a parent's current proficiency (Parenting Research Centre, 2017).

The kinds of issues that parenting supports can address include:

1. managing challenging behaviours of children;
2. acquiring basic information about parenting skills and children's developmental needs;
3. understanding changing contexts as children grow, in terms of responding to children's typical developmental needs and the parenting skills required for adaptation; and
4. responding to particular challenges such as sensitive/critical periods or unexpected developmental issues (e.g., early/late transition to puberty) or difficult life events (e.g., family separation/divorce; a bereavement; illness or other loss/trauma in the family).

In sum, parenting can be demanding for everyone at different times, and many families can benefit from parenting support in one way or another. Going further, reviews of family law, child protection services and the juvenile justice system point to a common set of family problems that typically lead to contact with these service systems—that is, family violence, mental health issues and addictions to alcohol, tobacco, other drugs and gambling (Higgins & Katz, 2008). Such problems exist on a continuum of severity and are reflected widely in families across the population. The common feature of such parental behaviours or circumstances is that they can impair a family's capacity to provide positive parenting and ensure that children are safe and protected from harm. Taking into account other sources of parenting stress, it is not surprising that many families could benefit from a population approach to parenting/family supports, above and beyond the aim of child maltreatment prevention. A population approach is a powerful way of reaching families at risk and to normalise parenting support across the entire population.

Nature and significance of child maltreatment in an Australian context

While there is currently considerable focus in Australia about children's exposure to sexual abuse in organisations (e.g., Royal Commission into Institutional Responses to Child Sexual Abuse–Case Study #57[1]), international evidence shows the greatest safety risks children face are at home in the form of abuse or neglect by parents. We do not have accurate, nationwide prevalence data in Australia on child maltreatment (Mathews et al., 2016). Instead, to understand the scope of the problem we rely on counting the activities of the statutory child protection services; namely the receipt and investigation of reports of harm, service provision to families who meet thresholds to address child protection concerns, and the removal of children when positive change does not occur. Such counting is a poor substitute for capturing the extent of harm or risks faced by children across the country.

According to surveys, approximately 5–10% of children experience physical abuse; around one-in-ten are emotionally maltreated; 12–23% witness family violence; and 4–8% experience serious (i.e., penetrative) sexual abuse

1 See <www.childabuseroyalcommission.gov.au/case-study/e341c435-f077-4a98-96eb-8d48779c1d98/case-study-57,-march-2017,-sydney>

(Price-Robertson, Smart, & Bromfield, 2010). However, such retrospective self-report surveys may underestimate the full extent of parental maltreatment. It is now widely acknowledged that maltreated children are often subject to multiple types of harm (Higgins, 2004).

Compromised conditions of safety within the family environment coupled with variable parenting capacity and skill is the common denominator. When families struggle to provide consistently warm, nurturing and safe environments, children sometimes require protection. Statutory systems provide the safety nets for responding to children at risk (Mullan & Higgins, 2014); however, if we look at the survey results, such systems only come into contact with a small proportion of children who experience maltreatment (Mathews et al., 2016). This is the gap that the population approach seeks to close.

How a population approach fits Australia's child maltreatment prevention framework

The National Framework for Protecting Australia's Children 2009–2020 (Council of Australian Governments [COAG], 2009) identifies six action areas that are needed to prevent the abuse and neglect of children, and how to respond if prevention efforts are unsuccessful. These are very similar to the wellbeing domains recognised by the Australian Research Alliance for Children and Youth (ARACY).[2] Rather than narrowly targeting the activities of the state/territory statutory child protection authorities, the framework makes clear that addressing the problem of child maltreatment is everyone's business, it requires a primary focus on prevention activities and intervention as early as possible to address risk factors that are known to contribute to maltreatment. The framework acknowledges that this is most effectively delivered through a population health approach, equipping and supporting those service delivery mechanisms where many families are already engaged, such as maternal and child health services, early childhood services, education and broader health services.

A population health approach emphasises promoting safe and supportive environments for all children rather than concentrating exclusively on those environments where children might be at high risk of abuse or neglect. Instead of seeing parents who maltreat children strictly as a distinct psychological category, they can be understood as being at one end of a continuum that includes all parents. In their analysis of data from the *Growing Up in Australia* study (a representative sample of Australian families), Mullan and Higgins (2014) provided empirical evidence of the opportunity for public health interventions to improve the dimensions of the family environment that are strongly associated with children's social and emotional wellbeing.

2 See <www.aracy.org.au/the-nest-in-action/common-approach-resources>.

Why adopt a population approach to child maltreatment prevention?

Prevalence reduction as ultimate goal

A hallmark of population health strategies is an emphasis on addressing community-wide prevalence. This type of metric is highly relevant to child maltreatment prevention, where the shared goal is a reduction in the proportion of children experiencing adverse parenting and family environments. Crisis and emergency services notwithstanding, child maltreatment prevention strategies need to be considered and evaluated in terms of the potential to reduce the prevalence of adverse outcomes (e.g., injuries, foster care placements, childhood mental health disorders) and to increase the prevalence of wellbeing outcomes (e.g., reaching developmental milestones, school achievement, behavioural self-regulation).

Broader prevention to overcome low-frequency outcomes

Official investigated and substantiated cases of child maltreatment in statutory systems, though troubling, nonetheless occur at relatively low rates in the population. The difficulty of trying to prevent a low-frequency outcome such as child maltreatment that comes to the attention and meets the threshold of statutory services is further compounded by difficulties in predicting which parents will engage in child maltreatment and show up in the child protection system. A population approach that enacts broader prevention has the potential to address this challenge.

Programming that is designed for broad population reach increases the likelihood of engaging more parents who might mistreat their children. A related advantage is that population-based prevention can address a wider range of adverse parenting practices than can be achieved by targeting the highest risk families. Child maltreatment experts know that official cases represent only a small percentage of the children who are exposed to deleterious parenting. For example, Theodore and colleagues (2005) in an anonymous telephone survey found that parents self-reported physically abusive behaviours at a rate 40 times higher than the official substantiated rate of child abuse. Similarly, Prinz and colleagues (2016) found in a random household survey that 10% of parents reported spanking their children with an object on a "frequent" or "very frequent" basis. In a similar household survey in Queensland of 4,010 primary caregivers, 43.4% of caregivers reported smacking with their hand and 7.7%, smacking more than once or with an object (Sanders et al., 2007).

Increased normalisation and lowered stigma

Singling out families for intervention on the basis of a risk profile might sound like a cogent approach on the surface

but parents so identified or characterised might have a different opinion. Common practices such as participation in birth preparation classes, the use of car seats and the incorporation of physical exercise into schools have become normalised and benefit the whole population without stigmatising individuals. Seeking out evidence-based parenting support (especially if such programs or services respect self-determination and a wide variety of acceptable parenting practices), needs to be normalised as a parent's pathway to happier, healthier children, rather than something that is punitive or that inadvertently marks the parent as deficient, incompetent or misguided.

There is no doubt that targeted interventions have the potential to reduce recidivism for families where child abuse has already occurred (Vlahovicova, Melendez-Torres, Leijten, Knerr, & Gardner, 2017) and have generated promising though uneven evidence of a preventive impact with individual families (Chen & Chan, 2016; Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van IJzendoorn, 2015). However, evidence is not yet forthcoming that such targeted strategies, if taken to scale, will reduce the prevalence of child maltreatment in actual population terms.

Universal and targeted strategies in blended prevention

One of the concerns about adopting a strictly universal approach to child maltreatment prevention is that families in the population who might need more intensive services will be ignored. The better option to universal prevention is a hybrid approach called blended prevention, which combines universal and targeted elements in an integrated strategy (Prinz, 2015).

Blended prevention has been applied in other areas. For example, universal public policy requires the use of car seats for infants and toddlers (i.e., passage of a law, which is universal in its application) but provisions have been made to make car seats available free of charge to parents who cannot afford them (a targeted facet). Similar strategies have successfully been employed to prevent tobacco-related cancers and heart disease: through price controls, restrictions on the supply and promotion of tobacco products, including the plain packaging introduced recently in Australia, tailored public messages and services, and addressing the underlying disadvantage that contributes to tobacco use (Scollo & Winstanley, 2017; Tobacco Working Group, 2009).

The same concept can be applied to parenting support. Drawing on blended prevention, a well-integrated system of evidence-based parenting support would include broad-reach strategies, such as large-group, low-intensity and media-based strategies, plus multiple levels of more intensive and extensive services and supports. In a well-crafted system, parents who do participate in the more targeted elements would also benefit from exposure to the universal facets. Similarly, parents who are exposed to universal services might be more receptive to targeted interventions when needed.

Impact multiple outcomes with the same intervention

It is legitimate to ask how a strategy for the whole population can be justified to prevent an outcome like substantiated cases of child maltreatment (or even the larger category of notifications) that occurs in a relatively small proportion of families. For example, during 2015–16 only 3.02% of children in Australia received child protection services (AIHW, 2017). The answer is that a smart prevention strategy will address not only the low-frequency outcomes but also have a positive impact on more common outcomes.

Evidence-based parenting support deployed in a blended prevention model can reduce child maltreatment but also has the potential to concurrently reduce or prevent children's social, emotional and behavioural problems (which are more prevalent than child maltreatment but share many of the same contextual factors and prevention strategies) (Sanders & Mazzuchelli, 2018), improve children's readiness at school entry (Votruba-Drzal & Dearing, 2017), and reduce trajectories for adverse outcomes in adolescence such as substance abuse, delinquency, school dropout and teen pregnancy (Sandler, Ingram, Wolchik, Tein, & Winslow, 2015).

Application of key population principles

To make a population approach to child maltreatment work, key principles and strategies of a population health approach need to be incorporated (Sanders, Burke, Prinz, & Morawska, 2017). These include the concept of "minimal sufficiency" and having culturally appropriate programs and service system support.

Minimal sufficiency refers to the need to have low-intensity programs that have wide reach in terms of parental participation at an affordable cost. Typically, the population approach involves having universal elements such as media and communication strategies that destigmatise parental involvement and that help to create "pull" demand from parents (legitimising the concept that all parents can benefit from help at some stage).

Interventions need to be culturally relevant to the population. Australia is a multicultural, multi-faith country; however, there is evidence that the basic principles and techniques of positive parenting are viewed as culturally relevant, acceptable and effective with a diverse range of parents (Morawska et al., 2011).

Even when programs are available, and shown to work in a multicultural context, there is no guarantee that the programs will be implemented with fidelity by service providers.

Therefore, any population-based intervention needs to apply learnings from implementation science so that practitioners are appropriately selected, trained, supervised and supported to ensure the sustained use of programs that work (see Sanders, Turner, & McWilliam, 2016).

Capitalising on multiple settings, delivery formats, and intensity of interventions

A population approach seeks to employ multiple, different service delivery contexts as an opportunity to promote safe, nurturing parenting in the community. This involves using widely accessed, normative care contexts such as primary health care settings and services, early childhood educational settings, schools, various government and non-government parenting and family support services and programs, and the media. Existing evidence in Australia relating to service access emphasises the importance of non-stigmatising entry points for services (Robinson, Scott, Meredith, Nair, & Higgins, 2012; Stewart, Lohoar, & Higgins, 2011).

Accumulation of evidence for population effects

The scientific case for tackling child maltreatment through a population-based approach rests on two complementary lines of evidence. There has been over 40 years of accumulated evidence on the efficacy of group and individual positive parenting programs based on social learning and cognitive behavioural principles through randomised controlled trials. The evidence clearly shows that parenting programs produce sustained positive changes in both child and parent outcomes (Sanders, Kirby, Tellegen, & Day, 2014).

There is also increasing evidence that low-intensity interventions designed to have wide population reach and low-cost, self-directed, technology-assisted interventions such as Triple P Online can be effective in changing parenting practices (Sanders, Turner, & Baker, 2014). Online platforms now provide greater flexibility in the delivery of evidence-based programs and supports. Such technology-based suites can be delivered on a tiered continuum of interventions of increasing intensity and narrowing population reach. Such online platforms can provide an excellent foundation for the development and testing of a system of parenting support.

The second line of evidence, and the subject of fewer studies, relates to trials that have adopted a true population approach to deliver multiple levels of intervention to defined geographical catchment areas and tracked outcomes at a population level. For example, in one of the few place-randomisation studies in the child maltreatment prevention area, Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009, 2016) demonstrated that community-wide implementation of evidence-based parenting support as a blended prevention strategy could reduce population prevalence of child maltreatment. "Place" in this study was a county with a population between 50,000 and 175,000 people. Randomising 18 counties in South Carolina to either the intervention or usual services, the US study implemented the full Triple P system, which is a tiered, multi-level approach to parenting support, through the existing workforce across several service sectors in the nine intervention counties. Controlling for the five-year baseline period prior to intervention, the study found significant reductions in rates of confirmed child maltreatment cases in the statutory child protection service, out-of-home care placements (i.e., foster care), and hospital-treated child maltreatment injuries compared with the comparison counties (Prinz, 2017; Prinz et al., 2009, 2016).

Another notable population-based initiative, a quasi-experimental study conducted in Ireland, similarly showed that the implementation of a multi-level system that comprised social marketing, low-intensity seminars (mainly delivered through schools—a valuable hub for non-stigmatising population-based service delivery), topic-specific workshops on common problems at different developmental stages (e.g., shopping trips), and an eight-session Group Triple P intervention reduced the level of serious behavioural and emotional problems in children by 37% over a 2.5-year period, as reported by parents in an epidemiological household survey (Fives, Purcell, Heary, Gabhainn, & Canavan, 2014).

A recent meta-analysis of economic analyses of public health interventions in the UK, Western Europe, USA, Canada, Japan, Australia and New Zealand targeting a range of health problems showed that national public health interventions across many diverse types of problems are highly cost saving with a cost–benefit ratio of 8.3 (Masters, Anwar, Collins, Cookson, & Capewell, 2017). Similarly, in the field of child maltreatment the Washington State Institute of Public Policy (2017) estimated that the return on investment was $8.14 for every dollar invested in the Triple P system based on the Prinz and colleagues (2009) population trial.

Challenges to adopting a population approach

Some might argue against a population approach in the belief that it is not possible to get the whole population of parents/families to participate. However, it is not necessary nor even desirable for all—or even most—parents to engage with in-person parenting programs or services. In most population-level implementations of positive parenting programs, the aim has been to encourage parents needing or seeking assistance with parenting to reach out and access evidence-based parenting programs, and for other parents—and the wider community—to support these efforts and

thereby remove stigma and other barriers often associated with completing a parenting program.

Marmot and colleagues' (2010) principle of proportionate universalism is relevant to child maltreatment prevention as it implies that all parents can benefit from support in parenting at various points in their parenting careers, but some need much more support. Having interventions based on the same core principles but which vary in intensity can be very useful. Evidence-based strategies or programs range from low-intensity seminars and discussion groups about specific child-rearing topics (e.g., bedtime problems), to more moderately intensive multi-session active skills training programs for parents with children with more serious child behaviour problems (e.g., oppositional behaviour problems, conduct problems, developmental disorders), to more intensive programs where parenting problems are complicated by domestic violence and/or additional parental relationship, mental health or substance abuse problems.

Others might contend that a targeted approach based on population screening is needed to more accurately identify children at greatest risk and parents most likely to benefit for parenting programs. However, screening and targeted delivery is still very *expensive* to implement at a population level and runs the risk of introducing *stigma* for someone identified as a parent who needs extra help with parenting.

An alternative approach is to promote the idea that all parents experience difficulties and challenges in raising their children from time to time and that confronting and dealing with the challenges that come with everyday parenting is normal and healthy, and that it is desirable to get involved in learning the skills and strategies that promote the healthy development of children and families. By only targeting the most vulnerable families, the vast majority of parents experiencing difficulties with parenting will be ignored and it will be very difficult to impact on the prevalence rates of child maltreatment.

Ways to strengthen the population approach

As experience grows with the implementation of large-scale population roll-outs of child maltreatment prevention programs, several strategies derived from the broader research literature in prevention science can strengthen the efficacy of the approach.

1. Ensure that the delivery of evidence-based parenting programs is *mainstreamed* by government agencies across the range of universal service delivery platforms (i.e., included in their funding streams and service requirements) rather than viewed as an add-on that is not the core business of an organisation or only for selected staff employed to deliver parenting support services.
2. Carefully select *agencies and staff who have the capacity and motivation to deliver evidence-based programs*. Select agencies that are committed to the adoption of a population approach and are prepared to reorient their service priorities to ensure that evidence-based parenting programs are delivered.
3. Build in strong end-user and *consumer engagement* (i.e., community stakeholders, GP networks, local government, NGOs) to ensure programs that are delivered are locally and contextually relevant.
4. Ensure that parents and children experiencing vulnerability have access to population-based programs. These programs need to be *appropriately tailored to the needs of diverse families*, including those with: Indigenous parents, parents with mental health and substance abuse problems, parents from culturally and linguistically diverse communities, parents who have been/are incarcerated, same-sex parents and parents of children with disabilities. Targeted engagement strategies are needed to promote the participation of families experiencing vulnerability to access universal services where population-level prevention activities are being undertaken, such as accessing high-quality early childhood care where prevention messages, supports and enablers of positive parenting are embedded.
5. *Target key normative developmental transitions* for the delivery of low-intensity universal parenting programs. There is heightened receptivity of parents at the point of developmental transition. Such developmental milestones include: the commencement of early childhood programs, kindergarten, primary school and high school.
6. Have a strong *social marketing strategy* supported by government to increase community awareness of the importance of parenting in influencing life course outcomes for children and families. These resources could be used by both government and non-government service providers, as well as advocacy/consumer representative groups. Public messages need to be aspirational, future-oriented, solution-focused and emphasise positive things that can be done by all stakeholders (across the range of universal service platforms) to promote child and family wellbeing (Frameworks Institute, 2016). Avoid media approaches that are alarmist or focus on the horrors of child maltreatment. That approach can inadvertently encourage parents who need support the most to avoid reaching out for support.

Implications for policy, research, and practice

The successful implementation of a population-based approach to child maltreatment prevention requires a concerted commitment by Commonwealth, state and territory, and local governments to ensure sufficient

resources are allocated to the task. There are some early signs of this in Australia—such as the initiative under the third action plan of the National Framework for Protecting Australia's Children, which is focused on early intervention in the early years, particularly the first 1,000 days for a child.[3] Whether this is implemented at a whole-of-population level (rather than at high-risk target groups), however, remains to be seen. There is also the need to complement such initiatives with parenting support strategies across childhood and adolescence. A major challenge in Australia is the absence of a detailed benchmark of parenting behaviours and capacities, which is needed to underpin the implementation and evaluation of such primary prevention strategies.

Policy

1. Fund child maltreatment prevention initiatives that use evidence-based parenting programs that apply population-health principles as a public policy priority. The centrepiece of the population approach needs to be the wide-scale implementation of a *tiered, multi-level, evidence-based system of parenting support*.
2. Provide longer periods of funding (minimum 5–7 years) to ensure proper planning, an establishment phase, interagency engagement and collaboration, the development of an evaluation framework, and detailed implementation plans conforming to best-practice principles derived from *implementation science*.
3. In line with the Productivity Commission (2017) recommendations, move towards *outcomes-focused funding mechanisms* with no discrimination based on whether an organisation is for-profit or not-for-profit. This would create greater flexibility around the types of organisations, including private providers, that can deliver parenting programs and services.
4. Ensure that *funding schemes do not inappropriately restrict access to evidence-based parenting programs*, such as with Medicare's Better Access to Mental Health Care Initiative for children with diagnosed mental health problems. To access the scheme, children need to be present during an intervention, whereas most evidence-based parenting programs do not require children to be physically present. Group-based parenting programs that have been demonstrated to be effective for parents of children with a disability should be funded under the National Disability Insurance Scheme. There should be no requirement that children must be present when parents participate in parenting programs to receive funding (unless the evidence-based program itself requires it for parents to practice skills in the presence of their own children).
5. Make greater use of *performance-based contracting* with agencies that government funds to implement evidence-based practices.
6. Require agencies funded to deliver evidence-based parenting programs to report on *key clinical outcomes for each participating family*. Mandatory reporting of clinical outcomes should be along the lines used in the UK with the Improving Access to Psychological Therapies (IAPT) scheme (Clark et al., 2009).
7. Build in *adequate funding for rigorous evaluations* to undertake outcome tracking through the linking of administrative state and Commonwealth data such as the Australian Early Development Census (AEDC), reports of child maltreatment, hospitalisation due to child maltreatment-related injuries and out-of-home care placements.
8. Provide ring-fenced funding for the implementation of a population-based intervention with *cross-portfolio commitment* similar to that used in the Healthy Child Manitoba initiative in Canada (Healthy Child Manitoba, 2002).
9. Provide funding for a *communications campaign* that normalises preparation for parenthood and, throughout the parenting journey, encourages participation in parenting programs targeting key developmental transitions such as starting early childhood education, kindergarten, primary school and high school.
10. Ensure strong advocacy and *public messaging from government about the importance of parenting* in influencing community outcomes for children, parents, families and communities.
11. Incentivise service providers to transform their service priorities to ensure *prevention-oriented activities around positive parenting become core business*.

Research priorities

1. *Build on findings from randomised controlled trials*, using well-constructed quasi-experimental design and longitudinal-observational *studies.*
2. *Develop population*-level indicators of parenting capacity (knowledge, skills, behaviours) and family wellbeing.
3. Conduct program evaluations that use *linked administrative data* to track population-level indicators.
4. Conduct implementation research to promote the *sustained implementation of evidence-based practices*.
5. Conduct research to explore the *mechanisms of population-level change* in child maltreatment relevant outcomes.

Practice

1. *Alignment:* Through peer support and supervision, encourage reflective practice and ensure activities and the focus of professionals' work aligns with the principles and priorities of a population-based public health approach.

3 See <www.dss.gov.au/families-and-children/programmes-services/children/protecting-children-is-everyones-business-national-framework-for-protecting-australias-children-2009-2020-third-action-plan-2015-2018>.

2. *Specialisation*: Develop parenting specialists within services who have advanced-level expertise in the delivery of more intensive evidence-based parenting programs.
3. Build on *local community resources*: In communities with limited resources, or where there is inadequate (or absent) availability of professionals, consider using well-trained and supervised community volunteers as co-facilitators in delivering parenting programs.
4. Conduct *interagency training* to facilitate local networking and interagency collaboration (e.g., see Stewart et al., 2011).
5. Provide dedicated funding to adapt and deliver evidence-based and culturally informed parenting programs *to address the needs of diverse families*, including Indigenous families.

Conclusions

After four decades of investment in the development and evaluation of parenting programs both overseas and in Australia, it is time for the Commonwealth and all state and territory governments to make sustained investments in the wellbeing of children and families by funding the implementation of a large-scale comprehensive, multilevel, population-based approach to enhancing the knowledge, skills and competence of Australian parents in the task of raising children. The sustained implementation of a multilevel evidence-based approach adhering to principles of "proportionate universalism" holds the greatest promise in turning the tide of unacceptably high rates of child maltreatment and inadequate parenting, and it must become a public policy priority. Australia is fortunate to have developed a range of high quality evidence-based programs that are readily deployable but the public benefits of these programs to promote the future generation of children requires political will and an ongoing commitment to monitoring outcomes.

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