EARLY INTERVENTION FOUNDATION

What Works for Children's Social Care

Coming together as What Works for Early Intervention & Children's Social Care

The Supporting Families Programme

A rapid evidence review

Appendices to the report

May 2023

Appendices

Appendix A.
Original set of research question from DLUHC

The research questions below were used as the basis for the evidence synthesis work. They were subsequently rationalised into the four main sections set out in this report based on subsequent discussions with DLUHC and insights gained from the evidence synthesis and EIF's feasibility and pilot studies.

Personal interactions: keyworker–family

This looks at the personal interaction between keyworker and the family. It considers the psychology of getting engagement, establishing a relationship with the family and effecting change.

Initial engagement: What are the most effective ways of getting initial engagement with this voluntary programme? Why do some families refuse to take part in the programme?

Trusting relationship: What are the most effective ways of building a trusting relationship with the family? By responding to the particular needs of the family? How do they effectively build trust?

Support and challenge: What is the balance of challenge and support? Are sanctions helpful and, if so, for which groups? Or do they just cause distrust and disengagement from services?

Drivers of behaviour change: What are the most effective drivers of individual behaviour change for families? How can families be motivated to change?

Specific interventions/programmes

Specific interventions: Do areas that invest in a suite of specialist interventions as part of their early help offer get better outcomes with families?

- Behaviour change: motivational interviewing, family group conferencing – Camden; multisystemic therapy – Leeds.
- Parenting: eg Empowering Parents, Empowering Communities (EPEC), Triple P, the Solihull approach.
- Employment: training, volunteering, CV writing and interview skills provided by TFEA or Jobcentre Plus.
- Crime and antisocial behaviour: school-based awareness programmes, role model-based and mentoring schemes.
- Mental health: Child and adolescent mental health services (CAHMS) and adult mental health services including Improving Access to Psychological Therapies (IAPT), social and emotional learning skills.
- Pregnancy and maternity services: health visiting plus, Family Nurse Partnership.
- Money: personal budgeting support, benefits advice, housing advice.

- Domestic abuse: specific interventions for victims and perpetrators.

Typology of families: Are there common combinations of needs? If there are common combinations of need such as unemployment and health problems or crime and domestic abuse, could we develop standard sets of interventions to address these?

Sequencing of interventions: What is the evidence around the most effective sequencing for interventions? Do you need to stabilise relationships first? Do you need to deal with mental health and then only look at employment later or is employment helpful for mental health?

Length/intensity of intervention: What intensity and length of intervention are most effective for families with different combinations of need?

Target cohort: Is the programme most effective for highly complex families or more effective in the preventative space for lower intensity families – or both? Where should resources be prioritised?

Innovative approaches/promising practice: Are there other specific approaches taken by local authorities that show promising results and could be more rigorously tested, such as better supporting children in families with domestic abuse before the children present with any issues?

Groups it does not work for: Are there groups of families with specific combinations of need for whom the programme is not effective at creating positive outcomes? If so, why?

Service configurations/system-wide approaches

We want to understand what service configurations are most effective in achieving positive outcomes for families and how we could further test or investigate this in the future.

Practice model: What evidence is there for different approaches? Practice models/ approaches include:

- Signs of Safety/Signs of Wellbeing – widely used in children's services but not rigorously tested. Being tested by the What Works Centre for Children's Social Care
- AMBIT model – Islington: focus on building trust and feeling of safety
- family safeguarding approach – Hertfordshire: tested by DfE, based on the theory that the specialisation of adults' and children's care services has resulted in some families not being supported as well as they should be. Being rolled out in Peterborough, Luton, Bracknell Forest and West Berkshire
- trauma-informed practices/focus on adverse childhood experiences – big focus in Wales
- community engagement and empowerment – Camden, Wigan
- restorative practice – focus on preventing and resolving conflicts
- public health approach – focusing on underlying cause of the problem
- contextual safeguarding – Hackney: looking at all factors in wider environment for family/child.

Multi-agency working: How does the level of multi-agency working impact on outcomes? Does it help some outcomes more than others? Does engagement of certain partners create better outcomes for families?

Identification of families: What are the best methods for identifying families in need of help? Most areas work on a referral basis but others use data to support this process. Is there evidence on what is most effective? Is there evidence of unmet need that could be better identified earlier by using data?

Workforce: Does a highly professionalised workforce achieve better outcomes? There is some evidence to suggest it does. However, there may be value in enabling people with fewer qualifications to be keyworkers? Are these keyworkers better able to relate to families? Does involvement of volunteers help reach certain families?

Family hubs: In family hubs a number of services for families are co-located in one place for families to access. Is this an effective model or could resources be better spent on outreach to families and home visits?

Cost profile: What is the profile of spending across the areas on early help services versus statutory services? Is there a relationship between spending profile and managing demand for statutory reactive services? Do areas that spend more on prevention really have lower need when other factors have been accounted for?

Appendix B. Methodology

Evidence standards used in this review

To assess effectiveness (that is, causal impact) the review uses the Early Intervention Foundation's evidence standards[1] that are used to evaluate the robustness of interventions assessed for the Early Intervention Foundation's Guidebook.[2] This assumes that an intervention works when there is robust evidence that it can impact an outcome of interest. 'Robust evidence' means the intervention has positively impacted at least one of these outcomes in at least one rigorously conducted evaluation that has provided causal impact.

- *Level 4* recognises programmes with evidence of a long-term positive impact through multiple rigorous experimental or quasi-experimental impact evaluations. At least one of these studies must have evidence of improving a child outcome lasting a year or longer.
- *Level 3* recognises programmes with evidence of a short-term positive impact from at least one rigorous evaluation and therefore a judgement about causality can be made.
- *Level 2* recognises programmes with preliminary evidence of improving a child outcome (involving at least 20 participants, representing 60% of the sample, using validated instruments), but where an assumption of causal impact cannot be drawn.

The term 'evidence-based' is frequently applied to an intervention with level 3 evidence or higher because these have sufficient evidence in the causal impact. The term 'preliminary' is applied to interventions at level 2 to indicate that although some evidence is available, causal assumptions are not yet possible. Interventions with preliminary evidence can be good candidates for further testing. The rating of NL2 – 'not level 2' – distinguishes programmes whose most robust evaluation evidence does not meet the level 2 threshold for a child outcome.

It should be noted that these evidence standards can be difficult to apply to everything that is funded by the Supporting Families Programme or that influences delivery of family support services. This is because many are system-level approaches that have huge variation in what they include and are therefore difficult to operationalise consistently. Where the evidence standards are not applicable this is made clear in the report.

The review also recognises that evidence on impact is not the only important evidence to draw on to understand how support is provided. Therefore, the review also includes a range of evidence from both quantitative and qualitative methods, which looks at implementation, process and delivery, and not at impact. Much of the evidence from the previous Troubled Families Evaluation and more recent case study research on the Supporting Families Programme falls into this category and is useful in explaining how support is being delivered and barriers and facilitators to delivery.

Methodology for Chapter 1. Evidence on the effectiveness of previous relevant programmes

Chapter 1 looks at the evidence on both impact and implementation of previous relevant intensive family support programmes. Programmes were chosen based how comparable they were to the Supporting Families Programme in terms of their aims, eligible cohort, methods and policy context.[3] To be included, programmes had to have: been delivered in England in the

1 For more on the Early Intervention Foundation's strength of evidence ratings, see: **https://guidebook.eif.org.uk/eif-evidence-standards**

2 The Early Intervention Foundation's Guidebook is an online toolkit that summarises evidence on impact of individual interventions: **https://guidebook.eif.org.uk**

3 For information on the Supporting Families Programme aims, eligible cohort, methods and policy context see: Department for Levelling Up, Housing and Communities. (2022). Supporting Families Programme guidance 2022 to 2025. **https://www.gov.uk/government/publications/supporting-families-programme-guidance-2022-to-2025**

past 15 years; delivered support to families or children and young people with a similar level of need; focused on intensive, targeted support (in terms of thresholds: were above universal provision but before child protection services); and aimed to support eligible children, young people or families to have better outcomes.

Each programme's impact was assessed using the Early Intervention Foundation's standards of evidence (see above). Information was reviewed on what the programme was, who and how it supported families and key learnings on its implementation.

Methodology for Chapter 2. Current evidence on identified approaches and interventions

Chapter 2 summarises current evidence on a broad range of system-level approaches and individual-level interventions relevant to the Supporting Families Programme. Drawing on the original set of research questions set out by the Department for Levelling Up, Housing and Communities (set out in Appendix A) and supplemented by the Troubled Families and Supporting Families research, a range of system-level approaches and individual-level interventions were identified. These were supplemented with a rapid search of approaches and interventions delivered in local Supporting Families Programmes using Google Scholar and citation forward methods of key studies identified. It should therefore be noted that the review does not represent all approaches or interventions delivered in local authorities funded by the Supporting Families Programme. This is mainly due to lack of reliable data and evaluations of what is delivered as part of the Supporting Families Programme. However, it does provide as thorough a list as possible of approaches and interventions known to be delivered in local Supporting Families Programmes.

Once an approach or intervention was identified, each was assessed to understand its implementation and evidence of effectiveness. Searches were conducted via What Works Centre websites, namely, the Early Intervention Foundation's Guidebook,[4] What Works for Children's Social Care's Evidence Store[5] and the Youth Endowment Foundation's Toolkit.[6] In addition, searches using academic databases, namely Campbell Library of Systematic Reviews, Cochrane Library, hand searches of Google Scholar and hand searches of reference lists of included sources were also undertaken. Citation forward methods of key studies identified also took place. Sources were predominantly academic, peer-reviewed publications, although grey literature from government research was also included when limited evidence was found from other sources. Where possible, evaluations that had taken place in the UK were favoured which utilised robust methodological design (such as randomised controlled trials, the use of validated measures) and supported families with similar needs to those eligible for the Supporting Families Programme.

Once evidence was collated, it was assessed, drawing out the relevant information to provide a brief description, including its prevalence in the UK, its target population and level of need, in addition to a summary of the evidence. From this the strength of the evidence was assessed using the Early Intervention Foundation's evidence standards (see above). This formed the basis of the matrix provided in Appendix C.

It should be noted that given the lack of systematic searching (such as the development of protocol, development of search strings), it is possible that relevant material has been missed.

Methodology for Chapter 3. Current evidence on important factors for effective intensive family support

Chapter 3 summarises evidence on a number of factors understood from previous research to be important for effective intensive family support. These factors were highlighted in the original set of research questions from the Department for Levelling Up, Housing and

4 **https://guidebook.eif.org.uk**

5 **https://whatworks-csc.org.uk/evidence-store**

6 **https://youthendowmentfund.org.uk/toolkit**

Communities (see Appendix A for more details). The summaries focus on families who would be eligible for the current Supporting Families Programme, as highlighted in Box 1 in the introduction.

These summaries draw mainly on systemic reviews and evidence synthesis, including those conducted by the What Works Network. However, where limited systematic evidence is available, the summaries also draw on a range of other evidence. The summaries provide information on the robustness of the evidence presented, but overall caution should be taken when drawing conclusions given the evidence review was not a full systematic review.

Each factor was assessed to understand its evidence within the Supporting Families Programme, and then in the wider evidence base.

Previous evidence from the Supporting Families Programme was drawn mainly from the research presented in Chapter 1. Evidence from wider research focused on evidence looking at the influence of the factor on family outcomes and evidence on its impact on delivery of support to families, including barriers and enablers. Searches were conducted using academic databases, namely Campbell Library of Systematic Reviews, Cochrane Library, hand searches of Google Scholar and What Works Centre websites (namely, the Early Intervention Foundation's Guidebook, What Works for Children's Social Care's Evidence Store and the Youth Endowment Foundation's Toolkit). Citation forward methods of key studies identified also took place. Sources were predominantly academic, peer-reviewed publications, although grey literature from government research was also included when limited evidence was found from other sources. Where possible, evidence reviews, in particular systematic reviews and meta-analysis, were favoured which utilised robust methodological design, as well as evidence that focused on families with similar needs to those eligible for the Supporting Families Programme. However, it is important to note that the evidence base for some factors is relatively small, meaning that research from a wide range of sources, including qualitative research and process evaluations, was used. The summaries provide information on the robustness of much of the evidence they report on, but caution should be taken when drawing conclusions from the evidence presented.

Appendix C. Matrix of identified family support system-level approaches and individual-level interventions

System-level approaches

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Trauma-informed care	Trauma-informed care (TIC) is a universal approach aimed at reducing the stress associated with adverse childhood experiences (ACEs)-related trauma and increasing children's resilience. A primary aim of TIC is to increase service providers' awareness of how trauma can negatively impact on families so that they can support families and avoid practices that might inadvertently cause further trauma.[7] According to Substance Abuse and Mental Health Administration (SAMSHA) guidelines on trauma-informed practice,[8] it is usually aimed at supporting organisations and their staff to: - **realise** the impact that trauma can have on children - **recognise** the signs and symptoms of trauma - **respond to trauma** by integrating knowledge and research on trauma into policies, procedures and practices - **prevent retraumatisation** by avoiding practices that could inadvertently trigger painful and traumatic memories. Under the umbrella term of TIC, there is a range of activities. The two main categories relevant to the Supporting Families Programme are on workforce development and redesign of services. According to the Youth Endowment Foundation's evidence summary for their toolkit,[9] adapted from Hanson & Lange (2016)[10] workforce development includes: • training staff on the impact of trauma and how to recognise its signs and symptoms • ensuring that staff have the knowledge and skills to respond effectively to trauma and avoid retraumatisation and building trusting relationship • attempting to address and reduce trauma among staff • assessing and monitoring staff knowledge and practice. Broader redesign of services includes, for example: • writing organisational policies that which provide support for the principles of trauma-informed practice • modifying the physical environment to reduce possible trauma triggers such as loud noises • introducing screening and assessment tools to assess children's trauma history and symptoms • attempting to increase access to specialist services for children who have experienced trauma and need additional help. **Level of need:** TIC can be used across levels of need from universal to specialist. However, it is usually found within services where there has been identified trauma, and therefore is usually used at the level of targeted-indicated where families have a specific or diagnosed problem. **Target population:** Adults and children who have experienced trauma.	approaches originated in healthcare organisations, but are now increasingly being adopted by schools, child welfare agencies, criminal justice systems and other frontline services for children and families. In the UK they have been widely adopted throughout the NHS as well as in local authority and child and adult services, in addition to the police and other services.	This summary comes from EIF's Review of Adverse Childhood Experiences (ACEs)[11] and Youth Endowment Foundation's more recent evidence summary for their toolkit.[12] Although trauma-informed practices are now widely implemented in schools, GP practices and other frontline services, relatively few have been rigorously evaluated. Several recently completed systematic reviews report that most evaluations primarily investigate service outcomes. Those that do consider child and family outcomes frequently lack a comparison group, meaning that their findings are at best, preliminary.[13] As a result, recent Cochrane reviews could not identify studies rigorous enough to inform the findings of the review.[14] Findings from less rigorous studies are positive, observing improvements in practitioners' knowledge of ACEs, screening and referral procedures, potential reductions in cases of child maltreatment, increased placement stability and reductions in reports of depression, family difficulties and child behaviour problems. Findings from the first rigorously conducted randomised trial delivered through the US state of New Hampshire's child welfare services found relatively little difference in practice outcomes (improvements in trauma screening practices, case planning, mental health and family involvement, progress monitoring, system performance etc).[15] It has been observed that while TIC training frequently includes information about the trauma-informed principles, it does not always provide practitioners with specific skills for putting this knowledge into practice. [16] It has also been observed that many TIC activities have a large overlap with practices that are already in place in many services, so the extent to which TIC represents a measurable improvement over current practice is frequently not specified or measured.[17]	Although evidence does exist, most evidence is of low strength, below a level 3. The only identified randomised control found limited evidence. As a result, there is not yet enough evidence to give it a robust evidence rating.	The potential for trauma-informed care to prevent ACEs or reduce ACEs-related trauma has therefore yet to be fully understood.[18] The implementation of TIC (such as training, improvements in practitioners' knowledge of ACEs, screening and referral procedures) has had limited robust impact evaluations, with none conducted in the UK. Therefore, there is not a good understanding of the potential for trauma-informed care in reducing ACEs-related traumas and improving child and family outcomes. This is due to a limited number of impact evaluations in addition to many trauma-informed activities requiring further specification and clear links to expected outcomes and value added.

7 Sweeney, A., Perôt, C., Callard, F., Adenden, V., Mantovani, N., & Goldsmith, L. (2019). Out of the silence: Towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse. Epidemiology and Psychiatric Sciences, 1–5.

8 SAMSHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. The US Department of Health and Human Services; Substance Abuse and Mental Health Services; Administration Office of Policy, Planning and Innovation. Washington D.C. **https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf**

9 Youth Endowment Foundation Evidence Toolkit. Trauma-informed training and service redesign. **https://youthendowmentfund.org.uk/toolkit/trauma-informed-training-and-service-redesign**

10 Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. Child Maltreatment, 21(2), 95–100.

11 Asmussen, K., et al. (2019). Adverse childhood experiences: What we know, what we don't know, and what should happen next. Early Intervention Foundation. **https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next**

12 Youth Endowment Foundation Evidence Toolkit. Trauma-informed training and service redesign. **https://youthendowmentfund.org.uk/toolkit/trauma-informed-training-and-service-redesign**

13 Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. Health & Social Care In The Community, 27(3); Berger, E. (2019). Multi-tiered approaches to trauma-informed care in schools: A systematic review. School Mental Health 11, 650–664; Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems – A rapid evidence review. International Journal of Environmental Research and Public Health, 16(13), 2365; Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-informed practices in schools across two decades: An interdisciplinary review of research. Review of Research in Education, 43(1), 422–452.

14 Maynard, B. R., Farina, A., Dell, N. A., & Kelly, M. S. (2019). Effects of trauma-informed approaches in schools: A systematic review. Campbell Systematic Reviews, 15(1–2).

15 Jankowski, M. K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., & Barnett, E. R. (2019). Effectiveness of a trauma-informed care initiative in a state child welfare system: A randomized study. Child Maltreatment, 24(1), 86–97.

16 Alessi, E. J., & Kahn, S. (2019). Using psychodynamic interventions to engage in trauma-informed practice. Journal of Social Work Practice 33, 27–39.

17 Atwool, N. (2019). Challenges of operationalizing trauma-informed practice in child protection services in New Zealand. Child & Family Social Work, 24(1), 25–32; Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. BJPsych Advances, 24(5), 319–333.

18 Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. Child Maltreatment, 21(2), 95–100.

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Restorative practices	Restorative practice is a term used to describe behaviours, interactions and approaches that help to build and maintain positive, healthy relationships, resolve difficulties and repair harm where there has been conflict. Restorative practices can be used anywhere to prevent conflict, build relationships and repair harm by enabling people to communicate effectively and positively. Restorative practices can involve both a proactive approach to preventing harm and conflict and activities that repair harm where conflicts have already arisen.[19] The Restorative Justice Council sets out six principles for restorative practice: restoration, voluntarism, impartiality, safety, accessibility and empowerment.[20] Restorative practices range from formal to informal processes that enable workers, managers, children, young people and their families to communicate effectively.[21] Restorative practices range from formal to informal, solutions-focused processes and activities. They can range from workforce training in the principles and use of restorative conversations and peer mediation to restorative conferences as well as the implementation of specific interventions such as family group conferencing or victim–offender mediation (VOM). **Level of need:** Restorative practices can be used across levels of need, from universal to specialist. However, they are usually found within practices where there has been conflict, and therefore at the level of targeted-indicated where families have a specific or diagnosed problem. **Target population:** Adults, children and whole families.	They are used internationally in a range of fields including education, counselling, criminal justice, social work and family support. They are widely used in England in a range of local authority children's services.	Evidence mainly comes from the criminal justice and education systems, with stronger evidence of impact compared with the limited evaluations found in family support and children's social care. *Family support and children's social care* As found in a previous review,[22] this review found limited evaluations of restorative practice at a system or service level in the UK in children's services. Individual-level interventions using restorative practices such as family group conferencing have been shown to have an impact on child and family outcomes.[23] (See separate entry on family group conferencing below.) Most evaluations were conducted as part of system-level models funded by the Children's Social Care Innovation Programme (CSCIP).[24] Evaluations included: - North East Lincolnshire's Creating Strong Communities model[25] - Gloucestershire's innovation project[26] - Stockport's Stockport Family programme[27] - Leeds's Family Valued programme[28] (see separate entry below). In summary, the evidence suggests that restorative practices are being implemented in family support and social work teams across the UK. Where evaluated as part of the Social Innovation programme and in a recent study,[29] they appear to have been well received by both practitioners and families (including those with vulnerabilities) and positively changed practice. However, apart from promising evidence of impact as part of the Family Valued programme, there is little evidence that restorative practices have measurable impacts on family outcomes. *Criminal justice* Meta-analysis shows that when used in criminal and youth justice restorative practices can have a positive impact on recidivism for offenders and outcomes for victims such as satisfaction and restoration.[30] In the UK, the Ministry of Justice evaluated three restorative justice schemes between 2001 and 2008, which found they positively impacted on reoffending rates, provide healing for victims and has a return on investment.[31] *Education* Systematic reviews show that when used in schools they can have an impact on reducing suspensions, exclusions and bullying, for instance, with some evidence from the UK.[32] [33]	There is strong evidence (at a level 3 and higher) that restorative practices can benefit a range of child outcomes in criminal justice and school settings through meta-analysis and systematic reviews, with some evidence from the UK. However, within children's services, the evidence is sparser, with no robust impact evaluations to date. Instead, studies have focused on implementation.	Restorative practices are typically used in a criminal or educational setting. While they have been implemented in a number of local authorities' children's services, their effectiveness in family support and children's social care has not been robustly tested. However, randomised control trials are being conducted on models that use restorative practices, including the Family Valued model being conducted as part of the Strengthening Families, Protecting Children (SFPC) programme.[34]

19 Restorative Justice Council. What is restorative justice? **https://restorativejustice.org.uk/what-restorative-justice**

20 Restorative Justice Council. RJC principles of restorative practice. **https://restorativejustice.org.uk/sites/default/files/The%20RJC%27s%20Principles%20of%20Restorative%20Practice.pdf**

21 Leeds City Council. One minute guide: restorative practice. **https://www.leeds.gov.uk/one-minute-guides/restorative-practice**

22 Gumz, E. J., & Grant, C. L. (2009). Restorative justice: A systematic review of the social work literature. Families in Society, 90(1), 119–126. **https://doi.org/10.1606/1044-3894.3853**

23 Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. Protecting children, 18(1–2), 2–11.

24 Department for Education. Children's social care innovation programme: Insights and evaluation. **https://www.gov.uk/guidance/childrens-social-care-innovation-programme-insights-and-evaluation**

25 Rodger, J. et al. (2017). Creating strong communities in north-east Lincolnshire. Children's Social Care Innovation Programme Evaluation Report 34. York Consulting for the Department for Education. **https://www.gov.uk/government/publications/creating-strong-communities-in-north-east-lincolnshire**

26 Erskine, C., Day, L., and Scott, L. (2017). Evaluation of the Gloucestershire innovation project. Children's Social Care Innovation Programme Evaluation Report 38. Ecorys for Department for Education **https://www.gov.uk/government/publications/evaluation-of-the-gloucestershire-innovation-project**

27 Panayiotou, S., et al. (2017). 'Stockport family' children's services project. Children's Social Care Innovation Programme Evaluation Report 35. Kantar Public and Manchester Metropolitan University for Department for Education. **https://www.gov.uk/government/publications/stockport-family-childrens-services-project**

28 Mason, P. et al. (2017). Leeds Family Valued programme. Children's Social Care Innovation Programme Evaluation Report 43. For Department for Education. **https://www.gov.uk/government/publications/leeds-family-valued-programme**

29 Williams, A. (2019). Family support services delivered using a restorative approach: A framework for relationship and strengths-based whole-family practice. Child & Family Social Work, 24(4), 555–564.

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

31 See here for links to all four evaluation reports: **https://restorativejustice.org.uk/resources/moj-evaluation-restorative-justice**

32 Weber, C., & Vereenooghe, L. (2020). Reducing conflicts in school environments using restorative practices: A systematic review. International Journal of Educational Research Open, 100009.

33 Lodi, E., Perrella, L., Lepri, G. L., Scarpa, M. L., & Patrizi, P. (2021). Use of restorative justice and restorative practices at school: A systematic literature review. Int J Environ Res Public Health, December 23, 19(1), 96. doi: 10.3390/ijerph19010096.

34 **https://whatworks-csc.org.uk/research-project/family-valued-model-trial-evaluation**

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Contextual Safeguarding	Contextual Safeguarding is an approach to understanding and responding to young people's experiences of significant harm beyond their families (ie extra-familial risk or harm) such as child sexual and criminal exploitation, peer-on-peer abuse and gang affiliation.[35] It aims to find effective ways to protect children from risks outside the family home, recognising that young people are increasingly being influenced by their peer groups and surroundings, which are outside the control of their families and cannot necessarily be addressed by traditional social work interventions, which focus on individual children and families. The approach has been in development in the UK since 2011 following a three-year review of practice responses to cases of peer-to-peer abuse.[36] From this the Contextual Safeguarding Framework[37] was developed, which aims to support local areas to develop systems to address extra-familial risk and harm on two levels: (1) practitioners bringing a 'contextual lens' to their work and (2) recording, assessing and addressing those contexts at every level of the service. Contextual Safeguarding is not a model but an approach to practice and system design and will vary depending on local system context and can be used with a range of practice frameworks and models used to improve child protection responses and systems.[38] **Level of need:** Targeted-selected through to statutory services. **Target population:** Young people identified as perpetrating harm as well as those experiencing extra-familial harm.	Developed in the UK initially working with a number of local areas, Contextual Safeguarding is widely referenced in children's safeguarding partnerships in England, with an estimated 45 implementing the Contextual Safeguarding Framework into systems and practice.[39]	Contextual Safeguarding has been evaluated as part of the Children's Social Care Innovation Programme (CSCIP) in Hackney.[40] The evaluation concluded that implementation of the contextual safeguarding system provided a workable framework and robust system to address extra-familial risk or harm and is better equipped than comparable local authorities to assess and respond directly to contexts in which extra-familial risk or harm occurs. It also suggested that it had the potential to exert a positive impact on practice, with staff feeling more confident in this aspect of their practice, and evidence of culture change. In addition, pre/post test scores on child outcomes (including wellbeing, life satisfaction and coping strategies) demonstrated positive differences. However, given the ambitious nature of the system redesign and the evaluation timeline, it was not able to robustly assess improved service user experiences or use a quasi-experimental design with a comparison group to test enhanced child-level outcomes.[41] There is currently no published evidence on the implementation or impact of the scale-up project in a further nine areas.[42]	The approach has only been evaluated in Hackney and although it employed a quasi-experimental design it was unable to robustly test child-level outcomes due to the approach not being fully embedded while the evaluation was being conducted. Therefore, the evidence should currently be considered low, as not to have reached a level 2 evidence standard.	To fill this evidence gap, contextual safeguarding should be evaluated through a robust implementation and impact evaluation including robust measurement of child-level outcomes through an experimental or quasi-experimental design and an economic evaluation.
Signs of Safety	Signs of Safety (SoS), is a strengths-based, safety-orientated practice framework for child protection casework designed for use throughout the safeguarding process. It aims to stabilise and strengthen families through working in collaboration to harness their strengths and resources, placing the relationship between professionals and parents at the centre of child protection, with risk assessment and case planning as central features. [43] **Level of need:** Signs of Safety can be used across levels of need; however, it is usually found within services that have a safeguarding element, and therefore is usually used at the level of targeted-indicated where families have a specific or diagnosed problem. **Target population:** Whole families with child protection risks.	Developed in Western Australia in the 1990s, SoS is also used widely internationally in the US, Canada, Sweden, the Netherlands, New Zealand and Japan, in addition to in the UK, where there are a large number of LAs who are said to be using SoS within their children's services.[44]	Despite being widely used around the world including in the UK, there is limited evidence on its implementation or effectiveness. In the only identified systematic review[45] there was found to be little to no evidence to suggest that Signs of Safety is or is not effective at reducing the need for children to enter care. This was based on four quantitative studies, none from the UK, two of which were randomised control trials and two were quasi-experimental designs. It found huge variation in how Signs of Safety is implemented and limited specification of how it is possible to be sure high-quality Signs of Safety is being delivered. But it did suggest Signs of Safety can increase positive engagement with parents, children, wider family and external agencies. In addition, 10 Signs of Safety pilots in England were evaluated as part of the Children's Social Care Innovation Programme; however, none looked explicitly at child- or family-level outcome changes over time.[46] But they did find that when local authorities had trained partner agencies in Signs of Safety, they reported improved communication, particularly over referrals to social care.[47] A subsequent quasi-experimental impact evaluation of Signs of Sign in nine local authorities carried out by What Works for Children's Social Care found no impact on referrals to children's social care, length of assessments or re-referrals.	The current strength of evidence is considered low according to What Works Centre for Children's Social Care based on one systematic review on the impacts of reducing the need for children to enter care.[48]Other evaluations conducted in the UK identified were not robust enough to look at impacts (below a level 2 evidence rating).[49]	The evidence base for Signs of Safety needs developing. A clear and practicable specification of what high-quality SoS looks like in practice is a first priority. Without it, implementation and evaluation are difficult. Evaluations of the impact of high-quality SoS compared with normal service or other models would then be possible. Given SoS is widely used in England, randomised controlled trials (RCTs) could be difficult to implement. Therefore, more QED designs may be needed where pre- and post-implementation could be compared on administrative data or implementation in several areas via an RCT. Once evidence for the impact of high-quality SoS is established, research evaluating the implementation of the approach is crucial. Currently there is little evidence about the contribution of different elements that purport to be necessary to deliver SoS well.

35 For more information see: **https://www.csnetwork.org.uk/en/about/what-is-contextual-safeguarding and https://hackney.gov.uk/contextual-safeguarding**

36 Firmin, C. (2017). Contextual risk, individualised responses: An assessment of safeguarding responses to nine cases of peer-on-peer abuse. Child Abuse Review.

37 Firmin, C. E., Horan, J., Holmes, D., & Hopper, G. (2016). Safeguarding during adolescence: the relationship between contextual safeguarding, complex safeguarding and transitional safeguarding. Contextual Safeguarding Network.

38 Firmin, C. (2019). Contextual safeguarding: A new way of identifying need and risk. **https://www.communitycare.co.uk/2019/03/25/contextual-safeguarding-new-way-identifying-need-risk See also: https://contextualsafeguarding.org.uk/wp-content/uploads/2020/12/Signs-of-safety-and-contextual-safeguarding-Briefing.pdf**

39 See: **https://www.contextualsafeguarding.org.uk/our-work/research-projects/reach-impact**

40 Lefevre, M., Preston, O., Hickle, K., Horan, R., Drew, H., Banerjee, R., … & Boyer, S. (2020). Evaluation of the implementation of a contextual safeguarding system in the London Borough of Hackney. London: Department for Education. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932353/Hackney_Contextual_Safeguarding.pdf**

41 It included a pre-/post intervention and external comparator quasi-experimental design evaluation used child-level data from the LAs' statutory returns to look at any changes in service patterns or child-level outcomes.

42 **https://www.contextualsafeguarding.org.uk/our-work/research/research-projects/scale-up-project**

43 **https://www.signsofsafety.net/what-is-sof**

44 See: - Signs of Safety was the most commonly cited practice model in Suffield, M. et al. (2022). Supporting Families Programme: Qualitative research: Effective practice and service delivery: Learning from local areas. Kantar Research for Department for Levelling Up, Housing and Communities. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064758/Supporting_Families_-_Effective_practice_and_service_delivery_-_Learning_from_local_areas.pdf** - a number of projects using Signs of Safety Children's Social Care Innovation Programme (CSCIP). **https://www.gov.uk/guidance/childrens-social-care-innovation-programme-insights-and-evaluation** |- organisations listed on the Signs of Safety website: **https://www.signsofsafety.net/orgs**

45 Sheehan, L., O'Donnell, C., Brand, S., Forrester, D., Addis, S., El-Banna, A., … & Nurmatov, U. (2018). Signs of safety: Findings from a mixed methods systematic review focused on reducing the need for children to be in care.

46 Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J., & Hickman, B. (2017). Evaluation of Signs of Safety in 10 pilots. London: Department for Education. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625376/Evaluation_of_Signs_of_Safety_in_10_pilots.pdf**

47 Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J., & Hickman, B. (2017). Evaluation of Signs of Safety in 10 pilots. London: Department for Education. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625376/Evaluation_of_Signs_of_Safety_in_10_pilots.pdf**

48 What Works for Children's Social Care, Signs of Safety Study review. **https://whatworks-csc.org.uk/evidence/evidence-store/intervention/signs-of-safety**

49 Sheehan, L., O'Donnell, C., Brand, S., Forrester, D., Addis, S., El-Banna, A., … & Nurmatov, U. (2018). Signs of safety: Findings from a mixed methods systematic review focused on reducing the need for children to be in care.

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
AMBIT	Adaptive Mentalization Based Integrative Treatment (AMBIT) is an approach to developing effective practice, integrating a range of specific techniques and practices, which encourages and supports local adaptation appropriate to the client group and local service arrangements.[50] It aims to support professionals who work with those who are particularly vulnerable and develops systems of help, who often have multiple professionals supporting them. It emphasises integration, which is principally achieved through a focus on delivery of multiple interventions using multiple techniques and tools overseen by a keyworker. This sits alongside mentalisation-based practices developed to enhance team and network functioning by supporting workers experiencing high levels of professional stress. It is supported by a framework designed to shape practice.[51] Mentalising is the ability to understand the mental state – of oneself or others – that underlies overt behaviour. AMBIT is built around eight core principles: a keyworker, a team-based approach, one that scaffolds existing relationships, emphasised local clinical accountability, aims to intervene in multiple domains, integration led by the keyworker and response for both practice and expertise and evidence. **Level of need:** Targeted selected. **Target population:** Children and families with complex problems coming into contact with multiple agencies.	AMBIT has been used widely internationally. In the UK there have been a number of children's services and NHS CAMHS or substance abuse services that have adopted an AMBIT model, such as Islington, Cambridgeshire, Bexley and Lothian.	Mentalisation-based interventions for individuals have been shown to be effective[52] for adults with mental health issues, mothers enrolled in substance abuse treatments and adolescents who self-harm.[53] However, to date there have been no robust impact evaluations of the AMBIT model at a service or system level. While the AMBIT approach emphasises the use of evidence-based interventions in practice, such as cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT) and inference-based treatment (IBT). AMBIT is a system-level approach and does not have a specified model by design (being integrated into existing local practices and therefore used differently in different services), which makes comparative evaluations difficult.[54] There have been a number of local evaluations of services that adopted the AMBIT model, which have shown some effect on the introduction of AMBIT but only have preliminary evidence (at a level 2 evidence standard) with no counterfactuals. These included: • a 10-year service evaluation[55] of an edge of care service based in Islington, which adopted the AMBIT model as one of its 10 key components, which saw improvements in social care outcomes (placement stability) as well as behavioural outcomes and family functioning • a pre/post test study[56] of the Cambridgeshire Child and Adolescent Substance Use Service with reductions in substance use • a two-year study[57] of NHS Lothian Tier 4 child and adolescent mental health service with observed improvements in quality of life, symptoms and distress.	To date there have been no robust impact evaluations of the AMBIT model at a service or system level. While there is evidence of the positive impact of mentalisation-based interventions on adults and adolescents, there is very limited evidence based on AMBIT as a system-level approach, with a number of local evaluations conducted in the UK only having preliminary evidence (at a level 2 evidence rating) of positive change with a lack of impact evaluations to date.	There is a lack of evidence on the implementation, impact and economic cost-benefit of services or local areas adopting the AMBIT model.
Family Safeguarding Model	Family Safeguarding Model is a strength-based whole-system approach to children's safeguarding focusing on supporting the needs of children and adults in order that children can safely remain within their families by addressing the compounding factors known as the 'trio of vulnerabilities' (domestic abuse, parental substance misuse and parental mental health). Using a strengths-based approach, it has five core components: multidisciplinary teams use motivational practice (including motivational interviewing – see below), an electronic workbook, group case supervision, an eight-module intervention programme and parenting assessment. **Level of need:** It is aimed at children and families with identified child protection risks and therefore targeted at a child protection and edge of care level. **Target population**: Families with child protection risks.	The model was first developed and trialled in Hertfordshire. It was subsequently trialled in four local authorities (Bracknell Forest, Luton, Peterborough and West Berkshire). It is now being trialled in six local areas (Cambridgeshire, Walsall, Lancashire, Telford and Wrekin, Wandsworth, Swindon) as part of the DfE Strengthening Families, Protecting Children (SFPC) programme.	The first evaluation was part of the DfE's Round 1 as part of the Children's Social Care Innovation Programme (CSCIP)[58] and looked at Hertfordshire's Family Safeguarding Model.[59] The pre/post evaluation (with no comparison group) found evidence of sizeable reductions in repeat police call-outs to domestic abuse incidents, emergency hospital admissions for adults, Child Protection Plans and care proceedings. Following on from this, the DfE's Round 2 Children's Social Care Innovation Programme (CSCIP) trialled the model in four additional councils. Using a mixed-methods approach with a range of data collection methods (no comparison group), the evaluation indicated that Family Safeguarding is effective in preventing children from becoming looked-after and reducing the number of children on Child Protection Plan, as well as reductions in police call-outs in the following 12 months after being transferred onto the programme and large reductions in the frequency of mental crisis contacts. Although it was not a comprehensive economic evaluation, the study did suggest that the financial case is strong.	While promising on a host of child, family and service outcomes and demonstrating replicability of the model across study sites, the strength of evidence is preliminary (at a level 2 evidence standard) due to the lack of counterfactual in previous evaluations to show a causal impact.	Robust impact and economic evaluation is needed to test previous promising findings replicated in other areas and look at long-term effectiveness. A further trial is currently being conducted (completing in 2025), which seeks to evaluate the roll-out of the Family Safeguarding Model in five local authorities[60] conducted by What Works for Children's Social Care as part of the DfE-funded Strengthening Families, Protecting Children (SFPC) programme. Until the current trial concludes there is limited robust evidence of the impact on children and families. A robust economic impact evaluation has not been undertaken to date.

50 Anna Freud. (2018). AMBIT in a nutshell. **https://manuals.annafreud.org/ambit-static/ambit-in-a-nutshell**

51 Anna Freud. (n.d.). AMBIT wiki. **https://manuals.annafreud.org/ambit**

52 Malda-Castillo, J., Browne, C., & Perez-Algorta, G. (2019). Mentalization-based treatment and its evidence-base status: A systematic literature review. Psychol Psychother, 92(4), 465–498. doi: 10.1111/papt.12195.

53 For example: Mentalization-based treatment for Adolescents (MBT-A) is a manualised treatment for adolescents with self injurious behaviour. For more information see: h**ttps://manuals.annafreud.org/ambit-static/mbt-a** See Rossouw, T. I., Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. J Am Acad Child Adolesc Psychiatry, December, 51(12), 1304–1313. doi: 10.1016/j.jaac.2012.09.018.

54 However, there is a measurement of AMBIT fidelity that has been developed: **https://manuals.annafreud.org/ambit-static/ambit-practice-audit-tool-aprat**

55 Talbot, L., Fuggle, P., Foyston, Z., & Lawson, K. (2020). Delivering an integrated adolescent multi-agency specialist service to families with adolescents at risk of care: Outcomes and learning from the first ten years. The British Journal of Social Work, 50(5), 1531–1550. **https://doi.org/10.1093/bjsw/bcz148**

56 Fuggle, P., Talbot, L., Wheeler, J., Rees, J., Ventre, E., Beehan, V., … & Cracknell, L. (2021). Improving lives not just saying no to substances: Evaluating outcomes for a young people's substance use team trained in the AMBIT approach. Clinical Child Psychology and Psychiatry, 26(2), 490–504.

57 Griffiths, H., Noble, A., Duffy, F., & Schwannauer, M. (2017). Innovations in practice: Evaluating clinical outcome and service utilization in an AMBIT-trained Tier 4 child and adolescent mental health service. Child Adolesc Ment Health, September, 22(3), 170–174. doi: 10.1111/camh.12181. Epub 2016 Jul 20. PMID: 32680382.

58 Department for Education. Children's social care innovation programme: Insights and evaluation. **https://www.gov.uk/guidance/childrens-social-care-innovation-programme-insights-and-evaluation**

59 Forrester et al. (2017). Family Safeguarding Hertfordshire: Evaluation report. Children's Social Care Innovation Programme Evaluation Report 55. Department for Education, **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf**

60 **https://whatworks-csc.org.uk/research-project/family-safeguarding-model-trial-evaluation**

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Leeds Family Valued	Family Valued is a system change programme aimed at embedding restorative practice across children's services,[61] [62] with four core strands: 1) RP training for all staff 2) an intensive programme of leadership, culture and practice development 3) creation or expansion of the Family Group Conference (FGC) service 4) work with local leaders to critically review local systems and structures. **Level of need:** Targeted indicated. **Target population:** Families with child protection risks.	Originating in Leeds, Family Valued has since been scaled up to five LAs (Warwickshire, Newcastle, Coventry, Solihull and Sefton).	The only current evidence of the model comes from the Leeds Family Valued evaluation[63] as part of the Children's Social Care Innovation Programme (CSCIP). The mixed-method implementation and impact evaluation found that 16 months into the programme, there were statistically significant reductions in the number of looked-after children (CLA) and their rate per 10,000 population as well as the number of Child Protection Plans (CPPs) and children in need (CIN). However, while no comparison group was included in the analysis, data from a statistical neighbour and national datasets suggests that the changes in Leeds are a result of Family Valued. However, causal claims to the impact of restorative practice could not be made. The cost-benefit analysis focused on the expansion of Family Group Conferences and not of the programme as a whole, comparing it with business as usual. It did not include savings from outcomes, because of the limited timescale for the evaluation, but did find savings as a consequence of less time spent in the social care system, which are estimated at £755 per family. If intended outcomes are achieved and sustained, it was suggested these savings would increase significantly.	Given the lack of counterfactual evidence in the Leeds Family Valued evaluation, the evidence cannot be considered causal, but preliminary (at a level 2 evidence standard), based on analysis of children's services statutory data.	Robust impact and economic evaluation is needed to test previous promising findings replicated in other areas and look at long-term effectiveness across. Further evaluations are beginning to address the present evidence gaps in the lack of robust impact evaluations in areas other than Leeds. This includes scaling up Family Valued to five LAs (Warwickshire, Newcastle, Coventry, Solihull and Sefton), and evaluating Family Valued using a stepped wedge cluster RCT design.[64] Conducted by What Works for Children's Social Care as part of the DfE-funded Strengthening Families, Protecting Children (SFPC) programme and reporting in 2025.[65]
Reclaiming Social Work model	Reclaiming Social Work (RSW) model is a whole-system model that aims to deliver systemic practice in children's services to improve practice in children's services through improving risk assessment and decision-making, providing more effective help, managing risk for children and families, and keeping families together (where appropriate). Key elements include in-depth training, small units with shared cases and group systemic case discussions, clinician support, reduced bureaucracy, devolved decision-making and enhanced administrative support. **Level of need:** It is aimed at children and families with identified child protection risks and therefore targeted at a child protection and edge of care level. **Target population:** Vulnerable children and families.	Developed in Hackney and then scaled in five LAs (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark).	Initial evaluation of the model in Hackney used a realistic evaluation methodology finding a positive impact on organisational culture and social work processes; however, the lower rates of Child Protection Plans and children in care found could not be linked to the model due to the limited impact design.[66] For the evaluation of the scaling and deepening of evaluation in five additional local authorities, the mixed-methods study was unable to report on outcome measures due to data collection issues.[67] A three-year longitudinal follow-up in the original area and four of the five scale-up areas found improvements across key performance outcome indicators only in areas continuing to implement the model. However, with no counterfactual the evaluation could not claim casual impact.[68]	From the evaluations conducted to date the strength of evidence is low (not at a level 2 evidence standard) due to a lack of impact study design and issues with fidelity to the model in some scale-up areas.	Further evaluations are needed with a robust implementation and impact design using validated outcome measures and a counterfactual to illustrate fidelity to the model and causal impact.

61 Social Care Institute for Excellence, Strengthening Families, Protecting Children (SFPC). (n.d.). Leeds Family Valued. **https://www.scie.org.uk/strengthening-families/leeds-family-valued#latest**

62 Mason, P., Ferguson, H., Morris, K., Munton, T., & Sen, R. (2017). Leeds Family Valued Evaluation Report. UK Department for Education. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625222/Leeds_Family_Valued_-_Evaluation_report.pdf**

63 Mason, P., Ferguson, H., Morris, K., Munton, T., & Sen, R. (2017). Leeds Family Valued Evaluation Report. UK Department for Education. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625222/Leeds_Family_Valued_-_Evaluation_report.pdf**

64 **https://whatworks-csc.org.uk/research-project/family-valued-model-trial-evaluation**

65 **https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_Family-Safeguarding_TP_Final_V1.pdf**

66 Cross, S., Hubbard, A., & Munro, E. (2010). Reclaiming Social Work London Borough of Hackney Children and Young People's Services Part 1: Independent Evaluation Part 2: Unpacking the complexity of frontline practice – An ethnographic approach.

67 Bostock et al. (2017). Scaling and deepening the Reclaiming Social Work model: Evaluation report. Children's Social Care Innovation Programme Evaluation Report 45. **https://www.gov.uk/government/publications/scaling-and-deepening-the-reclaiming-social-work-model**

68 Data wasere collected three years after the original project was completed in the four LAs (Derbyshire, Harrow, Hull and Southwark). Bostock, L., and & Newlands, F. (2020). Scaling and deepening the Reclaiming Social Work model: Llongitudinal follow up. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933120/Reclaiming_Social_Work_-_Bedfordshire.pdf**

Individual-level interventions

Parenting Interventions

Parenting interventions (sometimes referred to as parent training, parent management training or behaviour management training) were originally developed to reduce child behavioural problems but are now used to support a variety of child outcomes, including children's emotional wellbeing, school achievement and physical health.[68] Most parenting interventions primarily teach parents new skills for managing difficult child behaviour; some also include strategies for supporting the parents' own wellbeing and improving relationships between family members, as well as provide general advice about children's developmental needs.[69] A primary aim of many other parenting interventions is to improve the home learning environment, the parent–child relationship and often the language, literacy, cognitive skills and social-emotional development critical to school success. Some interventions aim to support both these outcomes and improve child behaviour. Often parenting interventions are delivered to groups of parents, who learn these strategies through practitioner-facilitated discussions and coached activities involving role play and feedback for activities implemented at home. Depending on the severity of the problems, parenting interventions can also be delivered to parents individually.

Set out below is a list of parenting interventions found in the EIF Guidebook with good evidence of improving child outcomes (at a level 3 or higher) that are delivered in the UK and can be delivered in local Supporting Families or broader early help services. Note that interventions found in the EIF Guidebook that are delivered by other professionals such as health visitors (ie Family Nurse Partnership (FNP) or Parents as First Teachers (PAFT)) are not included. In addition, a number of interventions with evidence below level 3 were identified. These included the Mellow Programmes[70] and the Solihull approach.[71]

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Triple P programmes	The Triple P Parenting programmes are a multi-level system of support to prevent and treat social, emotional and behavioural problems in children by enhancing parent knowledge, skills and confidence. Triple P combines social learning theory with a public health approach.[73] The Triple P Parenting programme is a system involving five different levels of intervention, using a tiered system, including universal, targeted and treatment interventions ranging from very low intensity to high intensity with a whole range of Triple P based programmes (eg Level 4, Stepping Stones and Resilience Triple P).[74] **Model:** Group or individual (depending on programme). **Level of need:** Universal to child protection and edge of care. **Target population:** Parents who have concerns about their child's behaviour at various ages and at various levels of intensity. **Practitioner**: Facilitators are trained Triple P practitioners, who can come from a range of professions (eg family support worker) with recommended minimum QCF-4/5 level qualifications.	It is used throughout England in early years and other settings, including as part of local Supporting Families Programmes. However, the extent of its use in local programmes is unknown.	The EIF Guidebook has provided different evidence ratings for the different Triple P programmes. Most are of level 3 or 3+, but some are of level 2. This suggests that those at or over level 3 have evidence of a short-term positive impact on child outcomes from at least one rigorous evaluation. The programme has demonstrated positive outcomes in the areas of preventing crime, violence and antisocial behaviour (reduced disruptive behaviour, reduced problem child behaviour and reduced negative child behaviour in parent–child interactions). EIF's Guidebook gives a low to low-medium cost rating of 1s and 2s for the various Triple P programmes. This is equivalent to an estimated unit cost of between less than £100 and £499.	The strength of evidence is considered to be good, as most Triple P interventions in the EIF Guidebook have an evidence rating of 3 or 3+. However, some also have an evidence rating of 2, which would be considered low.	Limited evaluations have taken place on the delivery of Triple P as part of early help services. More broadly further longitudinal evaluations are required to determine the long-term impacts of Triple P.
Incredible Years programmes	Incredible Years is for parents with concerns about the behaviour of a child where they attend a number of (mostly weekly) sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour through mediated video vignettes, problem-solving exercises and structured practice activities. There are a number of Incredible Years programmes, including advanced and basic and for different age groups (preschool and school age).[75] Some are also appropriate for children who have attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD) or difficulties with peer relationships. The Advanced add-on to Incredible Years Preschool includes a component that seeks to improve children's outcomes by improving the quality of interparental relationships. **Model:** Group. **Level of need:** Targeted indicated. **Target population:** Parents who have concerns about their child's behaviour at various ages. **Practitioners:** Delivered by two IY co-leaders with QCF-7/8 level qualifications and can be mental health practitioners, psychologists, nurses, teachers or social workers.	It is used throughout England in early years and other settings, including early help. However, the extent of its use is unknown.	Incredible Years Preschool Basic (3–6-year-olds) has a level 4 evidence of reducing child behavioural problems, improving the quality of the parent–child relationship and child reading skills, lasting up to 10 years. This evidence includes multiple studies conducted in the UK. Some studies also show reductions in parental reports of depression. Incredible Years School Age Basic (6–12-year-olds) has a level 3+ evidence of reductions in conduct problems and ADHD symptoms. Five out of the seven programmes listed in the EIF Guidebook have an evidence rating of 3 or higher. EIF's Guidebook gives a low to low-medium cost rating of 1s and 2s for the various programmes. This is equivalent to an estimated unit cost of between less than £100 and £499.	The strength of evidence is considered to be good, as most IY interventions in the EIF Guidebook have an evidence rating of 3 or 4	Limited evaluations have taken place on the delivery of IY as part of early help services. More broadly further longitudinal evaluations are required to determine the long-term impacts of IY.

69 Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). Foundations for Life: What works to support parent child interaction in the early years. Early Intervention Foundation. **https://www.eif.org.uk/report/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years**

70 Asmussen, K. (2011). The evidence-based parenting practitioner's handbook. Routledge.

71 Such as Mellow Toddlers. EIF Guidebook: **https://guidebook.eif.org.uk/programme/mellow-toddlers**

72 The Solihull approach (understanding your child's behaviour). EIF Guidebook: **https://guidebook.eif.org.uk/programme/the-solihull-approach-understanding-your-childs-behaviour**

73 See Triple P – Positive Parenting Program. Available at: **https://www.triplep.uk.net/uken/home**

74 There are 15 Triple P programmes currently listed in the EIF Guidebook, with 12 at a level 3 or higher evidence rating. See: **https://guidebook.eif.org.uk/search?search=triple+p**

75 There are seven listed Incredible Years interventions currently listed in the EIF's Guidebook, with five at a level 3 or higher evidence rating. See: **https://guidebook.eif.org.uk/search?search=Incredible+Years**

Name	Description	Where is it used in England/UK	Evidence of effectiveness	Strength of evidence	Evidence gaps
Empowering Parents, Empowering Communities (EPEC)	Empowering Parents, Empowering Communities (EPEC) is an intervention designed for parents to learn strategies for improving the quality of their interactions with their child, reducing negative child behaviour and increasing their efficacy and confidence in parenting. The sessions involve group discussions, demonstrations, role play and homework assignments.[76] An innovative feature is that it is delivered by parents who have completed the programme themselves, who are then trained, paid and supervised to implement it, making its costs low. **Model:** Group. **Level of need:** Targeted indicated. But as it is less intensive than many of the others, it is less appropriate if family needs are very serious. **Target population:** Disadvantaged families experiencing behavioural difficulties with a child between the ages of 2 and 11. **Practitioner:** Parent facilitators (QCF-3 qualified) supervised by a host agency supervisor (qualified to QCF-7/8).	It is used throughout England in early years and other settings, including early help. However, the extent of its use is unknown.	The EIF Guidebook has provided the programme with a Level 3 evidence rating, suggesting it has evidence of a short-term positive impact on child outcomes from at least one rigorous evaluation. The programme has demonstrated positive outcomes in the areas of preventing crime, violence and antisocial behaviour (reduced frequency of behaviour problems, reduced number of behaviour problems and reduced parent concerns about a child). EIF's Guidebook gives acost rating of 1, indicating that it has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than £100.	Level 3 evidence in the EIF Guidebook, illustrating evidence of impact on short-term outcomes of moderate reductions in coercive parenting behaviours, alongside small reductions in problematic child behaviours.	Limited evaluations have taken place on the delivery of EPEC as part of early help services. Further longitudinal evaluations are required to determine the long-term impacts.
Family Check-up for Children	Family Check-up for Children is a strengths-based, family-centred intervention that provides parents with strategies for encouraging positive child behaviour, to support child competence, mental health and risk reduction. The programme begins with a Family Check-up assessment, which determines what parenting support is required, depending on the severity of the family's problems. Family Check-ups begin when the child is 2 years old and then continue annually until the child attends primary school.[77] **Model:** Group or individual. **Level of need:** Targeted selected. Aimed at children 2–5 years. **Target population:** Families at risk of child behaviour problems. **Practitioner:** Delivered by a therapist or social worker (qualified to QCF-7/8 level who has received 35 hours of programme training). With the appropriate consultation and supervisory support, a paraprofessional/non-bachelor-level practitioner also may implement the programme.	Its use and prevalence are unknown in the UK and in local Supporting Families Programmes.	The EIF Guidebook has provided the programme with a level 3 evidence of short-term positive outcomes, including improved child behaviours, improved parent–child interactions and reduced maternal depression. EIF's Guidebook gives a cost rating of 2, indicating that it has a medium-low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of £100–£499.	Level 3 evidence rating in the EIF Guidebook ie. strong evidence.	Limited evaluations have taken place on the delivery of Family Check-up for children as part of early help services. Further longitudinal evaluations are required to determine the long-term impacts.
Parents Plus programmes	Parents Plus programmes are for parents who have concerns about the behaviour or emotions of a child. They can also be delivered as a universal/ preventative intervention or as a more targeted intervention. There are a number of Parents Plus programmes including Parents Plus Early Years,[78] Parents Plus Children's Programme,[79] Parents Plus Adolescent Programme[80] and Parents Plus Parenting when Separated.[81] **Model:** Group. **Level of need:** Targeted selected. **Target population:** Parents who have concerns about the behaviour or emotions of a child at various age ranges. **Practitioner:** Two practitioners deliver this programme. Both are Parents Plus Facilitators with QCF-6 level qualifications.	Parents Plus programmes are used throughout England in early years and other settings, including early help. However, the extent of its use is unknown.	The EIF Guidebook has provided each version of the programme with a level 2+ of evidence. The EIF Guidebook gives a cost rating of 2 (and 1 for Parents Plus Early Years) indicating it has a low-medium cost to set up and deliver compared with other interventions reviewed by EIF.	The strength of evidence is considered to be low, as each version of the programme has been assigned a level 2 + evidence rating.	Further longitudinal evaluations are required to determine long-term impact.
Non-violent resistance (NVR)	Non-violent resistance (NVR) is a form of systemic family therapy, first developed in the early 2000s. It was developed to help parents or carers challenge disruptive child behaviour in a manner that does not lead to further escalation. NVR lasts for approximately three to four months, though this may be longer in cases of multi-stressed families, looked-after children and/or where there have been cases of child abuse and complex attachment insecurity. Sessions are with the parents only and as such NVR can begin without the need for the child to be involved. **Level of need:** Targeted indicated. **Target population:** Children with a range of negative behavioural or psychological disorders.	NVR is being used by practitioners from a range of professional backgrounds including clinical psychology, systemic family therapy, psychotherapy, nursing and social work in a variety of contexts including family support, children's social care and schools. However, limited information was found on where it is being delivered in the UK.	There is a growing body of evidence that suggests NVR-based therapy is effective in reducing negative child outcomes such as problem behaviours, externalising behaviours, psychological disorders and other outcomes, from several international RCTs and one mixed-method pre/post UK evaluation.	NVR has not been assessed by the EIF. Although it has several robust international studies, it only has one UK study of less robustness (pre/post). The evidence could therefore be considered low but promising.	Robust impact and economic evaluation is needed to test promising international findings and look at long-term effectiveness within UK settings, in addition to studying its impacts on other outcomes such as DA and substance abuse.

76 Empowering Parents, Empowering Communities (EPEC). EIF Guidebook: **https://guidebook.eif.org.uk/programme/empowering-parents-empowering-communities**

77 Family Check-up for Children. EIF Guidebook: **https://guidebook.eif.org.uk/programme/family-check-up-for-children**

78 **https://guidebook.eif.org.uk/programme/parents-plus-early-years**

79 **https://guidebook.eif.org.uk/programme/parents-plus-childrens-programme**

80 **https://guidebook.eif.org.uk/programme/parents-plus-adolescent**

81 **https://guidebook.eif.org.uk/programme/parents-plus-parent-when-separated**

Parental mental health

Definition

A mental disorder – also called a mental health problem, mental illness or psychiatric disorder – is a behavioural or mental pattern that causes significant distress or impairment of personal functioning. Mental health problems encompass a wide range of conditions that include mood disorders (such as depression and anxiety), various psychoses (such as schizophrenia), cognitive impairments, stress-related disorders, behavioural and personality problems, and problems associated with the misuse of substances. There are currently two internationally recognised systems for classifying and diagnosing mental health disorders: The International Classification of Diseases, 11th revision (ICD-11)[81] and The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).[82]

Impact on children

Parental mental health problems can negatively impact parents' ability to understand and respond appropriately to their child's needs. Parental mental health problems (including during the perinatal period) are associated with a variety of poor child outcomes and are a particular risk for child behavioural problems.[83] Studies also show that serious mental health problems can reduce parents' ability to benefit from standard parenting and family interventions.[84]

Interventions with evidence of preventing and reducing the negative impact of parental mental health

Studies show that universal mental health screening is an effective means for increasing parents' access to effective treatments, as well as improving their mental health awareness more generally.[85] Validated screening tools include the Edinburgh Postnatal Depression Scale (EPDS) and Generalised Anxiety Assessment (GAD-7).[86]

Interventions offered to individuals who are at risk of developing a mental health problem, such as counselling to mother at risk of postnatal depression, have mixed evidence.[87]

There is clear evidence showing that various psychotherapies are effective at reducing problematic mental health symptoms once a psychological illness has occurred.[89] These therapies include CBT and other therapies highlighted below. The extent to which therapeutic treatments offered to parents also benefit children remains unclear, however. Although several studies have observed improvements in child outcomes after their parents have received therapeutic interventions, these positive outcomes are not consistent across all studies.[91]

Other therapeutic interventions include those that work with both the child and the family to support their mental health and other issues such as problem behaviours. These include multisystemic therapy (MST) programmes and functional family therapy (FFT) (see below).

The Incredible Years Basic programme (see parenting programmes), which is available through local Improving Access to Psychological Therapies (IAPT), has evidence of improving child outcomes when offered to clinically depressed mothers. However, not all studies have observed reductions in parents' self-reported symptoms of depression.[92]

In addition, studies consistently show that mental health support for parents can provide benefits for children – by helping parents to learn new strategies that support the parent–child relationship – even though they may be inadequate for resolving the parent's mental health problem.[93]

Child–parent psychotherapy (CPP),[94] infant–parent psychotherapy (IPP)[95] and Child First[96] are three EIF Guidebook interventions with level 3 evidence of improving child outcomes where there are child protection concerns associated with a parental mental health problem. However, they do not appear to currently be delivered in the UK.

82 International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorder. (2011). A conceptual framework for the revision of the ICD-10 classification of mental and behavioural disorders. World Psychiatry, 10, 86–92.

83 See: **https://www.who.int/standards/classifications/classification-of-diseases**

84 Barker, E. D., et al. (2012). Relative impact of maternal depression and associated risk factors on offspring psychopathology. The British Journal of Psychiatry, 200, 124–129; Asmussen, K., & Brims, L. (2018). What works to enhance the effectiveness of the Healthy Child Programme. Early Intervention Foundation. **https://www.eif.org.uk/report/what-works-to-enhance-the-effectiveness-of-the-healthy-child-programme-an-evidence-update;** Oyetunji, A., & Chandra, P. (2020). Postpartum stress and infant outcome: A review of current literature. Psychiatry Research, 284, 112769; Mulder, T. M., et al. (2018). Risk factors for child neglect: A meta-analytic review. Child Abuse & Neglect, 77, 198–210.

85 Barlow, J., et al. (2015). Parent-infant psychotherapy for improving parental and infant mental health: A systematic review. Cochrane Database of Systematic Reviews, 11, 1–30.

86 O'Connor, E., et al. (2016). Primary care screening for and treatment of depression in pregnant and postpartum women: Evidence report and systematic review for the US Preventive Services Task Force. JAMA, 315(4), 388–406. See: **https://www.nice.org.uk/guidance/cg192/chapter/recommendations#recognising-mental-health-problems-in-pregnancy-and-the-postnatal-period-and-referral-2**

87 Gibson, J., et al. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. Acta Psychiatrica Scandinavica, 119(5), 350–364; Löwe, B., et al. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. Medical Care, 46, 266–274.

88 Morrell, C. J., et al. (2016). A systematic review, evidence synthesis and meta-analysis of quantitative and qualitative studies evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. Health Technology Assessment, 20, 1–414

89 Asmussen, K., & Brims, L. (2018). What works to enhance the effectiveness of the Healthy Child Programme. Early Intervention Foundation. **https://www.eif.org.uk/report/what-works-to-enhance-the-effectiveness-of-the-healthy-child-programme-an-evidence-update**

90 Asmussen, K., & Brims, L. (2018). What works to enhance the effectiveness of the Healthy Child Programme. Early Intervention Foundation. **https://www.eif.org.uk/report/what-works-to-enhance-the-effectiveness-of-the-healthy-child-programme-an-evidence-update**

91 Stein, A., et al. (2018). Mitigating the effect of persistent postnatal depression on child outcomes through an intervention to treat depression and improve parenting: A randomised controlled trial. The Lancet Psychiatry, 5(2), 134–144; Cuijpers, P., et al. (2015). The effects of psychological treatment of maternal depression on children and parental functioning: A meta-analysis. European Child & Adolescent Psychiatry, 24(2), 237–245.

92 Stein, A., et al. (2018). Mitigating the effect of persistent postnatal depression on child outcomes through an intervention to treat depression and improve parenting: A randomised controlled trial. The Lancet Psychiatry, 5(2), 134–144; Cuijpers, P., et al. (2015). The effects of psychological treatment of maternal depression on children and parental functioning: A meta-analysis. European Child & Adolescent Psychiatry, 24(2), 237–245.

93 Baydar, N., Reid, M. J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. Child Development, 74(5), 1433–1453; Leijten, P., et al. (2018). Research review: Harnessing the power of individual participant data in a meta-analysis of the benefits and harms of the Incredible Years parenting program. Journal of Child Psychology and Psychiatry, 59(2), 99–109.

94 Baydar, N., Reid, M. J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. Child Development, 74(5), 1433–1453; Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., & Wei, Y. (2015). Parent-infant psychotherapy for improving parental and infant mental health: A systematic review. Cochrane Database of Systematic Reviews, 11, 1–30; Rayce, S. B., Rasmussen, I. S., Klest, S. K., Patras, J., & Pontoppidan, M. (2017). Effects of parenting interventions for at-risk parents with infants: A systematic review and meta-analyses. BMJ Open, 7(12), e015707.

95 **https://guidebook.eif.org.uk/programme/child-parent-psychotherapy**

96 **https://guidebook.eif.org.uk/programme/infant-parent-psychotherapy**

97 **https://guidebook.eif.org.uk/programme/child-first**

Therapeutic interventions: A number of evidence-based therapeutic interventions were identified as being used in local Supporting Families Programmes or wider early help services. These included multisystemic therapy (MST) programmes, functional family therapy (FFT) and cognitive behavioural therapy (CBT) programmes.					
Name	**Description**	**Where is it used in England/UK**	**Evidence of effectiveness**	**Strength of evidence**	**Evidence gaps**
Multisystemic therapy (MST) programmes	Multisystemic Therapy (MST) pairs families with a therapist who works intensively for three to five months to address issues that may be acting as barriers to positive behaviour. The therapy can take a range of different forms and is customised to the child's needs and setting, including strategic and strategic family therapy, as well as CBT. There are a number of versions of the programme in the EIF Guidebook, including: MST standard,[98] MST for Child Abuse and Neglect[99] and MST for Problem Sexual Behaviour.[100] **Model:** Individual and family therapy. **Level of need:** Targeted indicated or edge of care. **Target population:** Families with a young person aged 12–17 who is at risk of going into care due to serious antisocial and/or offending behaviour. **Practitioners:** MST therapist/practitioner with QCF-6 level qualifications.	MST teams are currently set up in over 30 locations in England, Scotland and Ireland.	MST has been robustly evaluated on multiple occasions, including systematic reviews demonstrating positive child outcomes in the area of supporting children's mental health and wellbeing, preventing child maltreatment, preventing crime, violence and antisocial behaviour and preventing substance abuse.[101] MST Standard has a level 4+ evidence rating in the EIF Guidebook. MST for Child Abuse and Neglect has an evidence rating of 3 and MST for Problem Sexual Behaviour a 4. EIF's Guidebook gives a high cost rating of 5 for all versions. This is equivalent to an estimated unit cost of more than £2,000.	The strength of evidence is strong, based on multiple RCTs, with MST Standard having a 4+ rating, and others 3–4.	Sub-group analysis or evaluations of differing population characteristics would further inform our understanding about who benefits most from MST. For example, The Youth Endowment Fund has commissioned an evaluation of MST-E, a version designed for situations where there is risk or evidence of criminal or sexual exploitation, in four LAs, with a feasibility study reporting in late 2022.
Functional family therapy	A therapeutic intervention for young people involved in serious antisocial behaviour and/or substance misuse, and their parents. Participants are taught behavioural strategies and skills including listening skills, anger management and parental supervision techniques to replace maladaptive behaviours (ie antisocial behaviour and substance abuse).[102] **Model:** Individual and family therapy. **Level of need:** Targeted or edge of care. **Target population:** Families with a young person aged 10–18 who is at risk of going into care due to serious antisocial and/or offending behaviour. **Practitioners:** Clinical psychologists or social workers with QCF-7/8 level qualifications.	Its use and prevalence are unknown in the UK and in local Supporting Families Programmes.	Level 3+ evidence from multiple studies of reducing substance misuse in teenagers. However, these benefits were not replicated in the only UK trial.	The EIF Guidebook has given Functional Family Therapy a Level 3+ evidence rating.	Sub-group analysis or evaluations of differing population characteristics would further inform our understanding about who benefits most from FFT.
Cognitive behavioural therapy (CBT) programmes	CBT is a type of talking treatment that focuses on how your thoughts, beliefs and attitudes affect your feelings and behaviour and teaches you coping skills for dealing with different problems.[103] One version of Trauma-Focused CBT is in the EIF Guidebook.[104] **Level of need:** Targeted-indicated, targeted selected and universal. **Target population:** Children and adults. **Practitioners:** Mental health professionals with QCF 7/8 level qualifications .	Used throughout England including in the NHS as well as in a range of adult and children's services, including in children's social care.	CBT has been found to be effective in improving outcomes associated with substance misuse, improving mental health[105] (eg depression, PTSD and anxiety) and reducing re-referrals in cases involving child physical abuse. But limited evidence of impact on other outcomes such as reducing domestic abuse recidivism and employment outcomes.[106] One manualised CBT intervention – Trauma-Focused CBT – is in EIF's Guidebook with an evidence rating of 3+ showing an impact on PTSD and depression. With a medium cost rating of 3 – equivalent to an estimated unit cost of £500–£999.	The strength of evidence is strong, with multiple clinical trials and meta-analyses. The EIF Guidebook has given Trauma-Focused CBT a Level 3+ rating, suggesting robust strength of evidence. However, studies assessed come from outside the UK.	Sub-group analysis or evaluations of differing population characteristics such as ethnic minorities and low-income samples would further inform our understanding about who benefits most from CBT.

98 **https://guidebook.eif.org.uk/programme/multisystemic-therapy**

99 **https://guidebook.eif.org.uk/programme/multisystemic-therapy-for-child-abuse-and-neglect**

100 **https://guidebook.eif.org.uk/programme/multisystemic-therapy-for-problem-sexual-behaviour**

101 Tan, J. X., & Fajardo, M. L. R. (2017). Efficacy of multisystemic therapy in youths aged 10–17 with severe antisocial behaviour and emotional disorders: systematic review. London J Prim Care (Abingdon). August 9, 9(6), 95–103. doi: 10.1080/17571472.2017.1362713.

102 **Functional family therapy. EIF Guidebook: https://guidebook.eif.org.uk/programme/functional-family-therapy**

103 Youth Endowment Foundation. Evidence Toolkit. Cognitive Behavioural Therapy. For more information see: **https://youthendowmentfund.org.uk/toolkit/cognitive-behavioural-therapy**

104 Early Intervention Foundation Guidebook. Trauma-Focused Cognitive Behavioural Therapy. For more information see: **https://guidebook.eif.org.uk/programme/trauma-focused-cognitive-behavioural-therapy**

105 Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. Cognit Ther Res, 1, 36(5), 427–440. doi: 10.1007/s10608-012-9476-1.

106 Riise, E. N., Wergeland, G. J. H., Njardvik, U., & Öst, L-G. (2021). Cognitive behavior therapy for externalizing disorders in children and adolescents in routine clinical care: A systematic review and meta-analysis. Clinical Psychology Review, 83. **https://doi.org/10.1016/j.cpr.2020.101954;** Hayday, S., Rick, J., Carroll, C., Jagger, N., & Hillage, J. (2008). Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to help recipients of incapacity benefits return to employment (paid and unpaid). **https://www.nice.org.uk/guidance/ng146/evidence/effectiveness-and-cost-effectiveness-of-interventions-strategies-programmes-and-policies-to-help-recipients-of-incapacity-benefits-return-to-employment-paid-and-unpaid-pdf-6967148223**

Therapies: In addition to therapeutic interventions, a number of therapies were highlighted within the Supporting Families Programme, which are also set out below.				
Name	**Description**	**Evidence of effectiveness**	**Strength of evidence**	**Evidence gaps**
Narrative family therapy	Narrative therapy is a method that sees personal experiences or issues as personal stories that shape an individual's identity and life stories. It uses these stories to help individuals discover and become experts in them, creating a space between the individual and their issues that seeks to have an empowering effect in a non-blaming and non-pathological way. In doing so it seeks to encourage individuals to use their own skills to minimise problems that exist in their lives. **Level of need:** Targeted indicated. **Target population:** Individuals, couples or families.	There is a limited number of impact evaluations looking at the impact of narrative family therapy, although these mainly come from clinical settings. It has shown significant improvements in children's self-awareness, self-management, social awareness/empathy and responsible decision-making and, consequently, in children's social and emotional skills and social phobia, in addition to reducing psychological distress in young people with autism. However, the evidence comes from small sample sizes mainly in clinical settings. There is some indication that it can also improve parent–child conflict, but this evidence is even more limited.	The strength of evidence is considered low, given the limited number of robust impact evaluations, with most being undertaken in clinical settings with small sample sizes.	More robust evaluation (ie RCTs) is required when measuring its effectiveness in children. Research is typically pre/post in this area, while RCTs are conducted on an older population. More UK research is also required on families with vulnerabilities, including low-income families.
Systemic family therapy	Systemic family therapy and practice seeks to see the individual as part of a larger unit or system, so rather than seeing the individual in isolation, the individual is seen as part of a couple, a family, an organisation or a community. By helping families develop more supportive and functional relationships and the development of positive family routines and rituals, this practice and therapy looks to address child-focused problems. It attempts to identify the deeply entrenched patterns of behaviours and feelings that exist within relationships, based on beliefs about their respective roles. It has become a widely used intervention in the past five decades in child and adolescent mental health services. **Level of need:** Targeted indicated. **Target population:** Whole families (children and adults).	Systemic therapy has consistently been found to be effective and, in some cases, more effective than individual therapy in clinical settings, in reducing problems associated with a wide range of child and adult outcomes. Regarding child outcomes, evidence suggests positive outcomes in the following: attachment problems in infancy, aspects of child abuse, childhood disruptive behaviour disorders and adolescent eating disorders. In a meta-analysis of 48 trials, comparing outcomes of systemic and individual interventions for internalising and externalising child behaviours, for child-focused problems, outcomes improved more when both the parents and children were included in the intervention. There is also evidence of effectiveness in the outcomes on relationship distress, psychosexual problems and intimate partner violence in adults.	The strength of evidence is considered moderate. Although the evidence is consistent and conclusive regarding its effectiveness in improving outcomes associated with mental health and interpersonal relationships, research has typically been conducted within a clinical setting with small sample sizes.	The effectiveness of systemic family therapy by non-clinicians or the use of systemic family practice (rather than specific therapy) in services to support families has not been tested. Moreover, there is currently a range of under-researched populations (eg LGBTQ+ and ethnic minorities or those with SEND).
Art therapy	Art therapy is a type of psychotherapy that uses art media as its primary mode of expression and communication. It is not considered a diagnostic tool, but rather a medium to address emotional issues that may be confusing and distressing. It can be conducted in groups or individually, depending on individual needs. Art therapy has been inspired by theories such as attachment-based psychotherapy and has developed a broad range of client-centred approaches such as psycho-educational, mindfulness and mentalisation-based treatments, compassion-focused and cognitive analytic therapies, and socially engaged practice. **Level of need:** Targeted indicated – individuals may have a wide range of difficulties, disabilities or diagnoses. **Target population**: At all ages.	Art therapy has been evidenced as being effective in the following domains: • improving self-esteem • reducing PTSD symptoms • improving externalising behaviours • improving problem-solving skills, reducing worry and anxiety and improving total quality of life.	In summary, while being well evidenced by RCTs, findings remain mixed. Limitations in the literature include a lack of heterogeneity in how, where and by whom art therapy is delivered and as such the results are often non-generalisable outside the single studies. Moreover, studies are typically of low sample size, again reducing generalisability of findings. The success of art therapy appears dependent on population of focus and the outcomes it measures.	Gaps remain on how and when art therapy may be most beneficial. For example, the optimal number of sessions and how art therapy may be used to treat different mental health disorders. Similarly, there is much heterogeneity within the evidence base and as such it can be difficult to apply the findings to particular settings or formats.
Play therapy	Play therapy is a form of psychotherapy that uses play to help children deal with emotional and mental health issues. Rather than having to explain in their own words, much like in adult-based therapy, children can play to communicate at their own level and at their own pace, without feeling interrogated or threatened. Sessions typically last 30 minutes to an hour and are held once a week or so. How many sessions are needed depends on the child and how well they respond to this type of therapy. Therapy can take place individually or in groups. **Level of need:** Targeted indicated – individuals may have a wide range of difficulties, disabilities or diagnoses. **Target population:** Children (aged 3–12)	In a meta-analysis of 70 studies between 1940 and 2000, play therapy was found to be effective treatment for treating poor child behaviour, with a large effect size found, suggesting that play therapy had a large positive effect on the treatment group. The analysis also indicated that the effectiveness of play therapy increased as the number of sessions increased and then levelled out. The optimal number of sessions appeared to be between 30 and 35. Moreover, it was identified that parental involvement was a significant predictor of play therapy outcomes, namely that parental involvement in treatment significantly affected the success of the intervention outcome. Due to the lack of reported information on therapist training, no conclusions could be formed regarding the extent to which training and experience influenced the impact of play therapy.	The evidence available is low to moderate strength, with evidence typically being of small sample sizes and a limited number of RCTs. Evidence could be strengthened by a clear outcome measurement as, to date, the evidence focuses on a broad range of outcomes, which results in mixed findings. The comparison of evidence (and therefore generalisability of findings) is made more difficult because intervention dosage varies so much (eg a child participating in daily therapy sessions for 12 consecutive days might have a very different experience and outcome compared with a child participating in weekly sessions for nine months).	It is still often unclear how play therapy is implemented (ie the specific components). Consequently, it is difficult to determine the most effective form of play therapy. Similarly, less is known on how it is implemented with low socio-economic children.
Solution-focused brief therapy (SFBT)	Solution-focused brief therapy (SFBT) was developed in the late 1970s. It is a short-term goal-focused evidence-based therapeutic approach, which incorporates positive psychology principles and practices and which helps individuals change by constructing solutions rather than focusing on problems. It lasts on average for 6–10 weeks but can be used in one stand-alone session. SFBT is one of the theoretical underpinnings of the Signs of Safety model in the UK. **Level of need:** Targeted indicated with the evidence relevant to 'children in need'. **Target population**: Children, adults and whole families.	There is evidence to indicate that SFBT can: • improve child's externalising and internalising behaviours • reduce child maltreatment • improve child wellbeing • improve child academic outcomes.	The strength of available evidence is low. The evidence base is of low-quality evidence, given the poor reporting of studies (eg practitioner and setting information), low sample sizes and the lack of RCTs. Moreover, SFBT can be used with multiple other interventions and as such it is difficult to assess just how much an effect SFBT is having over the other interventions.	SFBT has been studied more extensively in the US and more UK-based research is required. More robust evidence is required (eg RCTs) that focuses on larger sample sizes.

Domestic abuse interventions

Definition

'Domestic violence', 'domestic abuse', 'intimate partner violence' and 'spousal abuse' are terms that are used interchangeably to describe high levels of physically and psychologically damaging interactions occurring between adult partners in a romantic relationship.[106] Within the UK, domestic abuse is defined in the Domestic Abuse Act 2021 as any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners and includes: physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse and psychological, emotional or other abuse.[107]

Prevalence

UK crime statistics estimate that at least 5% of adults have been involved in some form of domestic abuse within any given year, and up to one-fifth of children will have witnessed a serious domestic abuse incident before the age of 18.[108] Domestic abuse is also the most common reason why a child is assessed as in need.[109]

Impact on children

Domestic abuse is strongly predictive of a wide variety of negative outcomes for victims (also widely referred to as survivors). Children who are exposed to domestic abuse are also at significantly greater risk of poor outcomes, including doubling the risk of a serious adult mental health problem and tripling the risk of being either a victim or perpetrator of domestic abuse.[110]

Interventions with evidence of preventing and stopping domestic abuse and reducing its negative impact

Very few interventions have robust evidence of stopping domestic abuse once it has occurred. For this reason, the US Centers for Disease Control (CDC) and the World Health Organization (WHO) both strongly advise that prevention strategies play a primary role in public health approaches targeting domestic abuse.[111] Antenatal domestic abuse screening,[112] healthy relationship training for young people[113] and healthy relationship training for parents are three examples of intervention activities that have causal evidence of preventing behaviours associated with domestic abuse.

Targeted interventions for children and parents exposed to domestic abuse

Many of these activities have been identified as effective in previous UK reviews, including by the National Institute for Health and Care Excellence's (NICE) 2013 review of interventions to identify, prevent, reduce and respond to domestic abuse[114] and the National Institute for Health's 2016 IMPROVE evidence synthesis,[115] as well as in EIF's recent review on what works for vulnerable children.[116] These activities include:

- **'empowerment' interventions** offered to pregnant mothers identified as being at risk during a routine antenatal check-up [117]
- **shelters and supportive housing:** Findings from a recently conducted Cochrane review observed that the effectiveness of supportive housing for reducing revictimisation was promising, but non-conclusive owing to of a lack of robust studies[118]
- **individual therapy offered to mothers and children** who have witnessed domestic abuse. For mothers this includes CBT;[119] although the extent to which therapeutic interventions offered to victims provide benefits for children, however, remains untested. For children, Trauma-focused CBT (TF-CBT) provides children with cognitive strategies aimed at managing negative emotions and beliefs stemming from highly distressing or abusive experiences and has evidence of reducing trauma symptoms[120]

107 World Health Organization. (2012). Understanding and addressing violence against women: Intimate partner violence.

108 **See: https://www.legislation.gov.uk/ukpga/2021/17/contents**

109 **See: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021**

110 **See: https://www.gov.uk/government/collections/statistics-children-in-need**

111 Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. Journal of Consulting and Clinical Psychology, 71(2), 339; Gewirtz, A. H., & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. Journal of Family Violence, 22(3), 151–163; Brown, S. M., Rhoades, G. K., Marti, C. N., & Lewis, T. (2021). The co-occurrence of child maltreatment and intimate partner violence in families: Effects on children's externalizing behaviour problems. Child Maltreatment, 26(4), 363–375.

112 World Health Organization. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence; Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: A technical package of programs, policies and practices. National Center for Injury Prevention and Control.

113 Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., … & US Preventive Services Task Force. (2018). Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: US Preventive Services Task Force final recommendation statement. JAMA, 320(16), 1678–1687.

114 Piolanti, A., & Foran, H. M. (2021). Efficacy of interventions to prevent physical and sexual dating violence among adolescents: A systematic review and meta-analysis. JAMA Pediatrics, 176, 142–149.

115 See: **https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence3**

116 Howarth, E., Moore, T. H., Welton, N. J., Lewis, N., Stanley, N., MacMillan, H., … & Feder, G. (2016). IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE): An evidence synthesis. Public Health Research, 4(10), 1–342.

117 See Asmussen, K., et al. (2022). What works to improve the lives of England's most vulnerable children: A review of interventions for a local family help offer. Early Intervention Foundation. **https://www.eif.org.uk/report/what-works-to-improve-the-lives-of-englands-most-vulnerable-children-a-review-of-interventions-for-a-local-family-help-offer**

118 Kiely, M., El-Mohandes, A. A. E., El-Khorazaty, M. N., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. Obstetrics & Gynecology, 115(2 Part 1), 273–283. doi: 10.1097/AOG.0b013e3181cbd482.

119 Yakubovich, A. R., Bartsch, A., Metheny, N., Gesink, D., & O'Campo, P. (2021). Housing interventions for women experiencing intimate partner violence: A systematic review. The Lancet Public Health, 7.

120 Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011). Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. Journal of Consulting and Clinical Psychology, 79(2), 193; Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2020). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. Trauma, Violence, & Abuse, 21(2), 311–325.

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

- **parenting support interventions for families exposed to domestic abuse:** This includes five parenting interventions listed in the EIF Guidebook that have causal evidence of improving child outcomes when offered to mothers and children exposed to domestic abuse, but are currently not known to be delivered here in the UK: child–parent psychotherapy (CPP),[121] Child First,[122] GenerationPMTO,[123] parent–child interaction therapy[124] and Project Support.[125] There are a number of UK-based interventions, but the evidence base is weak; predominantly driven by the lack of robust impact evaluations. These interventions include: Domestic Abuse, Recovering Together (DART);[126] Opening Closed Doors;[127] For Baby's Sake[128] and NewDay[129]
- **family therapy for families who have experienced domestic abuse:** This includes multisystemic therapy (MST) and functional family therapy (FFT) (see above for more information on them) with evidence of improving child outcomes when offered to families who have experienced domestic abuse. However, neither has specific evidence of stopping the violence and abuse occurring between parents, and in some instances families may be ineligible for MST or FFT if high levels of domestic violence are ongoing
- **perpetrator interventions:** A wide variety of interventions have been developed to change the attitudes and abusive behaviours of perpetrators of domestic violence, with the primary aim of reducing reoffending rates and keeping victims and children safe. To date, His Majesty's Prison and Probation Service (HMPPS)[130] offers four accredited programmes for those convicted of intimate partner violence (IPV), including: Building Better Relationships; Becoming New Me + (BNM+); New Strength Me (NSM); and Kaizen. However, this review was unable to identify how many are being delivered in England or information on whether any of these accredited programmes has been robustly evaluated.[131] Project Drive[132] and Cautioning and Relationship Abuse (CARA)[133] are other perpetrator interventions being delivered in England with preliminary evidence of reductions in related incidents. However, overall international findings are mixed, and therefore the current consensus is that perpetrator programmes do not, as yet, provide robust evidence for keeping children and victims safe – particularly in situations where the perpetrator has exerted high levels of coercive control.[134] The US Centers for Disease Control and other international public health organisations therefore advise against using perpetrator programmes as a primary means for stopping or reducing domestic abuse.[135]

While there is a good understanding of the broad harm domestic abuse can do to both children and adults, the strength of the evidence base is weaker on the multidimensional and long-term harm caused. The evidence is even weaker on interventions to address domestic abuse. While there are numerous victim/survivor interventions, some with robust international evidence, there is limited evidence within the UK context. More research is required to test the effectiveness of advocacy, psycho-educational and therapy-based interventions using larger sample sizes and validated measures. The evidence base is even less for perpetrator interventions.

122 Child–parent psychotherapy (CPP) that combines therapeutic support for the mother's symptoms of trauma with parenting advice to support the needs of the child. **https://guidebook.eif.org.uk/programme/child-parent-psychotherapy**

123 Child First combines CPP with support from a care coordinator, who ensures that practical family needs (including access to safe housing and healthcare) are addressed. It was developed specifically for families where domestic abuse and parental substance misuse exist. **https://guidebook.eif.org.uk/programme/child-first**

124 GenerationPMTO is an intervention that teaches parents effective family management skills to reduce antisocial and problematic child behaviour. **https://guidebook.eif.org.uk/programme/generation-pmto-group**

125 Parent–child interaction therapy, an intervention delivered in two phases: child-directed interaction (CDI), which resembles traditional play therapy, and parent-directed interaction (PDI), which resembles clinical behaviour therapy. For more information see: **https://www.blueprintsprograms.org/programs/145999999/parent-child-interaction-therapy**

126 Project Support combines parent management training with therapeutic support to mothers. See: Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing conduct problems among children exposed to intimate partner violence: A randomized clinical trial examining effects of Project Support. Journal of Consulting and Clinical Psychology, 77(4), 705–717. **https://doi.org/10.1037/a0015994**

127 DART, developed by the NSPCC, is a psycho-educational intervention for children and mothers to talk to each other about domestic abuse, learn to communicate and rebuild their relationship with emerging evidence of its impact on children and mothers. For more information see**: https://learning.nspcc.org.uk/media/2356/impact-evaluation-scale-up-domestic-abuse-recovering-together.pdf**

128 The Opening Closed Doors Service provides support to children and young people who are exposed to domestic abuse and/or violence. The model involves an approach where a keyworker facilitates support for the wider family unit to embed sustainable change. For more information on its evaluation see: **https://www.barnardos.org.uk/opening-closed-doors-one-year-evaluation**

129 For more information see: **https://www.forbabyssake.org.uk**

130 For more information see: **https://www.cordisbright.co.uk/admin/resources/newhamnewdayreport.pdf**

131 Ministry of Justice and HM Prison and Probation Service. (2018). Offending behaviour programmes and interventions: Guidance. **https://www.gov.uk/guidance/offending-behaviour-programmes-and-interventions**

132 **https://www.gov.uk/guidance/intimate-partner-violence-domestic-abuse-programmes**

133 Hester, P. (2019). Evaluation of the Drive Project – A three-year pilot to address high-risk, high-harm perpetrators of domestic abuse. **http://driveproject.org.uk/wp-content/uploads/2020/01/Drive-Evaluation-Report-Final.pdf**

134 Strang, H., et al. (2017). Reducing the harm of intimate partner violence: Randomized controlled trial of the Hampshire Constabulary CARA Experiment. Cambridge Journal of Evidence-Based Policing, 1(2–3), 160–173.

135 Myhill, A., & Hohl, K. (2019). The 'golden thread': Coercive control and risk assessment for domestic violence. Journal of Interpersonal Violence, 34(21–22), 4477–4497.

136 Babcock, J., et al. (2016). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. Partner Abuse, 7(4), 355–460; Niolon, P. H., et al. (2017). Preventing intimate partner violence across the lifespan: A technical package of programs, polices, and practices. National Center for Injury Prevention and Control.

Substance misuse

Definition

Substance misuse (also referred to as a substance use disorder) is a broad term applied to persistent alcohol and drug use that is measurably detrimental to an individual's physical and mental health, as well as the wellbeing of others.[136] It is characterised by chronic and heavy use that escalates despite clear evidence of harm. Problematic substance misuse is therefore recognised as a diagnosable mental health disorder within a spectrum of increasingly problematic behaviours.[137]

Prevalence

Reliable estimates of the prevalence of parental substance misuse in the UK are difficult to obtain, as studies involving adult populations rarely identify participants as parents.[138] Public Health England currently estimates that just under 5% of English children live with a parent who engages in harmful or dependent alcohol or drug use.[139] This includes 1% who live with a dependent opiate-using parent and 2% who live with an alcohol-dependent parent. It is estimated that an additional 30% of all children live with a parent with a harmful substance use problem that does not meet the threshold for dependence.[140] While substance abuse was not mentioned by keyworkers in the 2017 survey of the type of support provided to families regularly, it was mentioned in recent research as an area where specialist interventions are delivered as part of local Supporting Families Programmes referring to rehabilitation programmes such as SHARPS.

Impact on children

Studies show that children are negatively impacted by parental substance misuse, even when it does not meet thresholds for dependent use.[141] In these instances, parental substance misuse substantially increases the risk of internalising and externalising behavioural problems in childhood and substance use problems in adolescence and adulthood,[142] with parental substance misuse a key risk for child maltreatment and a primary reason why children are taken into care.

Parental substance misuse negatively impacts children's development by reducing the parent's capacity to understand and support the child's needs and often exposes children to other risks related to the substance misusing behaviour, including domestic violence, parental incarceration and physical and mental health problems.[143] However, understanding the risks associated with parental substance misuse and their impact on family life is a challenging and complex process, as the risks and impacts vary with each substance, the child's age and the parent's age.[144]

Interventions to improve child outcomes

Studies show that children rarely benefit from interventions that target parents' substance misuse problems alone.[145] A recent Cochrane review found that parental substance misuse treatment is most likely to benefit children when it is combined with evidence-based treatments aimed at supporting the parent–child relationship.[146] The sequencing of treatment (whether substance misuse support should be offered in combination with other therapies, or if it is always preferable to address substance misusing behaviours first, before offering additional family interventions) is often contingent on the severity, the extent to which one or both parents are addicted and the extent to which other adults are available to meet the child's needs.[147] There is clear evidence that parental substance misuse also negatively impacts parents' ability to benefit from other interventions, including individual therapy, couples counselling, parenting support and systemic family support.[148] Parents with persistent substance misuse problems are therefore ineligible for many of the interventions described in other parts of this review.

It is important to know that for many, full recovery can take months or years to achieve and, given the high risk of relapse, harmful or dependent substance use is viewed as a chronic condition that requires ongoing management throughout the life-course, rather than a temporary illness that can readily be cured.[149]

Targeted indicated interventions for adults

A wide variety of targeted indicated interventions are available for adults with dependent drug and alcohol problems, although very few are specifically intended for parents. While many of these treatments have evidence for improving adult outcomes, their benefits for children remain untested.[150] Two of the most used and evidenced are:

- **twelve-step facilitation interventions (TSFIs**), perhaps the most widely implemented therapeutic response to adult substance misuse problems and a 2020 Cochrane review concluded that they are effective for increasing total abstinence, and that effectiveness is enhanced when the programme is manualised, offered through clinical support and 'prescribed',[151] in addition to being augmented with motivational interviewing[152]

137 Carvalho, A. F., Heilig, M., Perez, A., Probst, C., & Rehm, J. (2019). Alcohol use disorders. The Lancet, 394(10200), 781–792.

138 The International Classification of Diseases and Health Problems (ICD-11) identifies four distinct categories of problematic substance misusing behaviours. See: **https://www.who.int/standards/classifications/classification-of-diseases**

139 Galligan, K., & Comiskey, C. M. (2019). Hidden harms and the number of children whose parents misuse substances: A stepwise methodological framework for estimating prevalence. Substance Use & Misuse, 54(9), 1429–1437.

140 Public Health England. (2021). Parents with alcohol and drug problems: Adult treatment and children and family services. **https://www.gov.uk/government/publications/parents-with-alcohol-and-drug-problems-support-resources/parents-with-alcohol-and-drug-problems-guidance-for-adult-treatment-and-children-and-family-services**

141 Manning, V., Best, D. W., Faulkner, N., & Titherington, E. (2009). New estimates of the number of children living with substance misusing parents: Results from UK national household surveys. BMC Public Health, 9, 377..

142 McGovern, R., Gilvarry, E., Addison, M., Alderson, H., Geijer-Simpson, E., Lingam, R., … & Kaner, E. (2020). The association between adverse child health, psychological, educational and social outcomes, and nondependent parental substance: A rapid evidence assessment. Trauma, Violence, & Abuse, 21(3), 470–483; Syed, S., Gilbert, R., & Wolpert, M. (2018). Parental alcohol misuse and the impact on children: A rapid evidence review of service presentations and interventions. Children's Policy Research Unit.

143 Finan, L. J., Schulz, J., Gordon, M. S., & Ohannessian, C. M. (2015). Parental problem drinking and adolescent externalizing behaviors: The mediating role of family functioning. Journal of Adolescence, 43, 100–110; Kendler, K. S., Gardner, C. O., Edwards, A., Hickman, M., Heron, J., Macleod, J., … & Dick, D. M. (2013). Dimensions of parental alcohol use/problems and offspring temperament, externalizing behaviors, and alcohol use/problems. Alcoholism: Clinical and Experimental Research, 37(12), 2118–2127.

144 Velleman, R., & Templeton, L. J. (2016). Impact of parents' substance misuse on children: An update. BJPsych Advances, 22(2), 108–117; Roy, J. (2021). Children living with parental substance misuse: A cross-sectional profile of children and families referred to children's social care. Child & Family Social Work, 26(1), 122–131.

145 Kuppens, S., Moore, S. C., Gross, V., Lowthian, E., & Siddaway, A. P. (2020). The enduring effects of parental alcohol, tobacco, and drug use on child well-being: A multilevel meta-analysis. Development and Psychopathology, 32(2), 765–778.

146 Calhoun, S., Conner, E., Miller, M., & Messina, N. (2015). Improving the outcomes of children affected by parental substance abuse: A review of randomized controlled trials. Substance Abuse and Rehabilitation, 6, 15.

147 McGovern, R., Newham, J. J., Addison, M. T., Hickman, M., & Kaner, E. F. (2021). Effectiveness of psychosocial interventions for reducing parental substance misuse. Cochrane Database of Systematic Reviews, 3.

148 Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. Clinical Psychology Review, 39, 71–82.

149 Ward, H., Brown, R., & Hyde-Dryden, G. (2014). Assessing parental capacity to change when children are on the edge of care: An overview of current research evidence. Loughborough University.

150 Schuckit, M. A. (2009). Alcohol-use disorders. The Lancet, 373(9662), 492–501.

151 Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: What is the problem and what can be done to help? Addiction, 99(5), 552–559.

152 Kelly, J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics Anonymous and other 12-step programs for alcohol use disorder. Cochrane Database of Systematic Reviews, 3.

153 Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. Journal of Clinical Psychology, 65(11), 1232–1245.

- **cognitive behavioural therapy:** studies show that CBT is effective for helping individuals to manage substance use problems, with specific evidence of reducing use and increasing rates of abstinence.[153]

However, it is unlikely that these interventions are sufficient for providing benefits for children, because they do not specifically address the parenting impairments that frequently co-occur with parental substance misuse problems.[154]

Targeted indicated interventions for parents: Many interventions have been developed for parents with substance use problems, although only a handful have preliminary evidence of improving child outcomes. Below are three interventions delivered in the UK but not in the EIF Guidebook, but with evidence of improving child outcomes.					
Name	**Description**	**Where is it used in the UK**	**Outcomes**	**Strength of evidence**	**Evidence gaps**
Families Facing the Future (FFF)	Families Facing the Future (FFF) aims to serve families with one or more parents receiving methadone treatment who have children or young adolescents. To begin the programme, families attend a five-hour group retreat that focuses on family goal-setting. Then, parent(s) attend 90-minute group sessions twice a week for 16 weeks (a total of 32 sessions). Children attend 12 of these sessions with their parent(s). Families also receive approximately two hours of in-home case management per week. **Model:** Group and individual therapy combined with methadone treatment. **Level of need:** Indicated. **Target population:** Families with one or more parents receiving methadone treatment who have children or young adolescents. **Practitioner:** Case managers must have a master's degree as well as training in chemical dependency and parenting.	Families Facing the Future (FFF) is delivered and has been evaluated in the UK but its prevalence in local Supporting Families Programmes is unknown.		Not in the EIF Guidebook but has level 3 evidence of reducing parental substance misusing behaviours. Impact on child wellbeing is less well established.[156]	
Parents Under Pressure (PUP)	Parents Under Pressure (PUP) provides parents with a diagnosed substance misuse problem with a 12-module programme aimed at reducing their substance misusing behaviours and improving parenting practices. **Model:** Individual therapy combined with methadone treatment. **Level of need:** Indicated. **Target population:** Parents with a diagnosed substance misuse problem with a child aged up to 30 months. **Practitioner:** Methadone treatment overseen by a medical doctor combined with therapy provided by a clinical psychologist/social worker.	Parents Under Pressure (PUP) is delivered and has been evaluated in the UK but its prevalence in local Supporting Families Programmes is unknown.		Evidence from two RCTs showing reductions in child abuse potential and substance misusing behaviours.[157]	
Multisystemic Therapy – Building Stronger Families (MST-BSF)	MST-BSF is a new version of the original MST model combining the MST treatment with reinforced treatment for substance misuse, as well as any additional detoxification support required for individual family members. The MST clinician is expected to fully integrate all forms of care so that family issues and substance misuse issues are treated simultaneously. **Model:** Individual and family therapy. **Level of need**: Edge of Care. T**arget population:** Parents with a diagnosed substance misuse problem with a child between 6 and 17 years. **Practitioner:** MST therapist/practitioner with QCF-6 level qualifications.	MST-BSF is delivered and has been evaluated in the UK but its prevalence in local Supporting Families Programmes is unknown.		Level 3 evidence of reducing parent self-reported alcohol and opiate use, and of improving child-reported neglectful parenting.[158]	

154 Hadjistavropoulos, H. D., Mehta, S., Wilhelms, A., Keough, M. T., & Sundström, C. (2020). A systematic review of internet-delivered cognitive behavior therapy for alcohol misuse: Study characteristics, program content and outcomes. Cognitive Behaviour Therapy, 49(4), 327–346.

155 McGovern, R., Newham, J. J., Addison, M. T., Hickman, M., & Kaner, E. F. (2021). Effectiveness of psychosocial interventions for reducing parental substance misuse. Cochrane Database of Systematic Reviews, 3.

156 Title IV-E Prevention Services Clearinghouse Families Facing the Future: **https://preventionservices.acf.hhs.gov/programs/207/show**

157 Barlow, J., Sembi, S., Parsons, H., Kim, S., Petrou, S., Harnett, P., &, Dawe, S. (2019). A randomized controlled trial and economic evaluation of the Parents Under Pressure program for parents in substance abuse treatment. Drug Alcohol Depend., 1(194), 184–194. doi: 10.1016/j.drugalcdep.2018.08.044.

158 Schaeffer, C., Swenson, C., & Smith Powell, J., (2021). Multisystemic Therapy – Building Stronger Families (MST-BSF): Substance misuse, child neglect, and parenting outcomes from an 18-month randomized effectiveness trial, Child Abuse & Neglect, 122, **https://doi.org/10.1016/j.chiabu.2021.105379**

Reducing family conflict and improving the co-parenting relationships

Definition

Family conflict is normal and studies show that parents often disagree. However, frequent, intense and poorly resolved conflict between parents can have a significant impact on child outcomes and is used as a definition of 'harmful parental conflict'.

Prevalence

According to the latest DWP estimates, 12% of all children and 21% of children in workless families have parents in a distressed relationship.[158]

Impact on children

There is strong evidence that conflict between parents – whether together or separated – can have a significant negative impact on children's mental health and long-term life chances, including emotional, behavioural, social and academic development. Not all conflict is damaging, but where it is frequent, intense and poorly resolved it can harm children's outcomes.[159]

Poorly resolved family conflict negatively impacts children in several ways: children learn that aggressive behaviour is an effective method of resolving disputes with others, high levels of unresolved family conflict make many children anxious and self-blaming, and poorly resolved disputes can preoccupy parents in ways that reduce their sensitivity to their children's needs.[160]

Reducing Parental Conflict Programme

The government's Improving Lives strategy introduced a new focus on tackling the impact of parental conflict on children, with the aim that this will become mainstream, alongside support for parenting. As part of this work, the Department for Work and Pensions (DWP) is leading a national Reducing Parental Conflict Programme to embed evidence-based support to tackle parental conflict in local areas.[161]

The Early Intervention Foundation has created a Reducing Parental Conflict Hub,[162] which provides a central repository of key 'what works' evidence and tools, including why parental conflict matters for children's outcomes and guidance on how to take action.

Interventions aimed at reducing family conflict

None of the interventions described below are considered to be appropriate for parents where domestic abuse is an issue. Abusive attitudes and behaviours make it difficult for parents to empathise with each other's needs and make compromises when making co-parenting decisions.[163]

Parenting interventions

Some of the parenting interventions (see box above) include content that explicitly aims to reduce parental conflict as a means of improving child wellbeing. This content includes methods for helping parents regulate their own anger and stress, exercises for increasing empathy between parents, and strategies for non-hostile communication. For example, Family Check-up for Children. In addition, Triple P[164] and Incredible Years[165] (listed above) provide 'enhanced' versions that have strong and consistent evidence of improving parental mood and increasing couple satisfaction in the short term, but neither has specific evidence of improving the quality of the co-parenting relationship or reducing couple conflict.[166]

Co-parenting interventions

Group-based 'co-parenting' interventions also exist, which focus exclusively on the quality of the co-parenting relationship; some of these are also for parents who are separated.

The guidebook has a number of interventions with content aimed explicitly at reducing family conflict and enhancing the quality of the co-parenting relationship with an evidence rating of 3 or higher.[167] Three are included below. There is also a list of other interventions, not currently included in the Guidebook.

Studies showing that parents do not need to be in a couple relationship to be an effective co-parenting team.[168] Two interventions developed explicitly to improve child outcomes in families where the parents have separated or divorced are New Beginnings Programme for Divorced and Separating Parents[169] (which is not delivered in the UK so not listed below) and Family Transitions Triple P,[170] included below.

159 Department for Work and Pensions. (2020). Parental conflict indicator 2011/12 to 2017/18. Official Statistics. **https://www.gov.uk/government/statistics/parental-conflict-indicator-201112-to-201718/parental-conflict-indicator-201112-to-201718**

160 Harold, G., Acquah, D., Sellers, R., & Chowdry, H. (2018). What works to enhance inter-parental relationships and improve outcomes for children. Early Intervention Foundation. **https://www.eif.org.uk/report/what-works-to-enhance-interparental-relationships-and-improve-outcomes-for-children**

161 Webster-Stratton, C., & Hammond, M. (1999). Marital conflict management skills, parenting style, and early-onset conduct problems: Processes and pathways. The Journal of Child Psychology and Psychiatry and Allied Disciplines, 40(6), 917–927; Harold, G. T., & Sellers, R. (2018). Annual research review: Interparental conflict and youth psychopathology: An evidence review and practice focused update. Journal of Child Psychology and Psychiatry, 59(4), 374–402.

162 Department for Work and Pensions. Reducing Parental Conflict programme and resources. **https://www.gov.uk/government/collections/reducing-parental-conflict-programme-and-resources**

163 Early Intervention Foundation. Reducing Parental Conflict Hub. **https://reducingparentalconflict.eif.org.u**k

164 O'Leary, K. D. (2008). Couple therapy and physical aggression. In A. S. Gurman (Ed.), Clinical handbook of couple therapy (pp. 478–498). Guilford Press.

165 For couples see: Triple P Enhanced, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/triple-p-enhanced**

166 Incredible Years Advance. Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/incredible-years-school-age-basic-advance-parent-training-curriculum**

167 Li, N., Peng, J., & Li, Y. (2021). Effects and moderators of Triple P on the social, emotional, and behavioral problems of children: Systematic review and meta-analysis. Frontiers in Psychology, 12.

168 Early Intervention Foundation Guidebook: **https://guidebook.eif.org.uk/search?sets=improving-interparental-relationships**

169 Cookston, J. T., Braver, S. L., Griffin, W. A., De Lusé, S. R., & Miles, J. C. (2007). Effects of the Dads for Life intervention on interparental conflict and coparenting in the two years after divorce. Family Process, 46(1), 123–137; Cowan, P. A., & Cowan, C. P. (2019). The role of parental relationships in children's well-being: A modest set of proposals for improving the lives of children. Human Development, 62(4), 171–174.

170 New Beginnings Programme for Divorced and Separating Families, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/new-beginnings-programme-for-divorced-and-separating-families**

171 For separated parents see: Triple P Family Transitions, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/triple-p-family-transitions**

Interventions included in the EIF Guidebook

Name	Description	Where is it used in the UK	Outcomes / Strength of evidence	Evidence gaps
Family Foundations[172]	A group-based programme for couples expecting their first child. Couples learn strategies for enhancing communication, resolving conflict and sharing of childcare duties. **Model**: Group-based. **Level of need:** Universal. **Target population**: Couples expecting their first child. **Practitioner:** Practitioners trained in the programme model with at least QCF-6 level qualifications or higher.		Level 4 evidence of medium improvements in infant soothability, reductions in maternal symptoms of depression and anxiety and large improvements in co-parenting behaviours and relationship. Notably, these improvements include less self-reported interparental physical violence and parent–child psychological and physical violence six months following intervention completion. There is also evidence linking the intervention to improved child behavioural outcomes, as rated by their teachers, at age 3 and age 7. EIF's Guidebook gives ah cost rating of 1, indicating that it has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than £100.	
Schoolchildren and their Families [173] **(also known as Parents as Partners)**	A group-based programme for couples with a child entering primary school. Six couples attend 16 sessions of two hours' duration where they learn strategies for managing their child's behaviour and improving their co-parenting practices. **Model:** Group-based. **Level of need:** Universal. **Target population:** Couples with a child entering primary school. **Practitioner:** Two practitioners trained in the Schoolchildren and their Families model with QCF-7/8 level qualifications.		Level 3 evidence of improved parenting behaviours, parental mood and child behaviour, as well as reductions in marital conflict immediately after intervention completion. Improvements in couple communication and satisfaction and some child behaviours were observed at a 10-year follow-up. EIF's Guidebook does not give a cost rating.	
Family Transitions Triple P[174]	Family Transitions Triple P (FTTP) Level 5 is for parents who are separating. It aims to improve child and family outcomes by: (1) providing parents with skills for managing and coping with the transition through separation or divorce; (2) improving parents' competence and confidence in raising children; (3) reducing parents' level of emotional distress; (4) improving parents' communication about co-parenting issues; (5) reducing the use of coercive and punitive methods of disciplining children; and (6) improving the parent–child relationship. Family Transitions is delivered in conjunction with Level 4 Standard Triple P, to families individually or in groups. It exists as five sessions that are offered in addition to the Standard model. **Model:** Group or individual. **Level of need:** Targeted indicated. **Target population**: For parents with children aged 1–17 who are separating. **Practitioner:** Practitioners with QCF-7/8 level qualifications.		Level 3 evidence of significant reductions in child behaviour problems and coercive parenting behaviours in the first year and improved parental mood and co-parenting skills at the one-year follow-up. EIF's Guidebook gives a cost rating of 1, indicating that it has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than £100.	

Interventions <u>not</u> included in the EIF Guidebook

Name	Description	Where is it used in the UK	Outcomes	Strength of evidence	Evidence gaps
Family group conferencing	A family group conference (FGC) is a decision-making meeting in which a child's wider family network comes together to plan around meeting the needs of the child/ren. It is a time-limited process with the intention of creating a plan to support and improve a specific parental issue or a problem or issue a young person is experiencing. Through encouraging a family to address their own issues and create an informal support network, making people who are connected to the family more aware of the difficulties they're facing, it aims to build resilience and strengthen relationships.[175] **Level of need:** Used across levels of need. In England FGC has usually been used with families that have an identified child protection issue, and is therefore at the level of child protection / edge of care as well as in some targeted-indicated services such as early help. **Target population**: Whole families where a child is considered at risk.	Although there is no legal requirement to use FGCs in England and Wales, they are now being offered to families in the majority of local authorities on a range of child welfare issues, but mainly in children's social care. However, there is significant variation in how meetings are delivered and implemented.	Using a systematic evidence review, the What Works Centre for Children's Social Care concluded the findings were mixed and inconclusive.[175] Nonetheless, for the outcome of 'prevention of out-of-home care', despite the low strength of evidence, there was a positive direction of effectiveness.[176] A review of shared decision-making that included FGC by WWCSC found that shared decision-making meetings are no more effective in reducing referrals for child maltreatment when compared with control services.[177] In a review of predominantly US-based studies, FGC was found to have a small, but clinically significant, effect on reuniting children with families. However, many of these reviews highlighted the lack of evidence on how FGC is delivered and how accurately its effectiveness is measured. Very limited research has been conducted in non-child protection, family support services. WWCSC is currently undertaking an evaluation of pre-proceedings stage in 22 LAs, as part of the Department for Education's Supporting Families: Investing in Practice programme.[178]	The strength of evidence can be considered as mixed and currently low but is still developing.	More robust evaluations with larger sample sizes are needed and there is currently a dearth of evidence from the UK. A current WWCSC evaluation of FGC hopes to address this. Moreover, further evaluation is required on outcomes outside the remit of children in care.

172 Family Foundations, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/family-foundations**

173 Schoolchildren and their Families, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/schoolchildren-and-their-families**

174 For separated parents see: Triple P Family Transitions, Early Intervention Foundation Guidebook. **https://guidebook.eif.org.uk/programme/triple-p-family-transitions**

175 For more information see: **https://whatworks-csc.org.uk/evidence/evidence-store/intervention/family-group-conferencing & https://www.eif.org.uk/resource/family-group-conferencing-camden**

176 Stabler, L. et al. (n.d.). Shared decision-making. What is good practice in delivering meetings? What Works for Children's Social Care. **https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_Shared_Decision_Making_Rapid_Realist_Review_full_report.pdf and https://whatworks-csc.org.uk/evidence/evidence-store/intervention/family-group-conferencing**

177 McGinn, T., Best, P., Wilson, J., Chereni, A., Kamndaya, M., & Shlonsky, A. (2020). Family group decision-making for children at risk of abuse or neglect: A systematic review. Campbell Systematic Reviews, 16(3), e1088.

178 **https://whatworks-csc.org.uk/research-project/evaluation-of-family-group-conferences-at-pre-proceedings-stage**

Interventions not included in the EIF Guidebook					
Name	**Description**	**Where is it used in the UK**	**Outcomes**	**Strength of evidence**	**Evidence gaps**
Motivational interviewing	Motivational interviewing was designed to help engage individuals and assist them in exploring and resolving their ambivalence about behaviour change. **Level of need:** It can be used across the spectrum of need from universal to more targeted and specialist support. **Target population**: For adults and children to change behaviour.	It has its roots in the field of substance use, but is now used in a multitude of family services including youth offending, health settings (including mental health, GP, Family Nurse Partnerships) and social care and early help.	Positive changes as a result of motivational interviewing have been identified and have been found in a range of child outcomes including parenting, substance abuse and mental and physical health, although the evidence is inconclusive on its impact on other outcomes such as domestic abuse and child abuse and neglect. However, as it is usually used in conjunction with other interventions it can be difficult to disentangle its effects, with a number of reviews citing a lack of robust methodology used in studies. In addition, the evidence base for motivational interviewing in family support services is less developed, although it has been used in a number of promising system-level approaches including the Family Safeguarding Model (FSM) (see above).	Evidence can be considered strong for certain outcomes from robust studies such as parenting, substance abuse and mental and physical health, but more mixed or inconclusive results on outcomes such as domestic abuse and child protection. With limited evidence from family support in the UK.	More robust evaluations with larger sample sizes are needed and there is currently a dearth of evidence from the UK – especially in family support.