What works to improve the lives of England's most vulnerable children

A review of interventions for a local family help offer

May 2022

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About EIF

The Early Intervention Foundation (EIF) is an independent charity established in 2013 to champion and support the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes.

Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse. It also helps to foster a whole set of personal strengths and skills that prepare a child for adult life.

EIF is a research charity, focused on promoting and enabling an evidence-based approach to early intervention. Our work focuses on the developmental issues that can arise during a child's life, from birth to the age of 18, including their physical, cognitive, behavioural and social and emotional development. As a result, our work covers a wide range of policy and service areas, including health, education, families and policing.

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The Early Intervention Foundation (EIF) was commissioned by the Independent Review of Children's Social Care to carry out work to summarise information on interventions with the best evidence of improving the life chances of children known to children's social care services. The commissioner did not influence the reporting of our findings.

EIF IS PROUD TO BE A MEMBER OF
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What Works Network

This report was first published in May 2022.

The aim of this report is to support policymakers, practitioners and commissioners to make informed choices. We have reviewed data from authoritative sources but this analysis must be seen as a supplement to, rather than a substitute for, professional judgment. The What Works Network is not responsible for, and cannot guarantee the accuracy of, any analysis produced or cited herein.

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1. Introduction

Children known to children's social care are arguably the most vulnerable in society. The circumstances leading to this situation are never positive and frequently involve high levels of family dysfunction and economic deprivation.

Not surprisingly, the life-chances of these children are poor, with studies showing that maltreated children are 1.5 times more likely to have a physical health problem, twice as likely to have difficulty entering the workforce, and four times as likely to have a serious mental health problem before they reach adulthood.[1,2,3] Clearly, effective services and practices are necessary to improve the circumstances of these children and prevent them from occurring in the first place.

The *Case for Change* published by the Independent Review of Children's Social Care[4] proposed that family help should:

> *Improve children's lives through supporting the family unit and strengthening family relationships to enable children to thrive and keep families together, helping them to provide the safe, nurturing environments that children need.*

The Early Intervention Foundation (EIF) conducted this review on behalf of the independent review team to support its ambitions to improve the lives of vulnerable children through evidence-based interventions which might form part of a strengthened local family support offer. It considers how outcomes for this group of children might be improved through policies, practices and interventions with evidence of improving vulnerable children's life-chances. It includes activities with evidence of preventing child maltreatment from happening in the first place, as well as interventions with evidence of stopping or reducing its impact when it does occur. While this review was produced to support the response to the recommendations of the Independent Review of Children's Social Care,[5] it will also be relevant to all those engaged in working to improve support for vulnerable families at a local and national level.

A growing number of studies now confirm that when evidence-based activities are offered together at scale, population-wide benefits for children and families can be achieved.[6] This report therefore provides the details of 59 policies, practices and scalable interventions with evidence of improving child and family outcomes within five categories of vulnerability:

- problematic child behaviour
- family conflict

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1 Chandan, J., Thomas, T., Gokhale, K. M., Bandyopadhyay, S., Taylor, J., & Nirantharakumar, K. (2019). The burden of mental ill health associated with childhood maltreatment in the United Kingdom: A retrospective cohort study using the Health Improvement Network database. *The Lancet Psychiatry*, *6*(11), 926–934.

2 Archer, G., Pereira, S. P., & Power, C. (2017). Child maltreatment as a predictor of adult physical functioning in a prospective British birth cohort. *BMJ Open*, *7*(10), e017900.

3 Jaffee, S. R., Ambler, A., Merrick, M., Goldman-Mellor, S., Odgers, C. L., Fisher, H. L., ... & Arseneault, L. (2018). Childhood maltreatment predicts poor economic and educational outcomes in the transition to adulthood. *American Journal of Public Health*, *108*(9), 1142–1147.

4 See: https://childrenssocialcare.independent-review.uk/case-for-change/

5 See: https://childrenssocialcare.independent-review.uk/Final_report

6 Fagan, A. A., Bumbarger, B. K., Barth, R. P., Bradshaw, C. P., Cooper, B. R., Supplee, L. H., & Walker, D. K. (2019). Scaling up evidence-based interventions in US public systems to prevent behavioral health problems: Challenges and opportunities. *Prevention Science*, *20*(8), 1147–1168.

- parental mental health
- domestic abuse
- parental substance misuse.

The interventions described in this review have evidence of improving children's behaviour at home and at school, reducing family conflict, improving parenting behaviours, and preventing and stopping child maltreatment in families with a child at the edge of care.

The report aims to summarise the evidence as far as was possible in the time available and in light of work previously conducted by EIF. It has not however been possible to cover all the needs which may present to children's social care, such as children with disabilities, who will have a range of different support requirements to improve a wide range of outcomes. Any future extension or update of this work should consider adding these sections to the review.

1.1 How do we know what works?

In this review, we assume an intervention works when there is robust evidence that it can prevent, stop or reduce child maltreatment and its associated risks. This means the intervention has positively impacted at least one of these outcomes in at least one rigorously conducted evaluation that has carefully eliminated the influence of all other external factors that might also be providing this benefit. This evaluation study has therefore confirmed that the intervention has *caused* this positive effect, meaning that it has 'worked'.

The EIF Guidebook[7] describes the confidence we have in this effect through a set of evidence standards that have been used to assess the magnitude of this effect and its duration.

- **Level 3** recognises interventions with causal evidence of a short-term positive impact from at least one rigorous evaluation.
- **Level 4** recognises interventions with causal evidence of a long-term positive impact through multiple rigorous evaluations.

The 59 interventions and activities identified in this review all have evidence consistent with EIF's level 3 and 4 strength of evidence categories. Thirty-five have been assessed by EIF and listed on the EIF Guidebook, while an additional 24 have been assessed as having this level of evidence by other What Works clearinghouses and systematic reviews adopting assessment processes comparable to EIF's.

The EIF evidence standards also recognise interventions with more preliminary evidence (**level 2**) that may suggest promise but have not been sufficiently tested to permit an assumption of causality.

We believe that interventions with preliminary evidence are good candidates for further testing. We do not include them in this review, however, because we feel that causal certainty is necessary when offering interventions to highly vulnerable families at scale. Time and again, interventions with preliminary promise prove to be ineffective under more rigorous scrutiny. Hence, there is a risk of wasting time, energy and money on families who simply cannot sustain this risk. For this reason, this guidance only includes interventions with proven outcomes to reduce the likelihood of this risk.

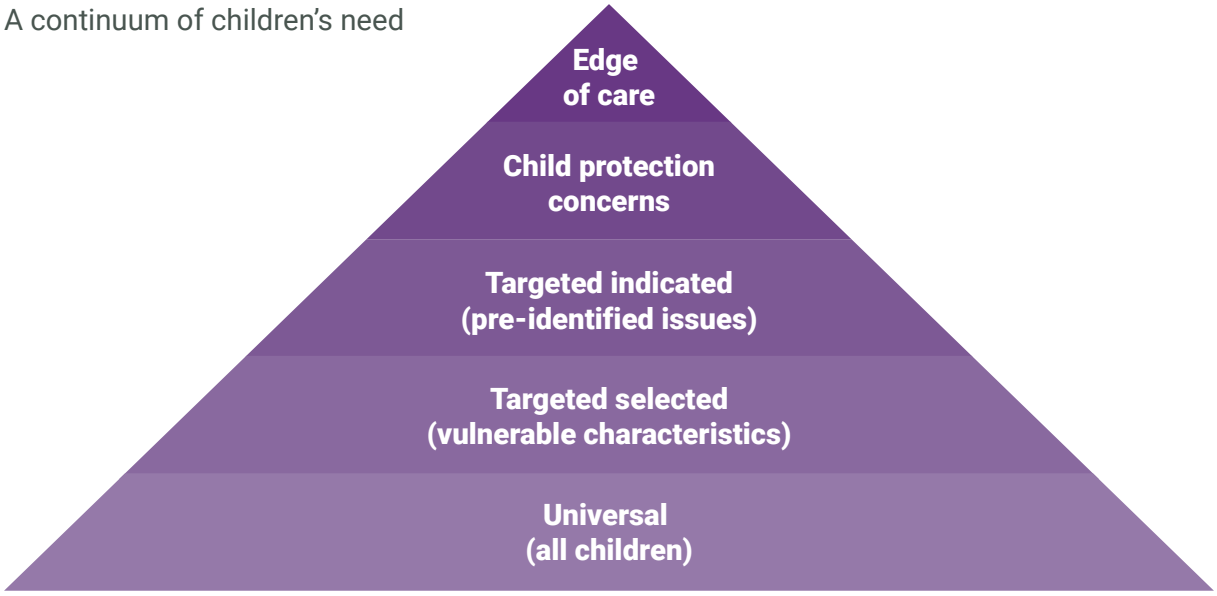
[7] The EIF Guidebook is our online toolkit which summarises evidence on impact of individual interventions: https://guidebook.eif.org.uk/. For more on EIF strength of evidence ratings, see: https://guidebook.eif.org.uk/eif-evidence-standards.

1.2 How do we understand need?

Children's social care commonly categorises services and interventions in terms of five tiers of need (see figure 1.1).

FIGURE 1.1

A continuum of children's need



Based on Hardiker, P., Exton, K. E. N., & Barker, M. (1991). The social policy contexts of prevention in child care. *The British Journal of Social Work, 21*(4), 341–359.

1. Activities that are made available to all families in the entire population regardless of need are referred to as **universal** interventions. They are typically made available to address needs that are shared by all children (such as education) or to prevent problems from occurring in the first place. Examples of universal interventions include schools, health visiting and primary healthcare.
2. **Targeted selected** interventions are those offered to children or families based on demographic risks, such as low family income, single parenthood or adolescent parenthood. Although children growing up in these circumstances may not be experiencing any specific problems, they are at increased risk of experiencing child maltreatment and related problems in comparison to the general population. Interventions that target these risks have the potential to prevent child maltreatment and other serious problems from arising in these groups.
3. **Targeted indicated** interventions are for children or families identified or assessed by practitioners as having a specific or diagnosed problem which requires intensive support to either stop it or keep it from getting worse. Examples of interventions falling within this category include treatments for pre-identified conditions such as diagnosed behavioural or mental health problems.
4. **Child protection need** refers to interventions that were developed specifically for children who have been maltreated, or for whom there is a significant risk of child maltreatment. These interventions are therefore offered to stop child maltreatment from reoccurring. In some cases, they may also provide an appropriate alternative to out-of-home care.
5. **Edge of care** applies to a child who is at serious risk of becoming looked-after because of concerns about their parents' capacity to care for them, or the child's behaviour is beyond the parents' control. These interventions have been specifically developed as an alternative to children going into care if the parents have been assessed as having sufficient capacity to benefit from the intervention and the risk of child harm has been judged to be manageable.

Demand for children's social care

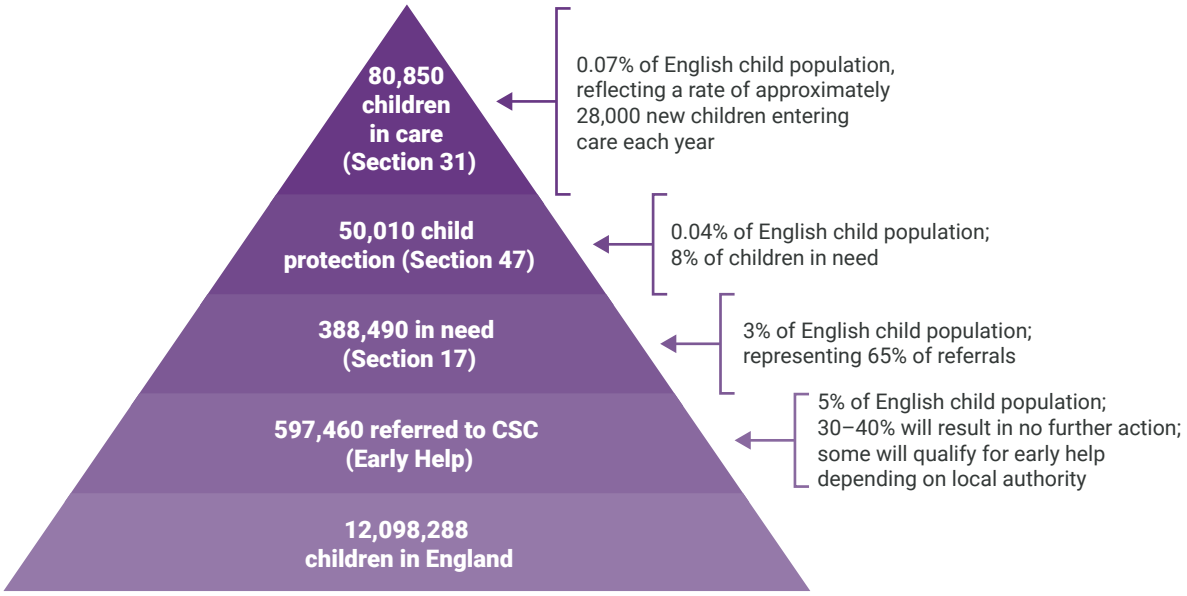
In 2020/21, just under 600,000 children were referred to children's social care, representing approximately 5% of the English child population (see figure 1.2).[8]

Approximately 36% of these referrals resulted in no further action, although some were offered preventative, non-statutory support in the form of early help. The remaining 64% went on to be assessed as 'in need' as defined in section 17 of the 1989 Children Act. This means that it was determined that they were 'unlikely to reach or maintain a satisfactory level of health or development … without the provision of children's social care services, or the child is disabled'.[9]

In over half of the episodes, this assessment was prompted by concerns about abuse and neglect. Domestic abuse, parental mental health problems and child emotional abuse were the three most common factors identified at the end of a children in need (CIN) assessment, although studies consistently show that multiple factors are typically present in CIN cases.[10]

FIGURE 1.2

Rates of referral and levels of statutory support for children in the English social care system



50,010 CIN were further assessed as needing a child protection plan, representing 8% of CIN referrals.[11] A child protection plan (CPP), as defined in section 47 of the 1989 Children Act, is inacted when 'there is reasonable cause to suspect that a child ... is suffering, or is likely to suffer, significant harm'.[12]

Neglect is the most common reason a child protection plan is inacted, followed by emotional abuse. The proportion of CPPs involving neglect and emotional abuse has steadily increased over the past eight years, while physical, sexual and multiple forms of abuse are less

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

9 See: https://www.legislation.gov.uk/ukpga/1989/41/contents

10 Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S., & Clements, K. (2021). Beyond the toxic trio: Exploring demand typologies in children's social care. *British Journal of Social Work*, *51*(6), 1942–1962.

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

12 See: https://www.legislation.gov.uk/ukpga/1989/41/contents

represented.[13,14,15] A child will remain the subject of a CPP until it is clear that the child is no longer at risk of significant harm.

Between 28,000 and 30,000 children enter the care system each year, meaning that it has been judged that 'harm, or the likelihood of harm, is attributable to ... the care given to the child', in accordance with section 31 of the 1989 Children Act. This means that the child can no longer live with their parents, and must be placed in either foster or residential care. This represents 21% of the CIN population, contributing to the annual rate of 80,000 children living in care. Abuse and neglect are the primary reasons children are in care (65%), followed by family dysfunction (14%).

1.3 What are the characteristics of children in the children's social care system?

Relatively little public information is provided about the characteristics of children identified as in need, with the exception of age, gender, ethnicity and locality,[16] as described below.

Age

While age is fairly evenly distributed across CIN referrals, infants are disproportionately represented in comparison to older children.[17] This is a common trend in child welfare statistics and is likely driven by the fact that infants are more physically vulnerable in comparison to older children.[18,19] Neglect is the most common reason infants are identified as in need, followed by domestic abuse, parental substance misuse and parental mental health problems.

Neglect continues to be the most common reason for children being identified as in need in all age groups, although special educational needs and disabilities (SEND), mental health problems or behavioural problems become increasingly more prevalent as children grow older. For example, a child between the age of 10 and 15 is five times more likely than a preschool child to be identified as in need because of problematic child behaviour. It is also clear that children aged 10 and older are disproportionately represented in the care system, with statistics showing a 21% rise between 2013 and 2018 for this age group.[20] Teenage children placed in care are often particularly vulnerable, as their looked-after status is likely due to a complex array of problems which frequently include antisocial and criminal behaviour on the part of the young person.[21]

Interestingly, school-age children (between the age of 5 and 10) are more likely than the other age groups to have experienced physical abuse. The reasons for this are unclear, but it is

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

14 Bilson, A., & Martin, K. E. (2017). Referrals and child protection in England: One in five children referred to children's services and one in nineteen investigated before the age of five. *British Journal of Social Work*, *47*(3), 793–811.

15 Bunting, L., McCartan, C., McGhee, J., Bywaters, P., Daniel, B., Featherstone, B., & Slater, T. (2018). Trends in child protection across the UK: A comparative analysis. *British Journal of Social Work*, *48*(5), 1154–1175.

16 Emmott, E. H., Jay, M. A., & Woodman, J. (2019). Cohort profile: Children in need census (CIN) records of children referred for social care support in England. *BMJ Open*, *9*(2), e023771.

17 Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S., & Clements, K. (2021). Beyond the toxic trio: Exploring demand typologies in children's social care. *The British Journal of Social Work*, *51*(6), 1942–1962.

18 Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist*, *35*(4), 320.

19 Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. *American Psychologist*, *49*(3), 173.

20 The Children's Commissioner. (2019). *The Stability Index*. https://www.childrenscommissioner.gov.uk/report/stability-index-2019/

21 Biehal, J. I., Baldwin, H., Cusworth, L. S., Wade, J. E., & Allgar, V. L. (2018). In-home support or out of home care? Thresholds for intervention with abused and neglected children. *Children and Youth Services Review*, *89*, 263–271.

noteworthy that physical abuse remains more prevalent in middle childhood, despite a steady decrease in rates over the past 20 years.[22,23]

Gender

Boys are consistently more likely to be identified as at risk of abuse and neglect at all ages (54% boys in comparison to 44% girls), with the primary reason being that boys are more likely to be assessed as having a disability or behavioural/mental health problem.[24] Girls, by comparison, are more frequently identified as in need for reasons involving emotional abuse and domestic abuse, although local authorities vary significantly in terms of how categories of abuse and neglect are applied.

Ethnicity

The highest percentage of children identified in need are White British, representing just under 71% of all need episodes in 2020/21. This is consistent with their representation in the British child population, which has declined slightly over the past four years. This decline is mirrored by a slight increase in other ethnic groups being identified as in need, which reflects, in part, recent increases in England's minority ethnic populations.[25] Black/Black British and Mixed and Other ethnic groups are disproportionately over-represented in CIN numbers in comparison to other ethnicities, particularly when it comes to episodes involving domestic abuse, physical abuse and problematic child behaviour.[26]

Locality

There are disproportionately more children in the social care system in the north of England than there are in the south. This difference is driven by a variety of factors, including differences in section 17 and section 47 thresholds, capacity in the children's social care teams, and levels of deprivation.[27]

Children living in the most deprived communities are 12 times more likely to be identified as in need as children living in the least deprived areas, with studies showing that rates of abuse and neglect are highest in neighbourhoods marked by strong income disparities.[28] In particular, rates of looked-after children are nearly five times higher in neighbourhoods where there is a mix of affluent and poor families compared with those marked by high levels of overall deprivation but relatively low income inquality.[29]

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22 Degli Esposti, M., Humphreys, D. K., Jenkins, B. M., Gasparrini, A., Pooley, S., Eisner, M., & Bowes, L. (2019). Long-term trends in child maltreatment in England and Wales, 1858–2016: An observational, time-series analysis. *The Lancet Public Health*, *4*(3), e148–e158.

23 See: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childphysicalabuseinenglandandwales/yearendingmarch2019

24 Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S., & Clements, K. (2021). Beyond the toxic trio: exploring demand typologies in children's social care. *The British Journal of Social Work*, *51*(6), 1942–1962.

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

26 Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S., & Clements, K. (2021). Beyond the toxic trio: exploring demand typologies in children's social care. *The British Journal of Social Work*, *51*(6), 1942–1962.

27 National Audit Office. (2016). *Children in need of help or protection*. https://www.nao.org.uk/report/children-in-need-of-help-or-protection/

28 Elliott, M. (2020). Child welfare inequalities in a time of rising numbers of children entering out-of-home care. *The British Journal of Social Work*, *50*(2), 581–597.

29 Webb, C., Bywaters, P., Scourfield, J., McCartan, C., Bunting, L., Davidson, G., & Morris, K. (2020). Untangling child welfare inequalities and the 'inverse intervention law' in England. *Children and Youth Services Review*, *111*, 104849.

1.4 What are the 'causes' of child maltreatment?

By definition, child maltreatment is caused by caregiving behaviours that impede a child's development through physical or psychological harm, or neglect of a child's needs. Maltreating behaviours therefore represent an obvious point for intervention – although studies consistently show that an exclusive focus on caregiving behaviours is rarely sufficient for preventing or stopping abuse and neglect.[30] This is because maltreating behaviours are predicted by additional risks which also must be addressed for caregiving interventions to be effective. From this perspective, there is no single cause of child maltreatment – rather, it is 'multidetermined' by a combination of risks existing at the level of the child, family, community and society.[31]

Figure 1.3 provides an overview of the more common risks associated with child maltreatment within each of these four ecologocial categories, starting with the child at the centre, and moving outwards to the family, community and society. All of these factors are risks known to influence general child development; those highlighted in pink (such as absolute poverty, community violence, substance misuse or child age) are factors that are consistently shown to increase child maltreatment risk in particular.

Examples of child-level risks include age and gender, family-level risks include parental use of substances and mental health problems, and community-level risks include area deprivation and income disparaties. Societal-level risks include cultural values and laws which influence the acceptability of certain maltreating behaviours: for example, many scholars attribute the steadly decline in physical abuse to changes in societal values regarding the use of physical punishment, such as smacking, for dealing with unacceptable child behaviour.[32]

To be clear, the risks identified in figure 1.3 do not cause child maltreatment, but significantly increase the likelihood of it occuring. These risk factors might therefore be viewed as stressors to the family system, which have the potential to weaken it in a way that increases the risk of a child being harmed or their needs not being met.

The family stress model[33] (figure 1.4) exemplifies how external stressors, such as economic deprivation, create stress within the family system and reduce the quality of the parent–child relationship. Specifically, long periods of economic hardship create financial pressures, which in turn increase the likelihood of parents experiencing mental stress, leading to anxiety, depression and persistent mental health problems in many individuals. Financial pressures also increase stress and conflict within the interparental relationship, as well as parents' relationships with their children. Ongoing family conflict, in turn, increases the risk of child mental health and conduct problems.[34] Economic stress has also been shown to increase the risk of domestic abuse, with studies showing domestic abuse rates increasing during long periods of economic hardship.[35]

30 Belsky, J. (1993). Etiology of child maltreatment: A developmental ecological analysis. *Psychological Bulletin*, *114*(3), 413.

31 Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry*, *56*(1), 96–118.

32 Finkelhor, D., Turner, H., Wormuth, B. K., Vanderminden, J., & Hamby, S. (2019). Corporal punishment: Current rates from a national survey. *Journal of Child and Family Studies*, *28*(7), 1991–1997.

33 Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*, *13*, 85–90.

34 Harold, G. T., & Leve, L. D. (2012). Parents as partners: How the parental relationship affects children's psychological development. In A. Balfour, M. Morgan, & C. Vincent (Eds.), *How couple relationships shape our World* (pp. 25–56). Routledge.

35 Lucero, J. L., Lim, S., & Santiago, A. M. (2016). Changes in economic hardship and intimate partner violence: A family stress framework. *Journal of Family and Economic Issues, 37*(3), 395–406.

FIGURE 1.3

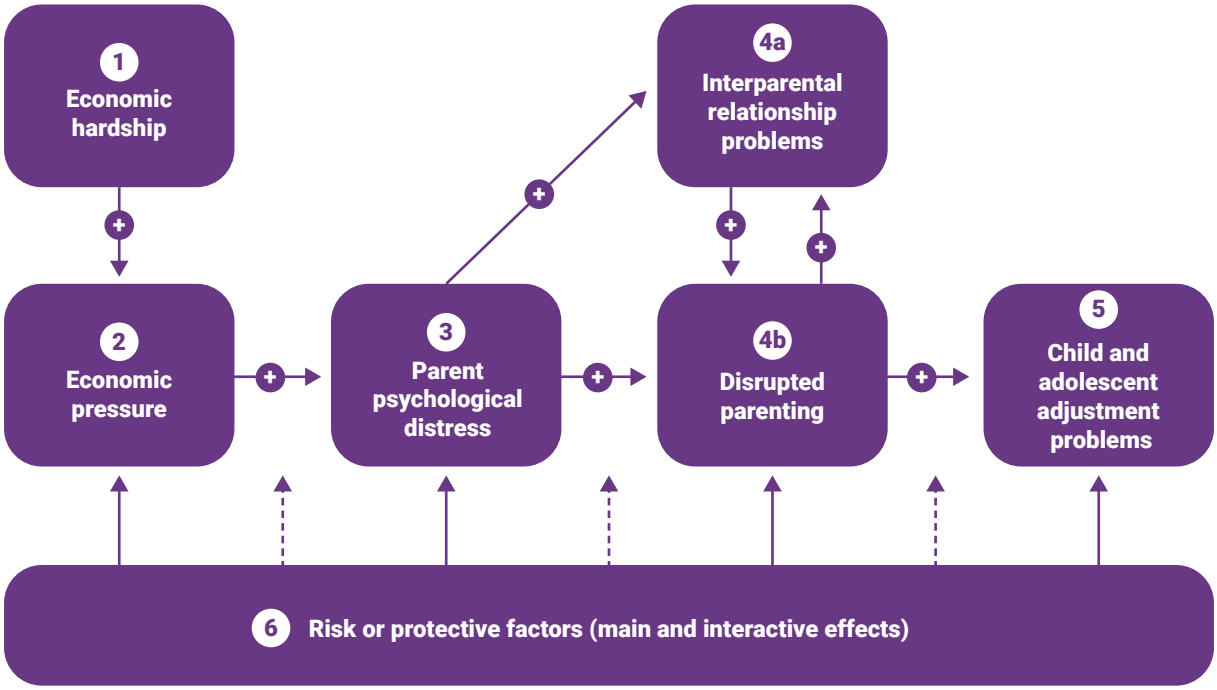
Factors commonly associated with child maltreatment existing at the level of the child, family, community and society

KEY

- Risk factors at individual level
- Risk factors at community level
- Risk factors at family level
- Risk factors at societal level
- Risk factors shown to consistently increase child maltreatment risk across multiple levels

FIGURE 1.4

The family stress model



Other hardships known to increase stress within the family relationship include housing insecurity, life-threatening illnesses (for example, a family member with cancer) and community violence, even in the absence of economic hardship.[36] Children can also introduce stress into the family system. For example, childhood disabilities are repeatedly associated with increases in interparental conflict and child maltreatment risk.[37]

While any source of stress can increase the risk of child maltreatment, it should be emphasised that these stressors are not deterministic and that the vast majority of caregivers will never maltreat their children – regardless of the amount of stress they may experience. For this reason, it should be remembered that the risk models described in this report have limited actuarial value at the population level and are never appropriate for predicting the risk of child maltreatment at the individual level.[38] Nevertheless, they provide useful insight into how child maltreatment is multidetermined and the pathways through which key risks operate.

1.5 Reading this review

In this review we consider how a range of evidence-based interventions and policies might be combined to improve children's wellbeing, reduce child maltreatment, and reduce pressure on the children's social care system. While no single intervention or policy is likely to eliminate child maltreatment entirely, we believe that the lives of many vulnerable children would be measurably improved if they were combined strategically at the population level.

[36] Masarik, A. S. & Conger, R. D. (2017). Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*, *13*, 85–90.

[37] Hartley, S. L., Papp, L. M., Mihaila, I., Bussanich, P. M., Goetz, G., & Hickey, E. J. (2017). Couple conflict in parents of children with versus without autism: Self-reported and observed findings. *Journal of Child and Family Studies*, *26*(8), 2152–2165.

[38] Alink, L. R., Cyr, C., & Madigan, S. (2019). The effect of maltreatment experiences on maltreating and dysfunctional parenting: A search for mechanisms. *Development and Psychopathology*, *31*(1), 1–7.

In the following chapters, we provide information about evidence-based activities aimed at improving children's wellbeing and reducing child maltreatment across five areas of vulnerability identified by the Independent Review of Children's Social Care (IRCSC), as described at the beginning of this report. In each chapter, we provide:

- A **definition** of the vulnerability, its prevelance and dominent theories of change for preventing or reducing it. The information provided in this section conforms with the definition and theories provided by a variety of public health bodies, including the UK Office for Health Improvement and Disparities (OHID), the National Institute for Health and Care Excellence (NICE), the US Centers for Disease Control and the World Health Organization (WHO).
- Information on the **key risks** associated with the vulnerability, identified through previous EIF reports and narrative review strategies. This information is provided to further describe the assumptions underpinning dominant theories of change, and to provide insight into risks that might be addressed through wider public health strategies. The risks covered in each section are consistently shown to be associated with the vulnerability in question but should not be viewed as deterministic, nor should each list of risks be considered exhaustive.
- **Interventions** with causal (level 3 or higher) evidence of improving outcomes within each of the vulnerability categories. Thirty-five of these interventions are currently listed on the EIF Guidebook and 24 were identified through systematic reviews and other What Works clearinghouses with evidence standards that are comparable to EIF's. We list these interventions on a continuum of need, starting with activities (including interventions and policies) with evidence of preventing vulnerabilities and improving outcomes at the population level (universal) and ending with interventions with evidence of improving outcomes for children at the edge of care.

  A case example of how interventions might be used to improve the lives of highly vulnerable children. Each case example was suggested by the IRCSC as indicative of the kinds of problems seen by English social care teams.

In chapter 7, we consider how evidence-based interventions might be combined to improve the wellbeing of vulnerable children and prevent child maltreatment at the population level. Here we provide specific examples of where evidence-based interventions have been successfully linked to population-wide benefits in other countries, as well as examples of where positive outcomes have been achieved within the UK. We also consider the factors that must be in place to ensure that these interventions are implemented to a high standard and are reaching the families who most need them.

We conclude this review with a summary of key messages arising from this review and some suggested next steps for how these messages might be taken forward. We recognise that the approach that we suggest is ambitious and will require further resources, effort and national and local coordination to come to fruition. However, we also believe that these steps will be effective in improving the lives of a significant number of children, including those who are the most vulnerable.

2. Interventions with evidence of improving difficult child behaviour

KEY POINTS

- Child behaviour problems are common. Parents sometimes respond to problematic child behaviour in ways that reinforce negative child behaviours through 'coercive' parent and child interactions.
- In a minority of families, some coercive parenting behaviours would be viewed as physically and psychologically abusive.
- Coercive parenting responses are more likely in families that are experiencing high levels of stress, or where one or both parents have a mental health or substance misuse problem, or experienced coercive interactions in childhood.
- Parent management training (PMT) interventions provide parents with strategies for rewarding positive child behaviours and preventing and reducing coercive parenting behaviours.
- As parents master these behaviours, child behaviour improves as the child learns how to better self-regulate their own behaviour at home and at school.

WHAT WORKS

- This review has identified 27 interventions with causal evidence of improving child behavioural outcomes. All of these provide parents with strategies for reducing coercive family interactions at home.
- Intensive, 'wrap-around' family support is often necessary when there are child maltreatment concerns or the child is involved in the criminal justice system. These interventions combine behavioural management strategies with systemic family therapy to help families develop new strategies for engaging more positively with each other and reduce abusive and violent behaviours.
- Child Parent Psychotherapy, Child First and MST-CAN are examples of three interventions with specific evidence of stopping the reoccurrence of child maltreatment in families where there are established child protection concerns.

WHAT IS LESS LIKELY TO WORK

- Universally offered parenting advice to prevent or stop problematic behaviour: there is particularly little evidence suggesting that such advice is adequate for preventing child maltreatment in individual families.
- Universal parenting advice offered to parents of babies with the aim of preventing problematic preschool child behaviour occurring.
- Light-touch parenting advice for families experiencing serious difficulties with the behaviour of their child.

2.1 Characteristics

Definition

Interventions developed to improve children's behaviour are typically delivered to parents, so are therefore often referred to as parent training, parent management training (PMT), behaviour management training or, more generically, as parenting interventions. The primary aim of these interventions is to change the behaviour of the parents so that the behaviour of the child improves.[39]

Originally, PMT interventions were 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.[40] While 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. It is also not uncommon for parenting interventions to provide general advice and information about children's developmental needs.[41]

A primary aim of many PMT interventions is to stop cycles of 'coercive' interactions that are common when parents try to manage difficult child behaviour. Examples of coercive parenting practices include arguing with the child, giving in to the child's demands, or using overly harsh discipline.[42]

Coercive interactions typically begin with non-compliant child behaviours that demand or 'coerce' a negative or aggressive response from the parent. The child may then respond negatively to the parent, who may in turn respond even more negatively to the child. In coercive cycles (see figure 2.1), the interactions will continue until either the child or parent relents. When the parent relents, the child learns that negative behaviour is an effective means of getting their way; when the child relents, the child still learns that conflict can be resolved through coercive and aggressive interactions with others.

Coercive family cycles are common and are often established during the preschool years.[43] From 18 months onwards, child behaviour naturally becomes more aggressive, and many parents inadvertently reinforce this aggression by either giving in to the child's demands or responding aggressively. Reasons for coercive parental responses include:

- a lack of knowledge about how to respond effectively
- inaccurate attributions of a child's lack of compliance
- poor conflict resolution skills learned in their own childhood
- high levels of stress, which interferes with the parent's ability to proactively discourage aggressive or non-compliant child behaviour.[44]

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39 Kazdin, A. E. (2008). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.

40 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

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

42 Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development*, *55*, 1299–1307.

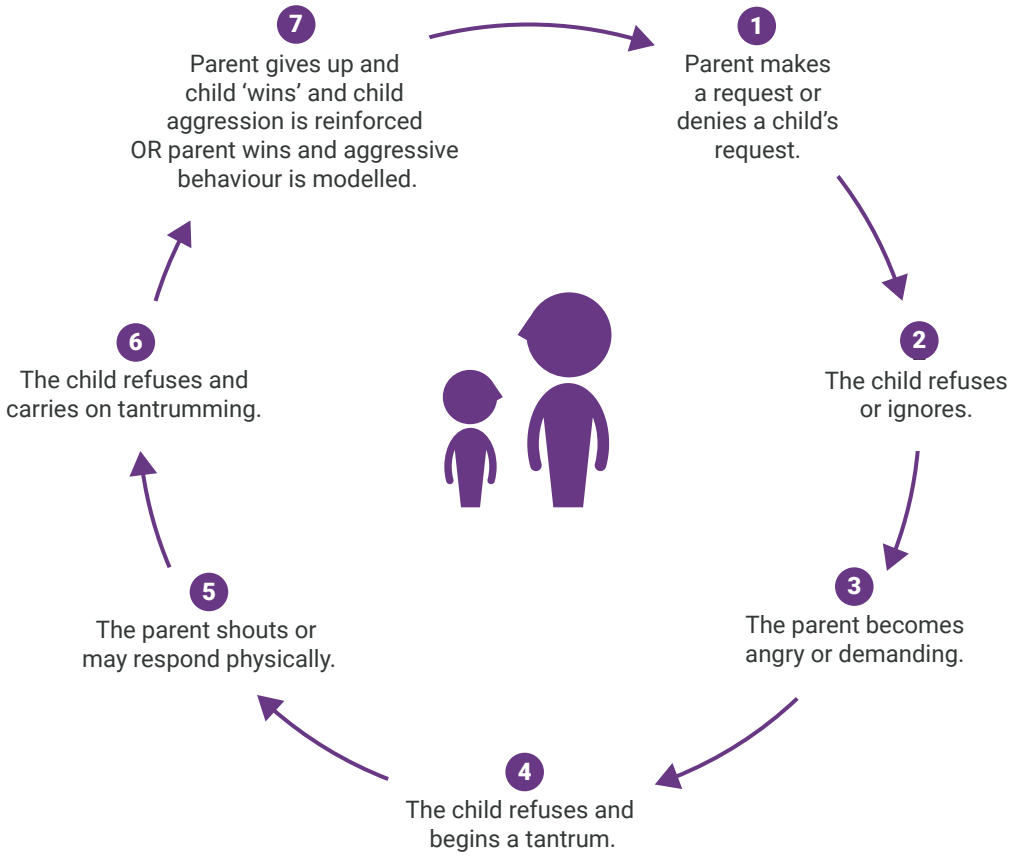
43 Asmussen, K. Feinstein, L., Martin, J., & Chowdry, H. (2016). *Foundations for Life: What works to support parent-child interaction in the early years.* Early Intervention Foundation. https://www.eif.org.uk/report/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years

44 Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development*, *55*, 1299–1307.

Coercive family cycles are particularly linked to child behavioural problems in school and conduct problems in adolescence.[45] In coercive households, children learn that 'might makes right' in resolving parent–child disputes, and then apply these strategies in disputes at school. Studies show that the use of physical punishment is a particularly good predictor of child conduct problems as children grow older.

FIGURE 2.1

Parent–child interactions in coercive family cycles



Prevalence

Coercive parent–child interactions occur in all families, although it occurs more frequently in some families than others. In a minority of cases, coercive family interactions include parental behaviours that would be considered physically and emotionally abusive.

Physical abuse is defined as the intentional use of physical force against a child that causes, or has the potential to cause, physical injury.[46] Physical abuse is viewed as an episodic form of child maltreatment, occurring within the context of family conflict or as a form of physical punishment.[47] Acts of physical abuse range from those which do not leave a physical mark on the child to those which cause life-changing injuries or death. Within the UK, estimates

[45] Snyder, J., Cramer, A., Afrank, J., & Patterson, G. R. (2005). The contributions of ineffective discipline and parental hostile attributions of child misbehavior to the development of conduct problems at home and school. *Developmental Psychology*, *41*(1), 30.

[46] Barnett, D. Manly, J. T., & Cicchetti D. (1991). Continuing toward an operational definition of child maltreatment. *Developmental Psychopathology*, *3*, 19–29.

[47] Gilbert, R. (2019). *Harmonising outcome measurement in studies of child and family focused child maltreatment interventions: Development of a core outcome set* [Paper presentation]. National Institute for Health and Care Research workshop on child maltreatment outcomes, 5 September 2019. UCL Institute of Child Health.

of physical child abuse range between 8.4% and 17% of households, depending upon the outcomes measured in the study.[48]

Emotional abuse refers to intentional adult behaviours which reject, belittle or demean a child's character or competence. Unlike physical abuse, emotional abuse is often ongoing and less explicit in its intent.[49] Examples of emotional abuse include various forms of verbal abuse (such as name-calling or making unkind insinuations), ignoring (rejecting, isolating or stonewalling) and intimidation through threats and hostile actions (slamming doors or smashing household objects).

The rates of emotional abuse vary dramatically, depending upon its definition. For example, shouting and accusations are common, with some studies showing these behaviours occurring in the majority of households.[50,51] Emotional abuse involving threats to physical safety or repeatedly telling the child they are worthless occur less frequently, with studies estimating their occurrence at 7–15% of households.[52]

Parent management training interventions

A primary aim of many PMT interventions is to provide parents with strategies for avoiding and de-escalating coercive interactions and incentivising prosocial child behaviour. Examples of these strategies include:

- the use of praise and age-appropriate incentives for encouraging positive behaviour
- communication strategies aimed at sharing information and de-escalating conflict
- age-appropriate discipline and limit-setting to discourage negative or risky child behaviour.[53]

Many 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.

The purpose, activities and short-, medium- and long-term goals of PMT interventions can be summarised in a generic theory of change (see figure 2.2).

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48 Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *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

49 Barnett, D. Manly, J. T., & Cicchetti D. (1991). Continuing toward an operational definition of child maltreatment. *Developmental Psychopathology*, *3*, 19–29.

50 Straus, M. A., & Field, C. J. (2003). Psychological aggression by American parents: National data on prevalence, chronicity, and severity. *Journal of Marriage and Family*, *65*(4), 795–808.

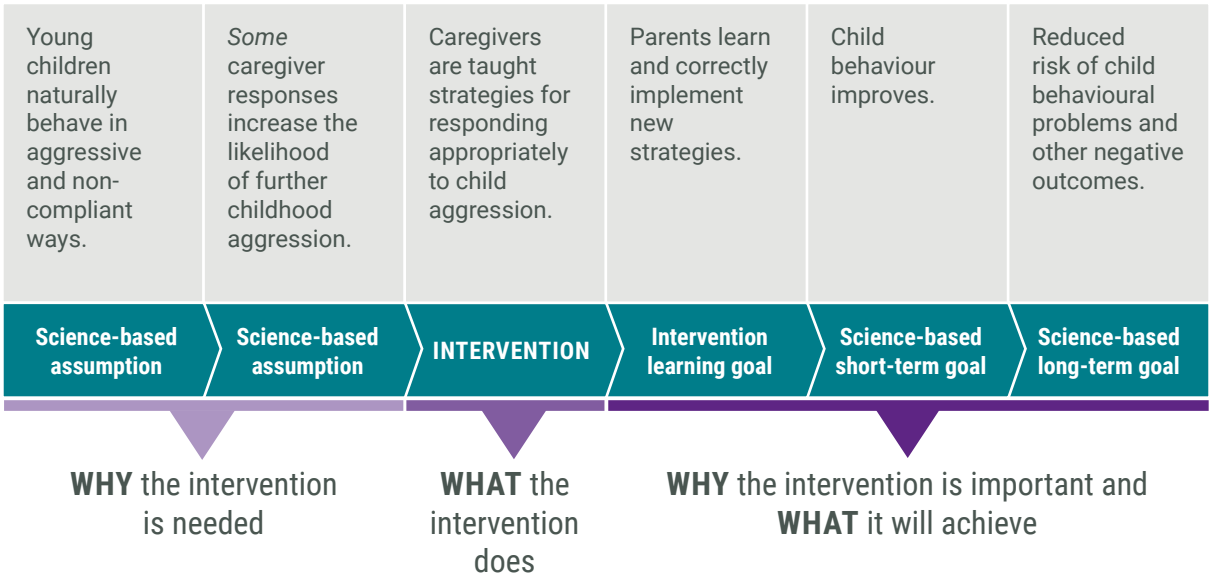
51 Kim, S., Runyan, D. K., & Lee, Y. (2022). Lack of maternal social capital increases the likelihood of harsh parenting. *Children*, *9*(1), 99.

52 Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *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

53 Reitman, D., & McMahon, R. (2011). Constance 'Connie' Hanf: The mentor and the model. *Cognitive and Behavioral Practice*, *20*, 106–116.

FIGURE 2.2

A theory of change linking parenting interventions to short-, medium- and long-term child benefits



2.2 Key risks

Child behavioural problems are associated with a variety of risks existing at the level of the child, family, community and society. Knowledge of these risks is useful for planning services and ensuring that interventions are made available to the families who most need them.

Child-level risks

Child's age: Recent studies show that physical abuse is especially prevalent among primary school-aged children.[54] Safeguarding concerns associated with physical abuse are also disproportionately high among babies and toddlers, when there is also an increased risk of a life-changing injury due to the young child's physical vulnerability.[55]

Child disabilities are also strongly associated with an increased risk of harsh parenting, as well as other categories of abuse. For example, studies show that children with a physical disability are at an 80% higher risk of sexual abuse and a 20% higher likelihood of physical abuse.[56] Similarly, cognitive disabilities also place children at risk. For example, a recent study involving the British E-Risk twin cohort observed that a diagnosis of ADHD in early childhood more than doubled the risk of severe abuse or neglect before the age of 18 in comparison to no diagnosis of ADHD, suggesting that parents are more likely to respond harshly to children who are disruptive.[57]

54 See: https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2021

55 Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. *American Psychologist*, *49*(3), 173.

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

57 Stern, A., Agnew-Blais, J., Danese, A., Fisher, H. L., Jaffee, S. R., Matthews, T., ... & Arseneault, L. (2018). Associations between abuse/neglect and ADHD from childhood to young adulthood: A prospective nationally-representative twin study. *Child Abuse & Neglect*, *81*, 274–285.

Family-level risks

Unplanned pregnancy: Family-level risks associated with physical and emotional abuse include whether the child was planned and the degree to which a parent harbours anger or resentment towards the child.[58,59,60]

Family-level factors more modestly associated with child physical abuse include **parental mental health and substance misuse problems**.[61] For example, parental substance misuse and mental health problems are commonly observed in serious case reviews – although it should be emphasised that there are many parents who have mental health problems and/or misuse substances who do not physically abuse their children.[62]

Intergenerational transmission: Studies show that physical abuse has a greater likelihood of being transmitted across generations than other forms of child abuse.[63,64] Studies particularly show that parents with a childhood history of physical abuse are more likely to abuse their own children.[65] However, it should be stressed that this intergenerational association is modest and not predictive at the individual level. Studies also show that most parents who experienced childhood physical abuse do not repeat abuse with their own children.

Community-level risks

Neighbourhood deprivation is consistently associated with increases in child physical and emotional abuse.[66] Neighbourhood deprivation is characterised by a constellation of factors that include high levels of crime, disrepair, unsafe spaces, poor housing availability, high rates of joblessness and high levels of poverty. Studies show that when neighbourhood deprivation improves, rates of physical abuse go down.[67,68]

Societal-level risks

Studies consistently observe increased rates of child physical abuse during prolonged **periods of economic deprivation**.[69,70] However, this relationship is modest, the mechanisms linking family income to child physical abuse remain unclear, and it is important to emphasise that parents facing economic hardship rarely maltreat their children.

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58 Black, D. A., Heyman, R. E., & Smith Slep, A. M. S. (2001). Risk factors for child physical abuse. *Aggression and Violent Behavior*, *6*(2–3), 121–188.

59 Beckerman, M., van Berkel, S. R., Mesman, J., & Alink, L. R. (2018). Negative parental attributions mediate associations between risk factors and dysfunctional parenting: A replication and extension. *Child Abuse & Neglect*, *81*, 249–258.

60 Beckerman, M., Van Berkel, S. R., Mesman, J., & Alink, L. R. A. (2017). The role of negative parental attributions in the associations between daily stressors, maltreatment history, and harsh and abusive discipline. *Child Abuse & Neglect*, *64*, 109–116.

61 Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Child Abuse & Neglect*, *27*(12), 1409–1425.

62 Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Garstang, J., Harrison, E., ... & Sorensen, P. (2016). *Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011–2014: Final Report*. Department for Education.

63 Assink, M., Spruit, A., Schuts, M., Lindauer, R., van der Put, C. E., & Stams, G. J. J. (2018). The intergenerational transmission of child maltreatment: A three-level meta-analysis. *Child Abuse & Neglect*, *84*, 131–145.

64 Madigan, S., Cyr, C., Eirich, R., Fearon, R. P., Ly, A., Rash, C., ... & Alink, L. R. (2019). Testing the cycle of maltreatment hypothesis: Meta-analytic evidence of the intergenerational transmission of child maltreatment. *Development and Psychopathology*, *31*(1), 23–51.

65 Savage, L. É., Tarabulsy, G. M., Pearson, J., Collin-Vézina, D., & Gagné, L. M. (2019). Maternal history of childhood maltreatment and later parenting behavior: A meta-analysis. *Development and Psychopathology*, *31*(1), 9–21.

66 Coulton, C. J., Richter, F. G. C., Korbin, J., Crampton, D., & Spilsbury, J. C. (2018). Understanding trends in neighborhood child maltreatment rates: A three-wave panel study 1990–2010. *Child Abuse & Neglect*, *84,* 170–181.

67 Chetty, R., Hendren, N., & Katz, L. F. (2016). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity experiment. *American Economic Review*, *106*(4), 855–902.

68 Morris, M. C., Marco, M., Maguire-Jack, K., Kouros, C. D., Bailey, B., Ruiz, E., & Im, W. (2019). Connecting child maltreatment risk with crime and neighborhood disadvantage across time and place: A Bayesian spatiotemporal analysis. *Child Maltreatment*, *24*(2), 181–192.

69 Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., & Steils, N. (2016). *The relationship between poverty, child abuse and neglect: An evidence review*. Joseph Rowntree Foundation.

70 Marmot, M. (2020). Health equity in England: The Marmot review 10 years on. *BMJ*, *368*.

Nevertheless, as described in chapter 1, economic problems inevitably increase the amount of stress parents experience, which can negatively impact upon their ability to cope and manage difficult child behaviour. For example, studies observe that increases in unemployment are mirrored by increases in child abuse.[71] Low family income also frequently co-occurs alongside neighbourhood deprivation, which (as above) has been shown to increase the stress parents experience and elevate the risk of child abuse.[72]

2.3 Interventions with evidence of improving children's behaviour and preventing or stopping physical and emotional abuse

PMT interventions have strong and consistent evidence of improving children's behaviour and preventing/reducing child conduct problems at school in the community. Several PMT models also have evidence of stopping maltreating parenting behaviours, especially those involving physical and emotional abuse. While questions remain about the extent to which these interventions can prevent child maltreatment from occurring within individual families, studies show that these programmes can reduce pressure on the children's social care system at the population level when offered in combination, as we describe in chapter 7.[73,74,75]

The EIF Guidebook has 24 interventions that include a PMT element (see interventions table 1), by providing caregivers with alternatives to harsh discipline and strategies for ending coercive family cycles. In this section we consider how these interventions could be offered to prevent or stop coercive family interactions, as well as reducing pressure on the care system through more targeted PMT support.

Universal support

Universal support is parenting advice offered to all parents, regardless of need. Examples of universal parenting support include interventions offered to all parents through schools, health providers (such as health visitors or nurses) and public awareness campaigns.

Studies repeatedly show that the impact of universal PMT interventions on child outcomes is minimal in comparison to more targeted (selected or indicated) PMT interventions.[76] For example, none of the universal PMT interventions identified in EIF's *Foundations for Life* review had evidence of significantly improving child outcomes.[77]

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71 Brown, D., & De Cao, E. (2018). *The impact of unemployment on child maltreatment in the United States* (ISER Working Paper No. 2018-04). Institute for Social and Economic Research (ISER), University of Essex.

72 Gracia, E., López-Quílez, A., Marco, M., & Lila, M. (2018). Neighborhood characteristics and violence behind closed doors: The spatial overlap of child maltreatment and intimate partner violence. *PLoS One*, *13*(6), e0198684.

73 Euser, S., Alink, L. R., Stoltenborgh, M., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2015). A gloomy picture: a meta-analysis of randomized controlled trials reveals disappointing effectiveness of programs aiming at preventing child maltreatment. *BMC Public Health*, *15*(1), 1–14.

74 Chen, M., & Chan, K. L. (2016). Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, & Abuse*, *17*(1), 88–104.

75 Gubbels, J., van der Put, C. E., & Assink, M. (2019). The effectiveness of parent training programs for child maltreatment and their components: A meta-analysis. *International Journal of Environmental Research and Public Health*, *16*(13), 2404.

76 Leijten, P., Gardner, F., Melendez-Torres, G. J., Van Aar, J., Hutchings, J., Schulz, S., ... & Overbeek, G. (2019). Meta-analyses: Key parenting program components for disruptive child behavior. *Journal of the American Academy of Child & Adolescent Psychiatry*, *58*(2), 180–190.

77 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

This finding is consistent with other reviews of universal PMT interventions – particularly those targeting parents with young children.[78] While studies show that most parents *value* this advice, and that improved child outcomes are observed in low-income countries, their impact on child outcomes in high-income countries is frequently small or non-significant.[79]

The reasons for this lack of impact are unclear. It may be that most parents are 'good enough', and so the advice provided through universal support is sufficient and any additional advice may provide little measurable value.[80,81] Additionally, parents may be less motivated to seek advice or 'absorb' it unless they perceive there is a genuine problem with their child.[82] In this respect, attendance at universal parenting interventions is often low.[83] Studies show that parents' reasons for not attending these interventions include not feeling the intervention is needed or not having the time.[84]

A fourth reason why universal parenting support provides little value is that it is often misaligned with the child's age. As a case in point, the 'Toddlers without Tears' initiative in Australia observed that advice offered to parents with babies did not prevent behavioural problems in toddlerhood, because parents either forgot it or misremembered how to apply it.[85]

Finally, it may be that the advice provided through universal PMT interventions is not sufficient for addressing the needs of vulnerable families. In this respect, studies show that vulnerable parents often need more intensive support that helps them to master new skills and apply them in a way that will support the development of their child.

There is nevertheless evidence linking the universal offer of Triple P programmes to a county-level decrease in abuse and neglect in the US state of South Carolina.[86] Specifically, counties were randomly assigned to either the full suite of Triple P programmes (involving public service announcements, group-based interventions and individualised support for families at risk of abuse and neglect) or no specific parenting support. Over time, the counties implementing the Triple P suite observed significant reductions in the rates of child abuse and neglect in comparison to the counties not implementing the full Triple P suite. The evaluators thus concluded that the universal Triple P offer increased all parents' knowledge of effective child behaviour management strategies, leading to reductions in abuse and neglect. However, others note that the evaluation did not isolate the impact of the universal advice from the more intensive interventions (such as Pathways Triple P, which is described

78 Jeong, J., Franchett, E. E., Ramos de Oliveira, C. V., Rehmani, K., & Yousafzai, A. K. (2021). Parenting interventions to promote early child development in the first three years of life: A global systematic review and meta-analysis. *PLoS Medicine*, *18*(5), e1003602.

79 Hurt, L., Paranjothy, S., Lucas, P. J., Watson, D., Mann, M., Griffiths, L. J., ... & Lingam, R. (2018). Interventions that enhance health services for parents and infants to improve child development and social and emotional well-being in high-income countries: A systematic review. *BMJ Open*, *8*(2), e014899.

80 Pontoppidan, M., Klest, S. K., & Sandoy, T. M. (2016). The Incredible Years parents and babies program: A pilot randomized controlled trial. *PloS One*, *11*(12), e0167592.

81 Popp, L., Fuths, S., & Schneider, S. (2019). The relevance of infant outcome measures: A pilot-RCT comparing Baby Triple P Positive Parenting Program with care as usual. *Frontiers in Psychology*, *10*, 2425.

82 Scott, S., Briskman, J., & O'Connor, T. G. (2014). Early prevention of antisocial personality: Long-term follow-up of two randomized controlled trials comparing indicated and selective approaches. *American Journal of Psychiatry*, *171*(6), 649–657.

83 Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review, 34*(10), 2061–2071.

84 Lindsay, G., & Totsika, V. (2017). The effectiveness of universal parenting programmes: The CANparent trial. *BMC Psychology*, *5*(1), 1–11.

85 Bayer, J. K., Hiscock, H., Ukourmunne, O. C., Scalzo, K., & Wake, M. (2010). Three-year-old outcomes of a brief universal parenting intervention to prevent behaviour problems: Randomized controlled trial. *Archives of Disease in Childhood*, *95*, 187–192.

86 Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The US Triple P system population trial. *Prevention Science*, *10*(1), 1–12.

below).[87,88] By comparison, studies that have isolated the impact of universal parenting interventions consistently observe few measurable benefits.[89]

Targeted selected interventions

Targeted selected interventions are those that are made available on a preventive basis to families where there is an increased risk for child behavioural problems (for example, to parents living in deprived communities). These interventions are often more intensive than the advice offered through universal support, as they are tailored to the needs of families who are demographically more vulnerable.

The EIF Guidebook has five parenting interventions with level 3 or higher evidence of reducing child behavioural problems when offered at the selected/prevention level. Three of these (**Family Nurse Partnership**, **Parents as First Teachers** and **ParentChild+**) are home visiting interventions that are offered either before the child is born, or during the child's first year. All three have evidence of improving children's behaviour, and in the case of the Family Nurse Partnership (FNP) programme, these improvements have lasted for 10 years or longer.[90,91] FNP additionally has evidence of reducing rates of child abuse and neglect in the US and Netherlands, although these findings were not replicated in the UK's most recent trial.[92] FNP does, however, have UK evidence of improving children's cognitive development and school performance. Both outcomes are considered protective of children's wellbeing as they develop.

ParentCorps is a fourth example of a group-based parenting intervention that has level 3 evidence of improving children's behaviour and school-related outcomes when offered to parents living in deprived communities. This intervention begins at the time of reception. Parents then attend 14 group sessions offered through their child's school, where they learn strategies for managing their child's behaviour and supporting their early learning.

The EIF Guidebook also has three interventions with level 3 evidence of helping parents manage difficult child behaviour when offered 'selectively' to families living in deprived communities. We believe all three programmes could also provide benefits when child behaviour problems are not particularly severe, or there is no suspicion of child maltreatment.

Age 0 to 5

Family Check-up for Children has level 3 evidence of preventing the escalation of child behavioural problems when offered to families living in disadvantaged communities. A key feature of the programme is the use of 'check ups' that begin at a health visit when the child is two years and then continue at regular intervals until the child enters school. A primary aim of these check-ups is to assess the extent to which parents are experiencing problems with their child's behaviour. Parents assessed as needing further support are then encouraged to attend the Everyday Parenting programme, where they learn strategies for managing difficult child behaviour. The number of sessions will then range from three to 15, depending upon the severity of the child's problems.

87 Schilling, S., Lanier, P., Rose, R. A., Shanahan, M., & Zolotor, A. J. (2020). A quasi-experimental effectiveness study of Triple P on child maltreatment. *Journal of Family Violence*, *35*(4), 373–383.

88 Wilson, P., Rush, R., Hussey, S., Puckering, C., Sim, F., Allely, C. S., ... & Gillberg, C. (2012). How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P. *BMC Medicine*, *10*(1), 1–16.

89 Pontoppidan, M., Klest, S. K., Patras, J., & Rayce, S. B. (2016). Effects of universally offered parenting interventions for parents with infants: A systematic review. *BMJ Open, 6*(9), e011706.

90 Kitzman, H., Olds, D. L., Knudtson, M. D., Cole, R., Anson, E., Smith, J. A., ... & Conti, G. (2019). Prenatal and infancy nurse home visiting and 18-year outcomes of a randomized trial. *Pediatrics*, *144*(6).

91 Olds, D. L., Kitzman, H., Anson, E., Smith, J. A., Knudtson, M. D., Miller, T., ... & Conti, G. (2019). Prenatal and infancy nurse home visiting effects on mothers: 18-year follow-up of a randomized trial. *Pediatrics*, *144*(6).

92 Robling, M., Lugg-Widger, F., Cannings-John R., Sanders J., Angel L., Channon S., … & Slater, T. (2021). The Family Nurse Partnership to reduce maltreatment and improve child health and development in young children: The BB:2 6 routine data-linkage follow-up to earlier RCT. *Public Health Research*, *9*(2).

Age 4 to 10

Empowering Parents, Empowering Communities (EPEC) provides parents in disadvantaged communities with strategies for managing a child's behaviour. An innovative feature of the EPEC model is that it is delivered by parents who have completed the programme themselves, who are then trained, paid and supervised by social workers to implement it. While it was developed as a targeted indicated intervention, it is less intensive than many of the others, so less appropriate if family needs are very serious.

Age 10 to 14

Strengthening Families 10 to 14 (SF 10–14) has level 3 evidence of preventing problematic adolescent behaviour when made available to disadvantaged families who are not experiencing serious issues with their child. A unique feature of SF 10–14 is that parents and children attend the sessions together. During the first hour, children learn strategies for resisting peer pressure while parents learn strategies for improving communication and managing conflict within the home. During the second hour, the parents and children are reunited to review and practise skills and competencies together.

Targeted indicated interventions

There is strong and consistent evidence showing that PMT interventions are effective when offered to families at the indicated level – in other words, when there is an identified problem with a child's behaviour.

The EIF Guidebook currently has nine interventions with level 3 or higher evidence of reducing child behaviour problems in families where there are pre-identified problems with a child's behaviour. Most of these interventions involve 10 or more sessions delivered over a period of four months. This means that they are sufficiently intensive for addressing many common child behavioural problems, although they are less likely to be effective in complicated cases where there are concerns about parental mental health problems, parental substance misuse, criminal child behaviour or a serious risk of child maltreatment.

Historically, PMT interventions were developed to address behavioural problems occurring between the age of 3 and 12. Some models provide separate versions for preschool and primary school children, whereas others cover both age groups simultaneously. There is also evidence showing that interventions may be more impactful if the parents attending them have children of similar ages, as this ensures that the information shared during the group sessions is more specific to age-related child needs.

There is an ongoing debate as to whether parenting interventions offered during the preschool years are more effective than those offered at later points in children's development.[93] In this respect, studies show that parenting interventions can prevent behavioural problems from getting worse when offered to parents with preschool children. However, there is also consistent evidence showing that parenting interventions can be effective in treating behavioural problems offered to parents with primary school-aged children when problems are less entrenched.

While models also exist for parents of teenage children, problems are typically much more serious at this age, meaning that standard 10-week group PMT programmes are less likely to be effective.

[93] Gardner, F., Leijten, P., Melendez-Torres, G. J., Landau, S., Harris, V., Mann, J., ... & Scott, S. (2019). The earlier the better? Individual participant data and traditional meta-analysis of age effects of parenting interventions. *Child Development*, *90*(1), 7–19.

Standard parent management training interventions

Incredible Years and **Triple P** are PMT interventions that are widely available in the UK, both of which have level 3 or higher evidence of improving child behaviour in vulnerable families. The Incredible Years programme has particularly well-established UK evidence, demonstrating positive impacts lasting 10 years of longer when offered to families with a preschool child with clinically elevated behavioural problems.[94]

Triple P's model is comparable to Incredible Years and can be offered to groups of parents or parents individually.[95] A digital version of the programme, **Triple P Online**, also has evidence of reducing child behavioural problems when offered to parents who have a pre-identified problem with their child. However, it should be noted that this evidence comes from a single randomised control trial (RCT) in Australia, involving highly educated parents with 76% earning more than the national average. Additionally, Triple P has models targeting parents of **teens**, parents with a child with **special educational needs and disabilities**, and parents with **a child who has been bullied** which also have causal evidence of being effective.

Child protection concerns

A child is identified as in need when there are serious concerns about whether they can reach or maintain a satisfactory level of health or development in the absence of social care services. As described in the introduction, most cases address concerns involving parental mental health problems, domestic abuse and child emotional abuse.

The EIF Guidebook currently has three interventions with level 3 evidence or higher of reducing the risk of physical abuse when there are concerns related to complex family issues that include parental mental health problems and domestic abuse. We view these interventions as potentially appropriate for a child in need because they have good evidence of improving a child's behaviour and reducing child maltreatment risk.

These interventions are substantially more intensive than the interventions described in the previous sections because they include content that addresses complex parental problems, which may include mental health problems, domestic abuse or parental substance misuse. Despite this, it should be emphasised that these interventions are not always sufficient for addressing very serious family issues, including those involving parental substance misuse, criminal violence and severe parental mental health problems. It is therefore important that these interventions are well embedded in a wider system of care that can provide immediate access to more intensive services when they are needed.

It is also important to note that these three interventions were designed to be delivered by practitioners with at least a masters-level qualification in social work or psychology. This ensures that the practitioner will be familiar with the theoretical basis of the model and has the skills to flexibly meet the needs of individual families with a strengths-based focus. It also ensures that the practitioner is sufficiently qualified and trained to escalate the case when necessary.

Higher qualifications also improve the likelihood that the practitioner is sufficiently skilled to form a positive working relationship with families. Studies show that this relationship – also referred to as the therapeutic alliance – creates the psychological context in which vulnerable individuals are more likely to feel safe to explore solutions to their family problems and accept the advice the practitioner has to offer.

Examples of how these three interventions work in practice are provided below.

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94 Leijten, P., Gardner, F., Landau, S., Harris, V., Mann, J., Hutchings, J., ... & Scott, S. (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.

95 Sanders, M. R., Kirby, J. N., Tellegen, C. L., & Day, J. J. (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review*, *34*(4), 337–357.

Child First is a home visiting intervention developed for families with a child aged 3 or younger where there is an established risk of abuse and neglect. The programme is delivered by a QCF-level 5 keyworker who connects families to community-based services as part of their family-driven plan and a QCF-level 6 (masters) qualified psychologist who provides home visiting support.

The programme begins with a comprehensive needs assessment of each family's strengths and challenges. Motivational interviewing is used during these first visits to actively engage and motivate parents to participate in the programme, and practitioners are trained in strategies for recruiting parents who are resistant or initially refuse programme participation. Once the family and practitioners have agreed a plan, weekly home visits begin and continue for a period of six to 12 months. Each visit lasts 45–90 minutes, depending on the family's needs and the number of family members present.

During the home visits, family members receive **Child-Parent Psychotherapy (CPP)**, which is a therapeutic intervention that has strong evidence of effectiveness when delivered independently of Child First. Both Child First and CPP have level 3 evidence of improving children's behaviour. CPP is has also been shown to be appropriate for families if domestic abuse is an issue (see chapter 5).[96]

Child First has level 3 evidence of improving the behaviour and language of young children and reducing rates of child maltreatment.[97] It is currently not available in the UK, but it is widely implemented in US child welfare services, with monitoring data consistently showing improved family outcomes upon programme completion.

GenerationPMTO is the most recent version of the first parenting intervention developed by Gerald Patterson and his team at the Oregon Social Learning Centre (OSLC).[98] This programme can be delivered in a wide variety of contexts, and demonstrates improved outcomes when offered either as a form of targeted intervention or to families where there are child protection concerns. The programme primarily aims to improve the behaviour of a child aged 3–18 by reducing coercive family cycles in complex family situations, including cases where child maltreatment is a known risk. While its efficacy for improving outcomes in families experiencing domestic abuse has not been tested, improved child behavioural outcomes have been observed in families where domestic abuse is an identified issue.

GenerationPMTO is delivered by a masters-level social worker or psychologist to families on an individual basis (frequently through home visiting) for a period of 19–30 weeks, depending on the individual family's needs. A core component of the training model is to provide practitioners with sufficient skills to form a positive therapeutic alliance with parents who may be particularly resistant to changing difficult behaviours.

Generation PMTO has level 4 evidence of improving children's wellbeing and reducing behavioural problems over three or more years. It is currently not available in the UK but has successfully been implemented in other European countries (such as Norway, as discussed in chapter 7) where many of these long-term benefits have been achieved.[99]

Level 5 Pathways Triple P is the most intensive model of the Triple P suite of interventions, developed specifically to address key risks associated with child maltreatment, including those involving emotion regulation and the misattribution of normal child behaviour. The programme is delivered over the course of five two-hour sessions to groups of parents

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

97 Crusto, C., Lowell, L., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S., & Kaufman, J. (2008). Evaluation of a wraparound process for children exposed to family violence. *Best Practices in Mental Health*, *4*, 1–16.

98 Gerald Patterson's research underpins much of what is known about coercive family cycles, and the components that he developed and tested at OSLC underpin all of the PMT interventions described in this chapter.

99 Kjøbli, J., Hukkelberg, S., & Ogden, T. (2013). A randomized trial of group parent training: Reducing child conduct problems in real-world settings. *Behaviour Research and Therapy*, *51*(3), 113–121.

or parents individually. During these sessions, parents learn how to develop appropriate expectations of their child's behaviour, manage their own behaviour, and discourage unwanted child behaviour. It can be delivered in a variety of settings including the family home or a clinic or community centre.

Pathways Triple P has level 3 evidence of improving child behaviour in families where there was a clinically significant risk as assessed by the Parenting Relationship Questionnaire.[100,101,102] The intervention does not, however, have specific evidence of reducing the reoccurrence of child maltreatment.

Edge of care

The term 'edge of care' is typically applied to a child who is at serious risk of becoming looked after because of serious concerns about the parents' capacity to care for the child, the child is involved with the criminal justice system, or the the child is engaging in behaviour that is out of the parents' control.

The EIF Guidebook has six interventions with level 3 evidence of improving the behaviour of teenage children who would be considered at the 'edge of care'. Of these, five – **Functional Family Therapy**, **Multidimensional Family Therapy** and three versions of **Multisystemic Therapy** – are available in the UK and are offered as an alternative to out-of-home care in many local areas.

These interventions are often referred to as 'wrap-around' care because they provide a highly comprehensive package of support that includes weekly individual home visits with the child and parents. This support includes components representing strengths-based working, shared family decision-making and motivational interviewing that are already viewed as best practice within children's social care. The length of the interventions vary, depending on the complexity of the family problems, but typically last six to nine months. Further details of how the core model of Multisystemic Therapy works are provided in greater detail in case example A.

It is worth noting that while Functional Family Therapy (FFT) and Multisystemic Therapy (MST) are both successful at reducing children's involvement in crime, findings from two recent UK trials show that comparable benefits can be achieved by other, equally intensive forms of family treatment.[103,104,105]

Treatment Foster Care Oregon – Adolescent (TFCO-A) differs from the other wrap-around models as it is for children already living in an out-of-home foster home placement. The programme seeks to both improve placement stability and reunify the child with their birth parents through intensive support provided to both sets of parents.[106]

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100 Lanier, P., Dunnigan, A., & Kohl, P. L. (2018). Impact of Pathways Triple P on pediatric health-related quality of life in maltreated children. *Journal of Developmental and Behavioral Pediatrics*, *39*(9), 701–708.

101 Sanders, M. R., Pidgeon, A. M., Gravestock, F., Connors, M. D., Brown, S., & Young, R. W. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy*, *35*, 513–535.

102 Wiggins, T. L., Sofronoff, K., & Sanders, M. R. (2009). Pathways Triple P-Positive Parenting Program: Effects on parent-child relationships and child behavior problems. *Family Process*, *48*, 517–530.

103 See: http://www.mstuk.org/evidence-outcomes

104 Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. *Journal of Child Psychology and Psychiatry*, *58*(9), 1023–1032.

105 Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., ... & Goodyer, I. M. (2020). Multisystemic therapy compared with management as usual for adolescents at risk of offending: The START II RCT. *Health Services and Delivery Research*, *8*(23), 1–114.

106 This support is based on the core model developed by Gerald Patterson and his team at OSLC, as described in the description of GenerationPMTO above.

All five interventions expect that practitioners delivering them will be qualified to a QCF-level 7/8 in social work or clinical psychologist, or at least a QCF-level 6 with additional experience. The therapists then undergo further training in the respective programme models, particularly to ensure that they are equipped to develop a positive therapeutic alliance with families who may be resistant or coping with highly complex issues. All five interventions also require a licence, which includes ongoing consultation support from the programme developer lasting for a year or longer. In the case of MST, this support includes software that allows the agency to monitor progress at the time it is set up.

CASE EXAMPLE A: MULTISYSTEMIC THERAPY

A 15-year-old is increasingly skipping school and is engaging in antisocial behaviour. There is suspected exploitation in the community. The teenager's parents feel they have lost control of their child's behaviour, and there is conflict in the home between the teenager and parents.

FFT, MDFT and MST are three examples of interventions developed specifically to meet the needs of families experiencing serious behavioural difficulties with their child, including difficulties at school, antisocial behaviour and criminal misconduct. All three interventions assume that the child's behavioural problems are 'multidetermined' by processes occurring around the child, parents, family, school and community.

In the case of MST, referrals are coordinated through a designated referral contact, who answers queries about the availability of spaces and notifies local agencies when spaces are available. Referrals typically come from social workers and youth offending teams.

Once the referral is accepted, an MST therapist makes contact with the young person and their family within 72 hours to assess eligibility. The young person is eligible for the programme if they are 12–17 years of age and at risk of going into care due to antisocial behaviour or involvement in juvenile offending. This may include showing physical or verbal aggression at home, at school or in the community, and/or substance misuse problems. Children are not eligible for MST if they live independently or a primary caregiver cannot be identified despite all efforts. Children are also ineligible if there are serious psychiatric concerns (including suicide or homicide risk), issues involving sex offending or pervasive developmental delays.

Once eligibility is confirmed, the therapist will solicit the views of each family member about the primary problems, their potential causes and their goals for treatment. During this process, the MST therapist will often use a genogram (a pictoral representation of a person's family relationships) to capture important information about the quality of the relationships between family members and their external family supports, with the aim of identifying strengths within the family system.

After this initial meeting, the therapist will consult with the teenager's school and other individuals from the community involved in their case. The therapist will use this information, as well as their own clinical judgment, to generate a hypothesis about the main problems the family is facing and the best strategies for treating these problems.

The therapist will then discuss with their MST supervisor various options in order to determine the best treatment 'fit' for the family. The therapist shares these ideas with the family, and uses shared decision-making methods to agree a treatment plan. The therapist and family members then review this plan on an ongoing basis to determine the extent to which it is meeting the family's needs. The appropriateness of the plan is also reviewed during the therapist's own ongoing supervision.

A primary aim of the plan is to help family members identify strengths within their immediate family, extended family and community, so that they do not need to rely on more formal support from external agencies. The MST model assumes that the parents are the primary agents of change. For this reason, the plan is likely to include intensive work with the parents to help them improve the quality of their relationship with their child. Typical examples of the kind of work MST therapists do include:

- supporting the parents in using effective behaviour management strategies
- helping parents to develop appropriate attributions of their child's behaviour
- working with parents to coordinate an effective response from other agencies, such as school or youth justice
- family sessions that work on improving communications
- working with the parents to resolve conflict and improve communication
- working with the young person to overcome specific problems, such as anger, impulsivity or poor social skills
- improving communication within the family
- working with the parents and/or young person to address alcohol or substance misuse problems.

Most plans include up to three sessions per week involving individual work with the child, the parents, and the parents and child together. The therapist is also expected to be available to the family '24/7' to provide additional support should the need arise. Additionally, MST therapists will help the child and family to liaise with the child's school and the criminal justice system, to seek their views and secure support for the treatment plan.

Therapists carry a caseload of four to five families, and see families for an average of three to five months, depending on the child's level of need. On average, MST therapists provide 60 hours of face-to-face contact to each family.

Interventions table 1

Interventions with evidence of improving a child's behaviour and reducing the risk of child physical and emotional abuse

Name	Description	Key features*	Evidence	Workforce
Targeted selected				
Family Check-up for Children FIND OUT MORE FAMILY CHECK-UP FOR CHILDREN ON THE EIF GUIDEBOOK	A strengths-based, family-centred intervention that provides parents with strategies for encouraging positive child behaviour and discouraging negative and aggressive child behaviour. The programme begins with a Family Check-up assessment which determines what parenting support is required. This package could include 1–15 sessions of the Everyday Parenting programme, 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.	Child age: 2–5 years Need: Selected Model: Group and individual Available in the UK? Yes Evaluated in the UK? Not known	Level 3 evidence of improved child behaviours, improved parent–child interactions and reduced maternal depression.	A social worker or clinical psychologist with QCF-7/8 level qualifications.
Family Nurse Partnership (FNP) FIND OUT MORE FAMILY NURSE PARTNERSHIP ON THE EIF GUIDEBOOK	A preventative home-visiting intervention for first-time adolescent mothers and their children. The programme has three goals: (1) to improve pregnancy health and behaviours; (2) to improve child health and development by helping parents provide responsible and competent care; and (3) to improve the mother's economic self-sufficiency. Mothers enrol in the programme early in their pregnancy and receive visits from a family nurse on a weekly basis before, and for the first six weeks after the birth of their child. Visits then continue fortnightly until three months before the child's second birthday when visits become monthly in preparation for the programme ending. 64 visits in total are scheduled. During these visits, mothers learn about their young child's health and development, and receive support for their own wellbeing.	Child age: Antenatal to 2 years Need: Selected Model: Individual Available in the UK? Yes Evaluated in the UK? Yes	Level 4+ evidence of improving a variety of child and maternal outcomes from multiple RCTs conducted in North America, Europe and the UK. This includes reductions in child maltreatment, improved behavioural outcomes and improved school achievement, lasting into adolescence in some studies. UK evidence includes improved school achievement, but no evidence of reducing child maltreatment.	Nurses, midwives or health visitors trained in the FNP model.
ParentChild+ FIND OUT MORE PARENTCHILD+ ON THE EIF GUIDEBOOK	A preventive home-visiting intervention for low-income families. It aims to improve the home learning environment, as well as provide parents with strategies for managing their child's behaviour and supporting the child's social and emotional development. An early learning specialist visit families twice a week for a minimum of 23 weeks in two cycles. Families therefore receive a minimum of 92 home visits.	Child age: 2–3 years Need: Selected Model: Individual Available in the UK? No Evaluated in the UK? No	Level 3+ evidence showing improvements in children's cognitive ability, language development and self-regulation.	Early learning specialists, typically with QCF-3 level qualifications.

* Information on interventions as being available or evaluated in the UK is based on desk research at the time of publication, and may be subject to change. Please check with intervention providers for further detail on availability and past evaluations.

Name	Description	Key features	Evidence	Workforce
ParentCorps FIND OUT MORE PARENTCORPS ON THE EIF GUIDEBOOK	A group-based programme for families with a 4-year-old child living in disadvantaged, urban communities. It provides parents with strategies for supporting their child's social, emotional and self-regulatory skills in order to encourage healthy development and school success. The programme consists of 14 weekly two-hour sessions. Additional support can be provided if needed.	Child age: Age: 4 (reception) Need: Selected Model: Group Available in the UK? No Evaluated in the UK? No	Level 3 evidence of improving parenting behaviours, improving children's school achievement and reducing child behavioural problems.	Delivered by seven practitioners: one mental health practitioner (QCF 7/8), three preschool teachers (QCF 7/8) and three assistant teachers (QCF 6).
Parents as First Teachers (PAFT) FIND OUT MORE PARENTS AS FIRST TEACHERS ON THE EIF GUIDEBOOK	A home-visiting intervention for families with a child aged 3 or younger living in deprived communities. During the visits, practitioners facilitate parent–child interaction through age-appropriate talk, play and reading activities. Practitioners also work with parents to develop strategies for managing behavioural issues and developmental concerns.	Child age: Birth to 3 years Need: Selected Model: Individual Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence from studies conducted in the US and Switzerland showing improvements in children's behaviour, language and early learning.	PAFT has been successfully delivered by health visitors and teachers with QCF-4/5 level qualifications.
Strengthening Families 10 to 14 (SF 10–14) FIND OUT MORE STRENGTHENING FAMILIES 10 TO 14 ON THE EIF GUIDEBOOK	A family-based programme that seeks to prevent adolescent risks by giving parents and children strategies for improving communication and reducing peer pressure. The programme consists of seven weekly sessions lasting two hours each. During the programme, families learn how to communicate effectively as well as specific skills such as parental limit-setting and child resistance to peer pressure.	Child age: 10–14 years Need: Selected Model: Group Available in the UK? Not known Evaluated in the UK? Yes	Level 3 evidence of reductions in substance misuse, risky sexual behaviour and aggressive behaviour. The intervention also has evidence of improved school outcomes.	Delivered by three facilitators: lead facilitator should have at least QCF-4/5 level qualifications; two co-facilitators should have QCF 3 qualifications.
Triple P Online FIND OUT MORE TRIPLE P ONLINE ON THE EIF GUIDEBOOK	A web-based parenting intervention. The programme can be used as an early intervention strategy or as a more intensive programme for parents with children up to 12 years old with significant social, emotional or behavioural problems. Parents are given access to a website which enables them to work through modules sequentially. It is the equivalent of Level 4 Standard Triple P, which is the face-to-face version of the programme (described below). It includes eight modules that focus on positive parenting principles and supporting parents to integrate and generalise parenting strategies through parenting plans. A practitioner should be available to provide support alongside the self-directed online programme.	Child age: 0–12 years Need: Selected Model: Self-administered online Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of improving child behaviour, reducing parental stress and reducing parental symptoms of stress and anxiety.	One practitioner with QCF-4/5 level qualifications and previously trained in a Triple P programme, who provides support to parents completing the self-directed online programme.

Name	Description	Key features	Evidence	Workforce
Targeted indicated				
Empowering Parents, Empowering Communities FIND OUT MORE EMPOWERING PARENTS, EMPOWERING COMMUNITIES ON THE EIF GUIDEBOOK	An intervention for disadvantaged families experiencing behavioural difficulties with a child between the ages of 2 and 11. Parents attend eight weekly two-hour sessions where they 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.	Child age: 2–11 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? Yes	Level 3 evidence of moderate reductions in coercive parenting behaviours, alongside small reductions in problematic child behaviours.	Parents who have completed the programme and EPEC training, with additional support and supervision from a social worker.
Helping the Noncompliant Child FIND OUT MORE HELPING THE NONCOMPLIANT CHILD ON THE EIF GUIDEBOOK	An intervention that helps parents to manage unwanted child behaviour.	Child age: 3–8 years Need: Indicated Model: Individual Available in the UK? Not known Evaluated in the UK? No	Level 3 evidence of improving child behaviour, including children with a diagnosis of ADHD.	QCF-7/8 level clinical psychologists.
Hitkashrut FIND OUT MORE HITKASHRUT ON THE EIF GUIDEBOOK	A parent training intervention aimed at reshaping parent–child interactions to reduce conduct problems. Interventions are delivered by two practitioners in 2.5-hour sessions for a period of two weeks.	Child age: 3–5 years Need: Indicated Model: Group Available in the UK? No Evaluated in the UK? No	Level 3 evidence of improved child behaviour, improved effortful control and reduced conduct problems. Additionally, parents reported improvements in their marital quality and parenting behaviours.	QCF-7/8 level clinical psychologists.
Incredible Years Preschool Basic FIND OUT MORE INCREDIBLE YEARS PRESCHOOL BASIC ON THE EIF GUIDEBOOK	A group parenting programme where parents learn strategies for interacting positively with their child and discouraging unwanted behaviour through mediated video vignettes, problem-solving exercises and structured practice activities.	Child age: 3–6 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? Yes	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.	Delivered by two IY co-leaders with QCF-7/8 level qualifications, who may be a psychologist, social worker, nurse or physician.
Incredible Years School Age Basic FIND OUT MORE INCREDIBLE YEARS SCHOOL AGE BASIC ON THE EIF GUIDEBOOK	A group parenting programme that teaches effective parenting strategies for dealing with unwanted child behaviour through group discussion, role plays, video vignettes and homework.	Child age: 6–12 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? Yes	Level 3+ evidence of reductions in conduct problems and ADHD symptoms.	Delivered by two IY co-leaders with QCF-7/8 level qualifications, who may be a psychologist, social worker, nurse or physician.

Name	Description	Key features	Evidence	Workforce
Resilience Triple P FIND OUT MORE RESILIENCE TRIPLE P ON THE EIF GUIDEBOOK	A family intervention for children bullied by peers. It combines social and emotional skills training for children, with 'facilitative parenting' training for parents. Facilitative parenting includes warm and responsive parenting, direct instruction (e.g. coaching children to manage peer problems), and opportunities to help the child develop peer relationships (e.g. supporting friendships through playdates).	Child age: 6–12 years Need: Indicated Model: Group Available in the UK? Not known Evaluated in the UK? No	Level 3 evidence of improvements in facilitative parenting, more peer acceptance and less victimisation of the child, and improved child behaviour.	Child and family mental health practitioners, or other school support professionals recommended to have at least QCF-4/5 level qualifications.
Triple P Discussion Groups (Level 3) FIND OUT MORE TRIPLE P DISCUSSION GROUPS (LEVEL 3) ON THE EIF GUIDEBOOK	An intervention for parents with specific concerns about the behaviour of a child between the ages of 0 and 12. Parents attend one to four small group sessions lasting approximately two hours each. Topics covered during the sessions include managing child disobedience, developing good bedtime routines, and shopping with children.	Child age: 0–12 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? No	Level 3+ evidence of reductions in disruptive child behaviours.	Practitioners can come from a range of professions (e.g. family support worker) but are recommend to have at least QCF-4/5 level qualifications.
Triple P Level 4: Group & Standard FIND OUT MORE TRIPLE P LEVEL 4 GROUP ON THE EIF GUIDEBOOK FIND OUT MORE TRIPLE P LEVEL 4 STANDARD ON THE EIF GUIDEBOOK	An intervention for parents with specific concerns about a child's behaviour. Parents attend five sessions over a period of eight weeks, as well as three individual telephone consultations lasting 15 to 30 minutes. During these sessions, parents learn 17 different strategies for improving their children's competencies and discouraging unwanted child behaviour. The intervention can be delivered to parents individually or groups of up to 12 parents.	Child age: 0–12 years Need: Indicated Model: Individual or group Available in the UK? Yes Evaluated in the UK? Not known	Level 3 evidence of significant reductions in coercive parenting behaviours and increasing parenting competence, as well as significant improvements in child behaviour, lasting for over three years.	QCF-7/8 level clinical psychologists or social workers.
Triple P Teen: Group & Standard Level 4 FIND OUT MORE TRIPLE P TEEN GROUP ON THE EIF GUIDEBOOK FIND OUT MORE TRIPLE P TEEN STANDARD ON THE EIF GUIDEBOOK	An intervention for parents who have concerns about their teenager's development and behaviour. Parents attend 10 one-hour face-to-face sessions, where they learn practical strategies for how to manage their child's problematic behaviour, promote healthy development, and improve the quality of the parent–child relationship. The programme can be delivered to groups of parents or parents individually.	Child age: 12–16 years Need: Indicated Model: Individual or group Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence showing significant reductions in parent reports of child behavioural difficulties.	Delivered by a single Triple P practitioner from a range of professions (e.g., school counsellor, nurse) but recommended to hold QCF-4/5 level qualifications and to be supervised by a QCF-7/8 level practitioner.

Name	Description	Key features	Evidence	Workforce
Child protection concerns				
Child First FIND OUT MORE CHILD FIRST ON THE EIF GUIDEBOOK	A 12-month home visiting intervention combining Child-Parent Psychotherapy with other forms of social support to reduce the risk of child maltreatment in vulnerable families with young children.	Child age: 6–36 months Need: Indicated Model: Individual home visiting Available in the UK? No Evaluated in the UK? No	Level 3 evidence of four-fold reductions in child behavioural problems and a two-fold reduction in reports of child maltreatment at a three-year follow-up. Also, a three-fold reduction in parenting stress and four-fold reduction in symptoms of psychopathology at a 12-month follow-up.	Delivered by one clinician with QCF-7/8 level qualifications and one care coordinator with QCF-6 level qualifications.
Child-Parent Psychotherapy (CPP) FIND OUT MORE CHILD-PARENT PSYCHOTHERAPY ON THE EIF GUIDEBOOK	A therapeutic intervention targeting mothers and preschool children who may have experienced trauma or abuse (such as domestic abuse) or are otherwise at risk of behavioural and emotional problems.	Child age: 3–6 years Need: Indicated Model: Individual parent/child therapy Available in the UK? No Evaluated in the UK? No	Level 3+ evidence of small to moderate improvements in child behaviour. Parent benefits include reductions in trauma-symptoms and symptoms of depression.	QCF-7/8 level clinical psychologist or social worker.
GenerationPMTO FIND OUT MORE GENERATIONPMTO ON THE EIF GUIDEBOOK	An intervention that teaches parents effective family management skills to reduce antisocial and problematic child behaviour. Promoting school success is also a factor that is woven into the programme throughout relevant components. The length of GenerationPMTO is determined by each family's needs. The number of sessions provided in parent groups ranges from six to 14; in clinical samples the mean number of individual treatment sessions is 25.	Child age: 3–18 years Need: Indicated Model: Group or individual Available in the UK? No Evaluated in the UK? No	Level 4 evidence of improving a wide variety of child outcomes, including reductions in antisocial behaviour.	Qualified GenerationPMTO practitioners with a minimum of QCF-6 level qualifications, preferably QCF-7/8.
Parent-Child Interaction Therapy FIND OUT MORE PARENT-CHILD INTERACTION THERAPY ON THE BLUEPRINTS REGISTRY	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. Parents must achieve mastery in the first phase to proceed to the second.	Child age: 3–12 years Need: Indicated Model: Group Available in the UK? No Evaluated in the UK? No	Level 4 evidence of improving children's behavioural outcomes in a range of populations.	Clinical psychologists or social workers with QCF-7/8 level qualifications.

Name	Description	Key features	Evidence	Workforce
Pathways Triple P (Level 5) FIND OUT MORE PATHWAYS TRIPLE P (LEVEL 5) ON THE EIF GUIDEBOOK	An intervention for parents who have difficulty regulating their emotions and are considered at risk of physically or emotionally harming their children. It aims to improve children's mental health and wellbeing, prevent maltreatment, and prevent crime, violence and antisocial behaviour.	Child age: 0–16 years Need: Indicated Model: Individual Available in the UK? Yes Evaluated in the UK? No	Level 3+ evidence of significant reductions in children's internalising behaviours and improved self-reported quality of life. Evidence of reductions in child maltreatment risk in terms of parents' blame and intentional attribution of children's misbehaviour, as well as reductions in unrealistic expectations of child behaviour.	A practitioner who has at least QCF-4/5 qualifications and experience of working with parents at high risk of physically maltreating their children. It is expected that this individual will be supervised by a clinical psychologist or social worker with QCF-7/8 level qualifications.
Edge of care				
Functional Family Therapy FIND OUT MORE FUNCTIONAL FAMILY THERAPY ON THE EIF GUIDEBOOK	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 (i.e. antisocial behaviour and substance abuse).	Child age: 10–18 years Need: Edge of care Model: Individual and family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 3+ evidence from multiple studies of reducing substance misuse in teenagers. However, these benefits were not replicated in the only UK trial.	Clinical psychologists or social workers with QCF-7/8 level qualifications.
Multidimensional Family Therapy FIND OUT MORE MULTIDIMENSIONAL FAMILY THERAPY ON THE EIF GUIDEBOOK	An intervention primarily for adolescents who have substance misuse, behavioural, delinquency, mental health, educational/school, family mental health problems or disorders.	Child age: 13–17 years Need: Edge of care Model: Family therapy Available in the UK? No Evaluated in the UK? No	Level 4 evidence of reductions in externalising symptoms and cannabis dependence at a nine-month follow-up. At 12 months, decreases in substance misuse were maintained. At 18 months, reductions were observed in externalising behaviours and felony arrests.	MFT therapist with QCF-7/8 level qualifications.
Multisystemic Therapy FIND OUT MORE MULTISYSTEMIC THERAPY ON THE EIF GUIDEBOOK	An intervention for families with a young person aged 12–17 who is at risk of going into care due to serious antisocial and/or offending behaviour.	Child age: 12–17 years Need: Edge of care Model: Individual and family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 4+ evidence from multiple, internationally conducted studies, including a US evaluation demonstrating reduced youth offending, antisocial behaviour and psychiatric symptomology, including findings involving 14- and 22-year follow-ups. MST has UK evidence consistent with these findings, although its most recent UK evaluation could not confirm that MST was superior to standard youth justice practice.	MST therapist/practitioner with QCF-6 level qualifications.

Name	Description	Key features	Evidence	Workforce
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) FIND OUT MORE MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT ON THE EIF GUIDEBOOK	An intensive treatment for families who have recently been reported to child protection services. A key aim is to help families assume greater responsibility for their behaviours and actively work to resolve serious family issues.	Child age: 6–17 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of reduced neglect, psychological aggression, minor and severe assault, non-violent discipline, symptoms of PTSD, dissociative symptoms, internalising symptoms and total behaviour problems and increased placement stability post-intervention.	Delivered jointly by a social worker/ psychologist and key worker.
Multisystemic Therapy for Problem Sexual Behaviour FIND OUT MORE MULTISYSTEMIC THERAPY FOR PROBLEM SEXUAL BEHAVIOUR ON THE EIF GUIDEBOOK	A programme for families with a young person aged 10–17.5 years who has committed a sexual offence or demonstrated problematic sexual behaviour. MST-PSB is delivered by a therapist who works individually with the young person and family in their home, for an average of 6–9 months. Therapy sessions typically last between 50 minutes and 2 hours. The frequency of the sessions vary depending on the needs of the family and the stage of the treatment, usually ranging from three a week to daily. Intervention strategies include family discussions, role play, structural family therapy, safety planning and sexual education.	Child age: 10–17 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? No	Level 4 evidence of supporting children's mental health and wellbeing, and reduced arrests for sexual misconduct and nonsexual crimes. Improvements in school and employment opportunities were also observed.	MST-PSB therapist with QCF-7/8 level qualifications.
Treatment Foster Care Oregon – Adolescent (TFCO-A) FIND OUT MORE TREATMENT FOSTER CARE OREGON ADOLESCENT ON THE EIF GUIDEBOOK	A programme for young people displaying delinquent behaviour in foster placements or residential placements. These young people are placed in a 'treatment foster family' trained in the TFCO-A model with the aim of improving a young person's social, emotional and relational skills, and thereby reducing the incidence of more challenging and antisocial behaviours.	Child age: 12–18 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 3+ evidence of reductions in running away from placements and the number of days incarcerated, as well as reduced delinquent behaviour and reduced rates of criminal referrals during the period from placement to one year post-placement.	Social worker with QCF-7/8 level qualifications.

3. Interventions with evidence of improving family relationships and reducing conflict in the home

KEY POINTS

- Family conflict is normal, so it is difficult to prevent entirely. However, there are interventions that have evidence of reducing the amount of family conflict and keeping it from escalating by providing parents with strategies for managing it in a way that is constructive and non-aggressive.
- High levels of family stress are a key risk for increased aggressive and non-constructive family interactions in the home.
- Therefore, interventions targeting family conflict often offer advice for managing stress, improving communication and negotiating disagreements, alongside support for reducing coercive family interactions.

WHAT WORKS

- Universal interventions that target couples at key transition points in family life, including the birth of a child and a child's transition to primary school or secondary school.
- The Family Foundations intervention has causal, long-term evidence of reducing conflict in the couple relationship and improving child behavioural outcomes up to seven years after intervention completion.
- Interventions offered to groups of fathers and mothers who are separating.

WHAT IS LESS LIKELY TO WORK

- Co-parenting interventions for couples experiencing domestic abuse. Indeed, couples experiencing domestic abuse are ineligible for the evidence-based co-parenting interventions identified in this review.

3.1 Characteristics

Definition

Family conflict is normal.[107] Studies show that parents often disagree and there is consistency in the issues they disagree about.[108] Common points of conflict include the division of household labour, when and what to eat, time spent watching television, child discipline, money management, and when and how to interact with friends and relatives. Parents and children must therefore learn how to manage family disputes peacefully, and experts agree that the ability to negotiate and compromise are important skills learned during childhood.[109,110]

Children typically learn their conflict resolution skills from their parents, and parents differ in their ability to resolve family conflict effectively.[111] The aggressive and coercive behaviours described in chapter 2 are clear examples of ineffective and potentially harmful family conflict resolution strategies.

However, many seemingly non-aggressive behaviours also represent poor conflict resolution skills. Behaviours such as stonewalling, poor communication, relationship avoidance and withdrawal also contribute to a hostile family climate, with studies showing that disputes often continue to escalate when these otherwise 'silent' methods are used.[112]

Poorly resolved family conflict negatively impacts children in several ways. First, children learn that aggressive power struggles are an effective method of resolving disputes with others.[113,114] Second, high levels of unresolved family conflict make many children anxious, causing some to wonder if they are to blame. Third, poorly resolved disputes can preoccupy parents in ways that reduce their sensitivity to their children's needs. Studies show that children exposed to high levels of family conflict are at risk of poor behavioural and emotional outcomes, regardless of whether their parents' conflict is openly aggressive or hostile.[115]

Interventions aimed at reducing family conflict

Some of the PMT interventions described in the previous chapter 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. Some of these programmes also provide advice aimed at helping parents to stay connected as a couple, and the use of leisure activities as a means for preventing family conflict. Hence, there is some overlap between the advice offered in PMT interventions and couples therapy, although the primary focus remains on parenting behaviours that are known to support children's development (see figure 3.1).

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107 Straus, M. A. (2017). *Measuring intrafamily conflict and violence: The conflict tactics (CT) scales* (pp. 29–48). Routledge.

108 Zill, N. (2020, July 29). What couples argue about most. Institute for Family Studies. https://ifstudies.org/blog/what-couples-with-children-argue-about-most

109 Bergman, K. N., Cummings, E. M., & Warmuth, K. A. (2016). The benefits of marital conflict. In D. Narvaez, J. M. Braungart-Rieker, L. E. Miller-Graff, L. T. Gettler, & P. D. Hastings (Eds.), *Contexts for young child flourishing: Evolution, family, and society* (pp. 233–245). Oxford University Press.

110 Cummings, E. M., & Schatz, J. N. (2012). Family conflict, emotional security, and child development: Translating research findings into a prevention program for community families. *Clinical Child and Family Psychology Review*, *15*(1), 14–27.

111 Rothenberg, W. A., Hussong, A. M., & Chassin, L. (2016). Multigenerational transmission of high conflict family environments. *Development and Psychopathology*, *28,* 293–308.

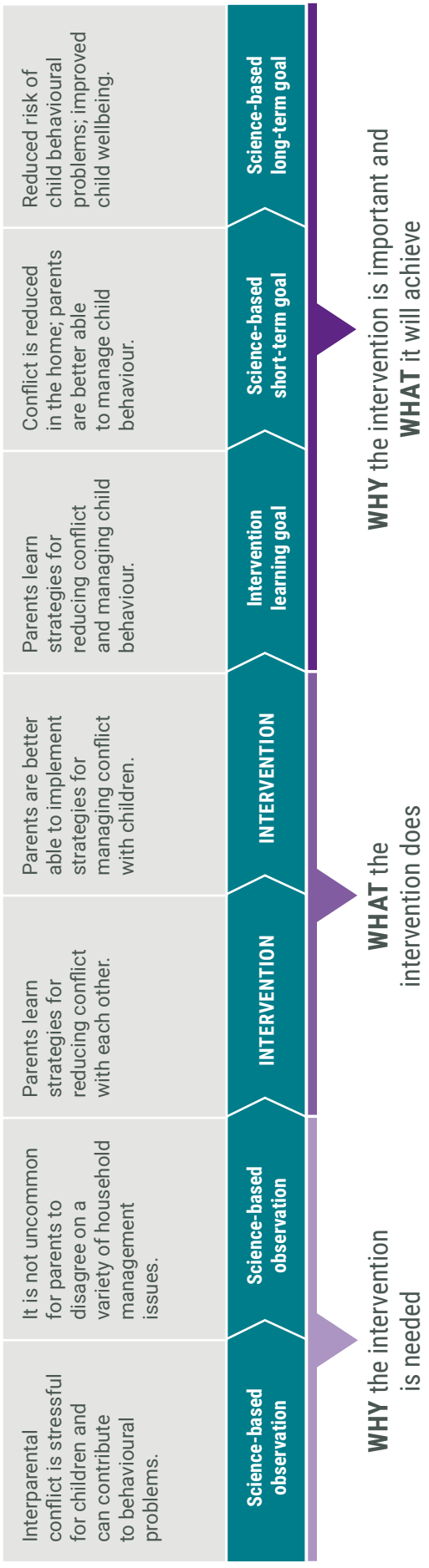
112 Goeke-Morey, M. C., Cummings, E. M., Harold, G. T., & Shelton, K. H. (2003). Categories and continua of destructive and constructive marital conflict tactics from the perspective of US and Welsh children. *Journal of Family Psychology*, *17*(3), 327.

113 Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development*, *55*, 1299–1307.

114 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.

115 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.

FIGURE 3.1
A theory of change for reducing family conflict and improving child outcomes



Several of the PMT interventions described in chapter 2 provide this information during sessions that are offered in addition to the core parent training model. For example, Triple P and Incredible Years both offer 'enhanced' versions of their programme that include sessions devoted to improving communication and coordination between parents. Parents are encouraged to attend these sessions together, although they are not required to do so. A second set of group-based 'co-parenting' interventions also exist, which focus exclusively on the quality of the co-parenting team, and which parents are expected to attend together as a couple for the duration of the intervention.

Co-parenting interventions also exist for parents who are separated, with studies showing that parents do not need to be in a couple relationship to be an effective co-parenting team.[116] These interventions include content which helps parents first dissociate any negative feelings they may have towards their ex-partner from the feelings they have towards their child. Parents also learn strategies for co-parenting effectively while living separately. Parents do not attend these interventions as a couple, but group sessions are offered to mothers and fathers separately. It is worth noting that co-parenting interventions assume that both parents will be involved in the child's upbringing, so are not appropriate for lone-parent families where one parent is fully absent.[117]

[116] 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.

[117] 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.

It is important to note that **none of the interventions described in this chapter are considered to be appropriate for parents where domestic abuse is an issue**. This is because these interventions will only work if there are sufficient levels of respect and consideration between the parents, so that they can agree mutual goals and cooperate as co-parents. Abusive attitudes and behaviours make it difficult for parents to empathise with each other's needs and make compromises when making co-parenting decisions.[118]

The features of abusive couple relationships are described further in chapter 5. While couples therapy may provide some benefits when aggression is low to moderate,[119] couples experiencing domestic abuse are ineligible for the interventions described in this chapter.

3.2 Key risks

A wide variety of circumstances increase the risk of family conflict, particularly if they introduce high levels of stress into the family system. In fact, studies show there is a linear relationship between parents' ability to manage family conflict and the number of stresses parents experience.[120] While it is beyond the scope of this review to exhaustively list all sources of family stress, several of the more common stressors contributing to family conflict are described briefly below.

Child-level stressors

Child's age: Although children can contribute to interparental conflict at any point during their development, there are two ages that are particularly stressful for parents: the child's first year and adolescence.[121,122]

The birth of a baby, especially the first baby, is often a happy but stressful time for both parents. At this point, most parents are still in a couple relationship, and the transition to parenthood inevitably requires some reorganisation and renegotiation on the part of each partner to adapt to the baby's needs.[123] Some babies may be more difficult to manage than others, introducing a new source of stress into the couple relationship.[124] It is therefore not uncommon for both parents to report a drop in relationship satisfaction in the months following a baby's birth, especially when parents are deprived of sleep.[125]

As couples adapt to this stress and reorient themselves to the needs of the baby, the roots of their co-parenting relationship are established. Studies show that this typically occurs within the first 100 days of the first baby's birth, and the quality of the co-parenting relationship at six months is predictive of its quality when the child is three years old.[126] Couple satisfaction prior to the birth of the baby is a strong predictor of the quality of the co-parenting

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118 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.

119 Karakurt, G., Whiting, K., Van Esch, C., Bolen, S. D., & Calabrese, J. R. (2016). Couples therapy for intimate partner violence: A systematic review and meta-analysis. *Journal of Marital and Family Therapy*, *42*(4), 567–583.

120 McDaniel, B. T., Teti, D. M., & Feinberg, M. E. (2018). Predicting coparenting quality in daily life in mothers and fathers. *Journal of Family Psychology*, *32*(7), 904.

121 Cowan, C. P., & Cowan, P. A. (1992). *When partners become parents: The big life change for couples.* Basic Books.

122 Macmillan, R., McMorris, B. J., & Kruttschnitt, C. (2004). Linked lives: Stability and change in maternal circumstances and trajectories of antisocial behaviour in children. *Child Development*, *75*, 205–220.

123 Belsky, J., & Rovine, M. (1990). Patterns of marital change across the transition to parenthood: Pregnancy to three years postpartum. *Journal of Marriage and the Family*, *52*, 5–19.

124 Schoppe-Sullivan, S. J., Mangelsdorf, S. C., Brown, G. L., & Sokolowski, M. S. (2007). Goodness-of-fit in family context: Infant temperament, marital quality, and early coparenting behavior. *Infant Behavior and Development*, *30*(1), 82–96.

125 Nelson, S. K., Kushlev, K., & Lyubomirsky, S. (2014). The pains and pleasures of parenting: When, why, and how is parenthood associated with more or less well-being? *Psychological Bulletin, 140*(3), 846.

126 Schoppe-Sullivan, S. J., Mangelsdorf, S. C., Frosch, C. A., & McHale, J. L. (2004). Associations between coparenting and marital behavior from infancy to the preschool years. *Journal of Family Psychology*, *18*(1), 194.

relationship,[127] as is knowledge of strategies for managing the stresses that can occur (such as lack of sleep) after the baby arrives.[128,129]

The teenage years are also more stressful for many families, as some reorganisation is required to adapt to the young person's needs and the risks associated with adolescence.[130] This reorganisation includes the recognition that teenagers have rights, freedoms and responsibilities within the family system, but that limits on risky behaviours are necessary. Parents often find themselves needing to learn new co-parenting skills to agree these limits and determine how they should be applied.

Child disabilities can also introduce high levels of stress into the interparental relationship, as well as a unique set of co-parenting challenges.[131] This can include the disappointment and guilt many parents experience when coming to terms with their child's disability,[132,133] or the additional stress of navigating complex health or educational systems to ensure that the child's needs are met.[134,135] In many instances, a child's disabilities can also increase the family's financial burden, resulting in decisions to sacrifice positive activities that might otherwise mitigate the negative impact of the child's disability.

Family-level stressors

The couple relationship: Studies show that satisfaction with the couple relationship supports the quality of the co-parenting relationship, although they reflect two separate processes:[136] the couple relationship is not the same as the co-parenting relationship, as couples can be quite fond of each other, but still be ineffective as co-parents.[137] However, co-parenting skills are more easily learned when parents feel positively towards each other as a starting premise, and studies show that couple satisfaction prior to the birth of the baby sets the tone for the co-parenting relationship after birth.[138] While separated parents can learn how to co-parent effectively, this is often more challenging, particularly in highly acrimonious separations.[139]

Studies also show that the quality of the couple relationship impacts that quality of the parent–child relationship. Hence, parents who share a fondness for each other are more

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127 Schoppe-Sullivan, S. J., Mangelsdorf, S. C., Brown, G. L., & Sokolowski, M. S. (2007). Goodness-of-fit in family context: Infant temperament, marital quality, and early coparenting behavior. *Infant Behavior and Development*, *30*(1), 82–96.

128 Feinberg, M. E. (2008). Establishing family foundations: Intervention effects on coparenting, parent/infant well-being and parent-child relations. *Journal of Family Psychology*, *22*, 1–19.

129 Mitnick, D. M., Heyman, R. E., & Smith Slep, A. M. (2009). Changes in relationship satisfaction across the transition to parenthood: A meta-analysis. *Journal of Family Psychology*, *23*(6), 848.

130 Cui, M., & Donnellan, M. B. (2009). Trajectories of conflict over raising adolescent children and marital satisfaction. *Journal of Marriage and Family*, *71*(3), 478–494.

131 Goetz, G. L., Rodriguez, G., & Hartley, S. L. (2019). Actor-partner examination of daily parenting stress and couple interactions in the context of child autism. *Journal of Family Psychology*, *33*(5), 554.

132 Risdal, D., & Singer, G. H. (2004). Marital adjustment in parents of children with disabilities: A historical review and meta-analysis. *Research and Practice for Persons with Severe Disabilities*, *29*(2), 95–103.

133 Myers, B. J., Mackintosh, V. H., & Goin-Kochel, R. P. (2009). 'My greatest joy and my greatest heart ache:' Parents' own words on how having a child in the autism spectrum has affected their lives and their families' lives. *Research in Autism Spectrum Disorders*, *3*(3), 670–684.

134 DePape, A. M., & Lindsay, S. (2015). Parents' experiences of caring for a child with autism spectrum disorder. *Qualitative Health Research*, *25*(4), 569–583.

135 Sanders, M. R., Mazzucchelli, T. G., & Studman, L. J. (2004). Stepping Stones Triple P: The theoretical basis and development of an evidence-based positive parenting program for families with a child who has a disability. *Journal of Intellectual and Developmental Disability*, *29*(3), 265–283.

136 Carlson, M. J., Pilkauskas, N. V., McLanahan, S. S., & Brooks-Gunn, J. (2011). Couples as partners and parents over children's early years. *Journal of Marriage and Family*, *73*(2), 317–334.

137 McBride, B. A., & Rane, T. R. (1998). Parenting alliance as a predictor of father involvement: An exploratory study. *Family Relations*, *47*, 229–236.

138 McHale, J. P., Kuersten-Hogan, R., Lauretti, A., & Rasmussen, J. L. (2000). Parental reports of coparenting and observed coparenting behaviour during the toddler period. *Journal of Family Psychology*, *15*, 220–236.

139 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.

likely to share this fondness for their children. Similarly, it is not uncommon for contempt within the couple relationship to 'spill over' into contempt for the child.[140]

Poor conflict resolution skills learned in childhood: As noted already, parents often learn their conflict resolution strategies from their own parents. A key aim of many interventions is to address the roots of this intergenerational pattern of conflict (including attitudes and insecurities left over from childhood) by providing parents with alternative, non-aggressive strategies for managing it.[141]

Job satisfaction and work-related pressures: Work-related pressures are highly correlated with increases in family conflict, regardless of whether they are accompanied by financial pressures.[142] Work-related factors shown to increase family conflict include low job satisfaction and high work–family conflict: that is, jobs that provide little flexibility for parents to manage work and family needs.[143] Studies also show that mothers are more negatively impacted by work–family conflict than fathers, as the majority of childcare and household duties are still the responsibility of mothers.[144]

None of the interventions described in this section have explicit content aimed at helping parents to manage work/life pressures, although there is evidence that employment, childcare and family policies can measurably reduce the pressures some families experience.

Poor parental mental health: Parental mental health problems consistently contribute to higher levels of stress within the couple/co-parenting relationship. In particular, mental health problems make it difficult for parents to manage negative emotions and engage constructively in co-parenting negotiations.[145]

The interventions described in this chapter provide advice to help parents to manage their moods and some have evidence of reducing symptoms of depression, anger and anxiety. However, none of the interventions described in this chapter are adequate for managing more serious mental health problems, such as chronic depression, anxiety and personality disorders. In these cases, additional treatments are necessary, as we describe chapter 4.

Parental substance misuse: Parental substance misuse is consistently linked to increases in family conflict in a way that is thought to directly contribute to problematic adolescent behaviour and substance misuse problems. As described in chapter 6, parental substance misuse does not need to occur at dependent levels to negatively impact the co-parenting relationship or children's wellbeing. To this point, studies show that occasional substance misuse, in the form of binge drinking and recreational use, also increases the risk of family conflict and poor child outcomes.[146]

None of the interventions described in this chapter have specific content targeting parental substance misuse, nor is there evidence of these interventions reducing family conflict

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140 Erel, O., & Burman, B. (1995). Interrelatedness of marital relations and parent-child relations: A meta-analytic review. *Psychological Bulletin*, *118*(1), 108.

141 Rothenberg, W. A., Solis, J. M., Hussong, A. M., & Chassin, L. (2017). Profiling families in conflict: Multigenerational continuity in conflict predicts deleterious adolescent and adult outcomes. *Journal of Family Psychology*, *31*(5), 616–628.

142 Bianchi, S. M., &. Milkie, M. A. (2010). Work and family research in the first decade of the 21st century. *Journal of Marriage and Family*, *72*, 705–725.

143 Haskins, R., Waldfogel, J., & McLanahan, S. (2011). *Work-family conflict: Look to employers and communities for solutions* [Policy brief]. Future of Children.

144 Borgmann, L. S., Kroll, L. E., Müters, S., Rattay, P., & Lampert, T. (2019). Work-family conflict, self-reported general health and work-family reconciliation policies in Europe: Results from the European Working Conditions Survey 2015. *SSM-Population Health, 9*, 100465.

145 Williams, D. T. (2018). Parental depression and cooperative coparenting: A longitudinal and dyadic approach. *Family Relations*, *67*(2), 253–269.

146 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.

in families where parental substance misuse is an identified issue. This is because high levels of parental substance misuse typically interfere with parents' capacity to participate in the intervention, and additional treatment for the substance misuse problem is often necessary.[147] The nature of parental substance misuse interventions and their level of efficacy are described in greater detail in chapter 6.

Community-level stressors

Any source of stress risks introducing or escalating conflict between parents and other family members. These stressors can include community-level factors such as **poor housing**, **high levels of crime**, **social isolation** and **poor transportation links**. All of these stresses are consistently linked to increases in family conflict and community-level increases in child abuse and neglect.[148]

Societal-level risks

Societal-level risks, including **economic downturns** and **entrenched poverty**, are also known to contribute to family conflict in a way that consistently contributes to poor child outcomes.[149] Economic hardship particularly impacts upon families by increasing the number of financial pressures parents most cope with on a daily basis,[150] including difficulty paying bills and restrictions on what can be purchased. These pressures, in turn, increase the amount of psychological stress parents experience and the risk of more serious psychological problems and hostility negatively impacting the co-parenting relationship.[151]

None of the interventions identified in this review have content that provides parents with specific strategies for managing the ongoing stresses associated with long-term economic hardship. However, there is evidence from several US demonstration projects showing that strategies for coping with financial pressures may reduce conflict within the co-parenting relationship and improve child outcomes in the longer term.[152]

3.3 Interventions with evidence of preventing and reducing family conflict and improving the co-parenting relationship

The EIF Guidebook has seven interventions (see interventions table 2) with content aimed explicitly at reducing family conflict and enhancing the quality of the co-parenting relationship. All have evidence of improving children's behaviour and improving parental mood. Three also have evidence of reducing conflict within the interparental relationship. While none of these interventions have evidence of improving outcomes in families where there are concerns about domestic abuse, parental mental health problems or substance misuse, some have evidence of preventing the escalation of family conflict when offered at the universal and targeted levels.

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147 McGovern, R., Newham, J. J., Addison, M., Hickman, M., & Kaner, E. (2022). The effectiveness of psychosocial interventions at reducing the frequency of alcohol and drug use in parents: Findings of a Cochrane review and meta-analyses. *Addiction.* Advance online publication.

148 Bywater, P., Skinner, G., Cooper, A., Kennedy, E., & Malik, A. (2022). *The relationship between poverty and child abuse and neglect: New evidence*. The NSPCC and Nuffield Foundation.

149 Loman, L. A., & Siegel, G. L. (2021). *Financial hardship and child maltreatment: Six studies in five states*. IAR Associates.

150 Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*, *13*, 85–90.

151 Conger, R. D., & Conger, K. J. (2002). Resilience in Midwestern families: Selected findings from the first decade of a prospective, longitudinal study. *Journal of Marriage and Family*, *64*(2), 361–373.

152 Wadsworth, M. E., & Markman, H. J. (2012). Where's the action? Understanding what works and why in relationship education. *Behavior Therapy*, *43*(1), 99–112.

Universal support

Universal programmes are made available to all families, regardless of level of need. As described in chapter 2, very few parent and family interventions have evidence of effectiveness when offered universally to all families. However, one exception is interventions that are made available to all families at key transition points in their children's development, such as at birth or when their child enters preschool or secondary school.

Family Foundations and **Schoolchildren and their Families** (also known as Parents as Partners) are examples of two co-parenting interventions with level 3 or higher evidence of improving child outcomes when offered to parents universally at key transitions during their child's development.

Family Foundations is a co-parenting intervention attended by couples expecting their first child.[153] It is typically delivered alongside a standard childbirth class beginning in the mother's second or third trimester. Parents attend five sessions prior to the baby's birth and then reconvene for four additional sessions when the baby is between four and six months old. During these sessions, parents learn strategies for working together effectively as co-parents through coordinating their child's care and responding sensitively to its needs.

Family Foundations has level 4 evidence of improving the quality of the couple relationship during the child's first year, supporting the quality of the attachment relationship at 12 months, and improving children's behaviour at three and seven years after completion.[154,155] This includes evidence of reducing stress within the interparental relationship, including the likelihood of conflict involving physical aggression.

An online version of the programme has also been developed for families where one or both partners are serving in the US military. This intervention also has causal evidence of improving the co-parenting relationship and increasing infant sleep, although the content is quite specific to managing the pressures associated with military life.[156]

Schoolchildren and their Families is a second universal intervention with causal (level 3) evidence of improving child and family outcomes when made available to all families during the first year of primary school. Parents attend six group sessions as couples, where they learn co-parenting strategies for managing their child's behaviour and family life. Schoolchildren and their Families' evidence includes improvements in parental mood, reductions in family conflict and improved child behaviour immediately after programme completion, as well as improved child behaviour at a 10-year follow-up.[157]

Targeted selected interventions

Family Check-up for Children is a PMT programme that includes content addressing the co-parenting relationship. While it has causal, long-term evidence of improving children's

[153] Feinberg, M. E., & Kan, M. L. (2015). Family foundations. In M. J. Van Ryzin, K. L. Kumpfer, G. M. Fosco, & M. T. Greenberg (Eds.), *Family-based prevention programs for children and adolescents: Theory, research, and large-scale dissemination* (pp. 23–41). Psychology Press.

[154] Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: Effects on coparenting, parenting, family violence, and parent and child adjustment. *Prevention Science*, *17*(6), 751–764.

[155] Feinberg, M. E., Jones, D. E., Roettger, M. E., Hostettler, M., & Solmeyer, A. (2014). Long-term follow-up of a randomized trial of family foundations: Effects on children's emotional, behavioral, and school adjustment. *Journal of Family Psychology*, *28*, 821–831.

[156] Feinberg, M. E., Boring, J., Le, Y., Hostetler, M. L., Karre, J., Irvin, J., & Jones, D. E. (2020). Supporting military family resilience at the transition to parenthood: A randomized pilot trial of an online version of family foundation. *Family Relations*, *69*(1), 109–124.

[157] Cowan, C. P., Cowan, P. A., & Barry, J. (2011). Couples' groups for parents of preschoolers: Ten-year outcomes of a randomized trial. *Journal of Family Psychology*, *25*(2), 240–250.

behaviour and reducing maternal depression, it has not been explicitly tested for reducing family conflict or improving the co-parenting relationship.[158]

Targeted indicated interventions

Triple P and **Incredible Years** are two established PMT programmes offering enhanced versions with content aimed at improving interparental communication and reducing family conflict. Both interventions have strong and consistent evidence of reducing child behavioural problems, improving parental mood and increasing couple satisfaction in the short term, as described in chapter 2. Neither intervention has specific evidence of improving the quality of the co-parenting relationship, however, or reducing couple conflict.[159]

Targeted indicated interventions for separated parents

New Beginnings Programme for Divorced and Separating Parents and **Family Transitions Triple P** are two interventions developed explicitly to improve child outcomes in families where the parents have separated or divorced. Both interventions include content aimed at helping parents to manage their anger towards their ex-partner and work more cooperatively as co-parents, as well as supporting their child's emotional needs during the family separation.

Both interventions are intended to be delivered by masters-level (or higher) social workers or psychologists. This is because a high level of knowledge, skills and experience are necessary for determining whether the intervention is working, or if the family situation is characterised by high levels of abuse that could be exacerbated by the intervention, leading to potentially worse outcomes for the child.

New Beginnings has level 4 evidence of improving the quality of the parent–child relationship in the short term and reducing child emotional and behavioural problems in the long term.[160] Family Transitions Triple P has level 3 evidence of reducing child behavioural problems in the short term, as well as improving the quality of the co-parenting relationship 12 months after intervention completion.[161]

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158 Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-year effects of the family check-up in early childhood, *Journal of Consulting and Clinical Psychology*, *74*, 1–9.

159 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*.

160 Wolchik, S. A., Sandler, I. N., Millsap, R. E., Plummer, B. A., Greene, S. M., Anderson, E. R., ... & Haine, R. A. (2002). Six-year follow-up of preventive interventions for children of divorce: A randomized controlled trial. *JAMA*, 288(15), 1874–1881.

161 Stallman, H. M., & Sanders, M. R. (2014). A randomized controlled trial of Family Transitions Triple P: A group-administered parenting program to minimize the adverse effects of parental divorce on children. *Journal of Divorce & Remarriage*, *55*(1), 33–48.

Interventions table 2

Interventions with evidence of reducing family conflict and improving the co-parenting relationship

Name	Description	Key features*	Evidence	Workforce
Universal				
Family Foundations FIND OUT MORE FAMILY FOUNDATIONS ON THE EIF GUIDEBOOK	A group-based programme for couples expecting their first child. Couples learn strategies for enhancing communication, resolving conflict and sharing of childcare duties.	Child age: Perinatal Need: Universal Model: Group Available in the UK? Yes Evaluated in the UK? No	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 three and age seven.	Practitioners trained in the programme model with at least QCF-6 level qualifications or higher.
Schoolchildren & their Families (Parents as Partners) FIND OUT MORE SCHOOLCHILDREN & THEIR FAMILIES ON THE EIF GUIDEBOOK	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.	Child age: Entry to kindergarten/reception Need: Universal Model: Group Available in the UK? Yes Evaluated in the UK? Yes	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.	Two practitioners trained in the Schoolchildren and their Families' model with QCF-7/8 level qualifications.
Targeted selected				
Family Check-up for Children FIND OUT MORE FAMILY CHECK-UP FOR CHILDREN ON THE EIF GUIDEBOOK	The Family Check-up (FCU) for Children is a strengths-based, family-centred intervention that provides parents with strategies for encouraging positive child behaviour and discouraging negative and aggressive child behaviour. The programme begins with a Family Check-up assessment that determines what parenting support is required. This package could include 1–15 sessions of the Everyday Parenting programme, depending on the severity of the families' problems. Family Check-ups begin when the child is 2 years old and then continue annually until the child attends primary school.	Child age: 2–5 years Need: Selected Model: Group & Individual Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of improved child behaviours, improved parent–child interactions and reduced maternal depression.	A social worker or clinical psychologist with QCF-7/8 level qualifications.

* Information on interventions as being available or evaluated in the UK is based on desk research at the time of publication, and may be subject to change. Please check with intervention providers for further detail on availability and past evaluations.

Name	Description	Key features	Evidence	Workforce
Targeted indicated				
Enhanced Triple P FIND OUT MORE ENHANCED TRIPLE P ON THE EIF GUIDEBOOK	The Standard Triple P model with three additional modules to additionally address family problems involving partner conflict, stress and parental mental health issues. Three modules target specific concerns. Parents can do one, two or three of the modules, which work on partner relationships and communication, personal coping strategies for high stress situations and other positive parenting practice.	Child age: 1–5 years Need: Indicated Model: Individual or group Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of significant reductions in coercive parenting behaviours and increasing parenting competence, as well as significant improvements in child behaviour, lasting for over three years.	Clinical psychologists.
Incredible Years Preschool BASIC and ADVANCE FIND OUT MORE INCREDIBLE YEARS PRESCHOOL BASIC AND ADVANCE ON THE EIF GUIDEBOOK	Incredible Years ADVANCE is an add-on programme to the Incredible Years Preschool BASIC programme, teaching parents strategies for improving interparental communication, emotion regulation and problem-solving as a means for supporting their child's development.	Child age: 3–6 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? No	Incredible Years Preschool BASIC has level 4 evidence from multiple studies showing short-term improvements in children's behaviour and parental mood. There is no specific evidence of BASIC combined with ADVANCED of improving the quality of the co-parenting relationship.	Delivered by two IY co-leaders with QCF-7/8 level qualifications, who may be a psychologist, social worker, nurse or physician.
For separating parents				
New Beginnings Programme for Divorced and Separating Parents FIND OUT MORE NEW BEGINNINGS PROGRAMME ON THE EIF GUIDEBOOK	An intervention that provides separating parents with strategies for improving positive family communication and effective discipline when parents are separated. Parents are also taught anger-management skills to reduce children's exposure to conflict.	Child age: 3–18 years Need: Targeted Model: Groups of mothers & fathers separately Available in the UK? No Evaluated in the UK? No	Level 4 evidence of long-term reductions in child behavioural and mental health problems.	Practitioners with QCF-7/8 level qualifications.
Triple P Family Transitions FIND OUT MORE TRIPLE P FAMILY TRANSITIONS ON THE EIF GUIDEBOOK	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.	Child age: 1–17 years Need: Targeted Model: Group or individual Available in the UK? Yes Evaluated in the UK? No	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.	Practitioners with QCF-7/8 level qualifications.

4. Interventions with evidence of improving parental mental health and supporting children's development

KEY POINTS

- Adult mental health problems are highly prevalent, affecting 25% of all adults at any point in time and more than 40% over the life course.
- The prevalence of mental health problems in parents parallels the prevalence in the general adult population, although rates of depression and anxiety can become slightly elevated in mothers during the perinatal period.
- Parental mental health problems can negatively impact parents' ability to understand and respond appropriately to their child's needs.
- Parental mental health problems are associated with a variety of poor child outcomes and are a particular risk for child behavioural problems.

WHAT WORKS

- Universal mental health screening during the perinatal period has good evidence of increasing mothers' awareness of their moods and helping them to access treatment when needed.
- There are a variety of effective therapeutic treatments for adult mental health outcomes, including cognitive behavioural therapy (CBT), psychodynamic therapy and counselling.
- Pharmaceutical treatments have causal evidence of helping adults to manage mental health problems. Their benefits for children have not been consistently tested, however.
- The extent to which children also benefit from effective mental health interventions offered to their parents has yet to be fully tested, although there is growing evidence that they may be beneficial for children as well.
- Child First and Child-Parent Psychotherapy are two examples of psychotherapeutic interventions with level 3 evidence of improving behaviour and reducing child protection risk in families where one or both parents has a mental health problem.
- MST-CAN also has level 3 evidence of supporting a variety of important child outcomes, as well as reducing the likelihood of parental neglect and the need for an out-of-home placement.

WHAT IS LESS LIKELY TO WORK

- Interventions that aim to prevent the onset of mental health problems through selective efforts targeting disadvantaged mothers and other parents who may be at risk.

4.1 Characteristics

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.[162] 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.

It is worth noting that definitions of mental health disorders are often controversial, and precise definitions frequently change on the basis of new research. There are currently two internationally recognised systems for classifying and diagnosing mental health disorders:

- The International Classification of Diseases, 11th revision (ICD-11)[163]
- The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).

Both systems manage the definition and classification of mental health disorders and are updated on a regular basis. The DSM-5-TR currently lists more than 250 separate disorders.

Prevalence

Mental health problems are prevalent. Between 40 and 50% of all adults will experience a mental health problem during their lifetime, including 25% of adults at any given moment in time.[164,165] For some, this problem will present itself as a negative mood that will eventually pass; for others, it will be a chronic and debilitating illness that requires ongoing management. Examples of debilitating mental health problems affecting 10–20% of the population include chronic depression, severe anxiety disorders, post-traumatic stress disorder (PTSD), personality disorders, bipolar disorder and schizophrenia.

The prevalence of mental health problems in parents is no different than in the general population, although some studies suggest that rates of depression and anxiety can become elevated in mothers during the perinatal period.

Supporting parents with mental health problems

Mental health problems not only interfere with parents' ability to find pleasure in activities, but also to concentrate and perform routine tasks. Mental health problems can also substantially reduce parents' capacity to understand and attend to their child's needs. This lack of sensitivity, in turn, increases the child's risk of social, emotional and self-regulatory problems throughout their development.[166]

Severe parental mental health problems are consistently associated with an increased risk of child maltreatment, with studies showing that parents with serious mental health problems

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[162] 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.

[163] See: https://www.who.int/standards/classifications/classification-of-diseases

[164] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 593–602.

[165] Cooper, C. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, *392*(10159), 1789–1858.

[166] Barker, E. D., Copeland, W., Maughan, T., Jaffee, S. R., & Uher, R. (2012). Relative impact of maternal depression and associated risk factors on offspring psychopathology. *The British Journal of Psychiatry*, *200*, 124–129.

are more than twice as likely to neglect their child.[167,168] It should be emphasised, however, that this risk is relative and influenced by a variety of factors, including the type of mental health problem the parent is experiencing, its severity, and the extent to which other family members are available to attend to the child's needs. For example, studies show that the impact of parental mental health problems is minimal when only one parent has a mental health problem and other adults are available to meet the child's need.[169]

Studies show that serious mental health problems can reduce parents' ability to benefit from standard parenting and family interventions, such as those described in chapters 2 and 3.[170] Interventions targeting parental mental health problems therefore include content that takes into account the parents' mental health needs in addition to the parenting advice provided by the intervention (see figure 4.1).

A primary aim of interventions targeting parents with mental health problems is to increase their sensitivity towards their children's needs.[171] Some interventions do this through individualised support that is provided to the parent and child in parallel, as they interact during play sessions, mealtimes and other daily activities. Many interventions also provide parents with therapeutic advice to help them manage their moods and any issues arising from childhood that may decrease their parenting sensitivity.[172]

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[173] – even though they may inadequate for resolving the parent's mental health problem.[174,175]

There is clear evidence that parents with mental health problems can benefit from a variety of established adult psychotherapies and psychopharmaceutical treatments; and growing evidence that children may also benefit when their parents' mental health problems are treated, as we describe later in this chapter.

167 Mulder, T. M., Kuiper, K. C., van der Put, C. E., Stams, G. J. J., & Assink, M. (2018). Risk factors for child neglect: A meta-analytic review. *Child Abuse & Neglect*, *77*, 198–210.

168 White, O. G., Hindley, N., & Jones, D. P. (2015). Risk factors for child maltreatment recurrence: An updated systematic review. *Medicine, Science and the Law*, *55*(4), 259–277.

169 Oyetunji, A., & Chandra, P. (2020). Postpartum stress and infant outcome: A review of current literature. *Psychiatry Research*, *284*, 112769.

170 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.

171 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.

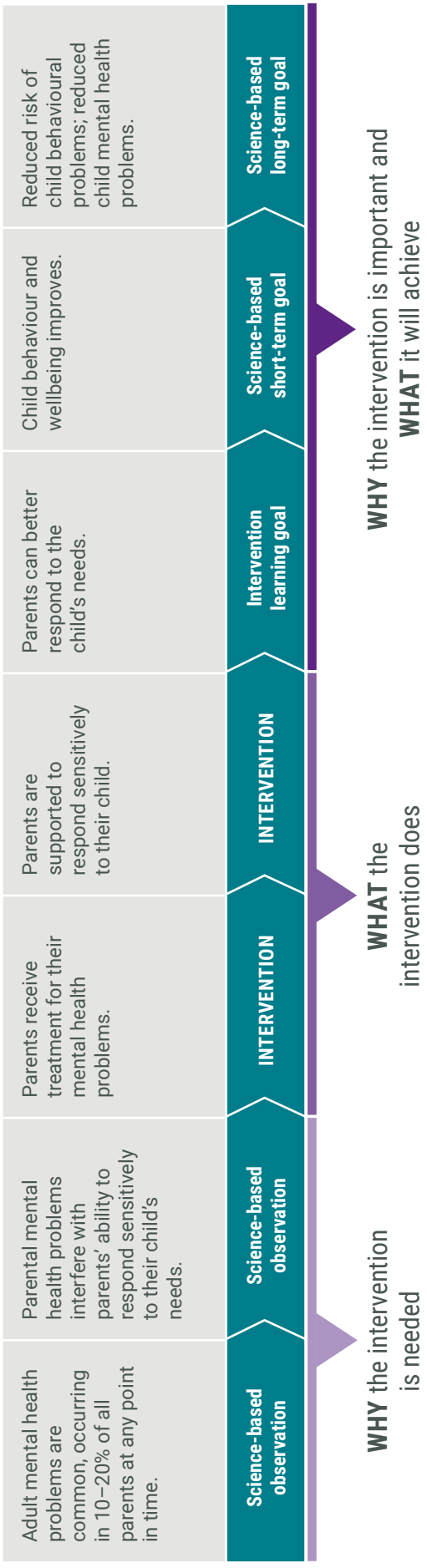
172 Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). *Foundations for Life: What works to support parent child interaction in the early years*. Early Intervention Foundation. https://www.eif.org.uk/report/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years

173 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.

174 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.

175 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.

FIGURE 4.1
A theory of change for interventions aimed at improving parental mental health problems and children's wellbeing



4.2 Key risks

A wide variety of circumstances increase the risk of mental health problems, and these factors vary with each disorder. For example, studies show that many psychotic illnesses (such as schizophrenia, bipolar disorder and severe forms of depression) have a strong, heritable component.[176] By contrast, certain forms of depression and anxieties (such as PTSD) appear to be more strongly associated with adverse circumstances and negative life events.[177] In our 2018 review, *What works to enhance the effectiveness of the Healthy Child Programme*, we describe in greater detail what is known about 19 of the most prevalent adult mental health problems, their associated risks and recommended treatments.[178]

Here, we consider the extent to which various risks predict the prevalence of adult mental health problems at the population level, with the aim of understanding how mental health problems might be prevented through comprehensive public health strategies. This analysis is informed by a series of recent systematic reviews that identify a consistent

176 Cardno, A. G., Marshall, E. J., Coid, B., Macdonald, A. M., Ribchester, T. R., Davies, N. J., ... & Murray, R. M. (1999). Heritability estimates for psychotic disorders: The Maudsley twin psychosis series. *Archives of General Psychiatry*, *56*(2), 162–168.

177 Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, *13*(4), 419–425.

178 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

set of risks existing at the level of the parent, family, community and society (see figure 4.2).[179,180,181,182,183,184,185,186,187]

Individual-level risks include genetic and inherited vulnerabilities, gender (for example, females are at greater risk of depression and anxiety disorders and males are at greater risk of suicide), a history of child maltreatment, a physical disability and young parenthood. Level of education is not a consistent predictor of adult mental health problems, as was once previously assumed.

Family-level risks include high levels of family conflict and domestic violence, lone parenthood, low job satisfaction, unsatisfactory childcare arrangements, stressful life events (including bereavement), low family income, food insecurity, social isolation and recent immigration status. The extent to which the child was the result of an unplanned pregnancy is also a significant risk.

Community-level risks include:

- neighbourhood deprivation, including high levels of crime and low levels of safety
- environmental factors, including pollutants and toxins, high traffic congestion and continually visible rubbish
- ethnic diversity, with some studies showing that a higher density of minority ethnic groups may provide a protective effect
- the density of newly immigrated and refuge families
- cultural factors, with the density of places of worship providing a protective effect
- socioeconomic factors, including high levels of joblessness, poverty and large disparities in income
- housing issues, including quality, availability and stability
- issues pertaining to diversity and equality, including racism and ethnic density (viewed as a protective factor).

Interestingly, studies observe that urban and rural characteristics do not consistently predict the prevalence of mental health problems.

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179 Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet, 384*(9956), 1775–1788.

180 Norhayati, M. N., Hazlina, N. N., Asrenee, A. R., & Emilin, W. W. (2015). Magnitude and risk factors for postpartum symptoms: A literature review. *Journal of Affective Disorders*, *175*, 34–52.

181 Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry*, *26*(4), 289–295.

182 World Health Organization. (2012). *Risks to mental health: An overview of vulnerabilities and risk factors*. https://www.who.int/publications/m/item/risks-to-mental-health

183 Arango, C., Dragioti, E., Solmi, M., Cortese, S., Domschke, K., Murray, R. M., ... & Fusar-Poli, P. (2021). Risk and protective factors for mental disorders beyond genetics: An evidence-based atlas. *World Psychiatry, 20*(3), 417–436.

184 Meyer, O. L., Castro-Schilo, L., & Aguilar-Gaxiola, S. (2014). Determinants of mental health and self-rated health: A model of socioeconomic status, neighborhood safety, and physical activity. *American Journal of Public Health, 104*(9), 1734–1741.

185 Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., ... & Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry, 5*(4), 357–369.

186 Ribeiro, W. S., Bauer, A., Andrade, M. C. R., York-Smith, M., Pan, P. M., Pingani, L., ... & Evans-Lacko, S. (2017). Income inequality and mental illness-related morbidity and resilience: a systematic review and meta-analysis. *The Lancet Psychiatry, 4*(7), 554–562.

187 World Health Organization and Calouste Gulbenkian Foundation. (2014*). Social determinants of mental health*.

FIGURE 4.2

Individual, family, community and societal risks consistently associated with parental mental health problems

Societal-level risks are those which are known to contribute to family- and community-level risks, although their direct impact has not been as consistently tested. Examples include structural inequalities, such as poverty and racism, as well as factors associated with a society's GDP, which determine participation in the workforce. Global pandemics, such as the Covid-19 crisis, also represent a significant societal-level risk that can negatively impact and amplify all other parent-, family-, community- and societal-level risks.

It is important to note that each risk identified in figure 4.2 has been shown to independently contribute to the prevalence of mental health outcomes at the population level. This means that its influence can be statistically separated from the contribution of other, co-occurring risks.

Additionally, there is an established graded relationship between the number of risks present and the prevalence of population-level mental health problems. For example, studies show that the prevalence of mental health problems can be as high as 80% in deprived areas with multiple risks, in comparison to lower than 10% in highly affluent communities.

It is important to note that the presence of multiple risks is not necessarily predictive at the individual level. In this respect, it is not uncommon for mental health problems to occur in individuals exposed to only one or two risks, while individuals exposed to 10 or more experience no difficulties. It is nevertheless assumed that the cumulation of adversities increasingly restricts an individual's ability to cope, by negatively impacting their mood, self-esteem and sense of mastery. In this respect, there is evidence that a sense of hopelessness and helplessness steadily increases in the face of multiple adversities, eventually increasing the risk of a diagnosable mental health problem over time.

4.3 Interventions with evidence of reducing parental mental health problems and supporting children's development

The World Health Organization has recently created a list of public health efforts viewed as effective for reducing the prevalence of mental health problems at the population level.[188] These efforts include public awareness campaigns, incentives to employers for reducing stress at the workplace, improved housing strategies, and violence reduction programmes.

A growing number of studies show that when offered collectively, these efforts could reduce the prevalence of many serious mental health problems.[189] However, studies also show that these efforts are typically not sufficient for preventing the onset of mental health problems at the individual level, even when specific risks are targeted. Hence, immediate access to effective treatments is still considered a vital component of any public strategy aimed at reducing the impact of mental health problems and preventing them from becoming worse.

In the sections that follow, we describe the efficacy of universal screening strategies aimed at increasing parents' access to effective mental health treatments, as well as effective targeted interventions for individuals with a diagnosed mental illness (see also interventions table 3).

Universal support

Studies show that 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.[190] Screening tools validated as effective for diagnosing depression include the Edinburgh Postnatal Depression Scale (EPDS), which also has

[188] World Health Organization. (2018). *Mental health: Strengthening our response*.

[189] World Health Organization. (2021). *Comprehensive mental health action plan 2013–2030*.

[190] O'Connor, E., Rossom, R. C., Henninger, M., Groom, H. C., & Burda, B. U. (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.

evidence of reliability detecting certain forms of anxiety.[191] The Generalised Anxiety Assessment (GAD-7) is also a validated tool for diagnosing various anxiety disorders.[192]

Maternal depression and anxiety during the perinatal period consistently increase the risk of poor child outcomes during the first two years of life.[193] The National Institute for Health Care Excellence (NICE) therefore recommends that pregnant mothers be routinely screened for depression and anxiety by midwives, by asking them the following two questions (also known as the Whooley questions) at her first antenatal visit:[194]

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

If the woman responds positively to either of these two questions, she should complete the EPDS or Patient Health Questionnaire to determine if depression is an issue and further treatment would be beneficial. NICE further recommends that women identified with mild to severe depression be offered antidepressants, with the full disclosure of the risks involved in taking them. A high-intensity psychotherapy, such as CBT or interpersonal therapy, might also be offered in conjunction with or as an alternative to antidepressant treatment.

While the NICE guidelines recommend that routine screening take place at the beginning of the antenatal period, studies show that parental mental health problems can arise any time during adulthood. Additionally, there is clear evidence that parental mental health problems are detrimental to children at all points of development, not just during the perinatal period.[195]

Given that many adult mental health problems go unrecognised and untreated in the absence of routine screening, public health organisations are increasingly recommending that mental health screening be integrated into routine healthcare for all adults.[196] This is based on evidence showing that such screening is effective for increasing adults' access to effective treatments, especially in comparison to practices that rely on self-referrals.

Targeted selected interventions

Targeted selected interventions are those offered to individuals who are at risk of developing a mental health problem. Examples of known risks include a blood relative with a mental health problem, or a previous history of mental health problems.

There is some evidence showing that offering **counselling** to mothers at risk of postnatal depression could prevent its severity or onset.[197] For this reason, the US Preventive Services Task Force has recently advised that counselling could be part of a useful strategy for

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191 Gibson, J., McKenzie-McHarg, K., Shakespeare, J., Price, J., & Gray, R. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta Psychiatrica Scandinavica*, *119*(5), 350–364.

192 Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care*, *46*, 266–274.

193 Oyetunji, A., & Chandra, P. (2020). Postpartum stress and infant outcome: A review of current literature. *Psychiatry Research*, *284*, 112769.

194 See: https://www.nice.org.uk/guidance/cg192/chapter/1-recommendations

195 England, M. J., Sim, L. J., & National Research Council. (2009). Associations between depression in parents and parenting, child health, and child psychological functioning. In M. J. England & L. J. Sim (Eds.), *Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention*. National Academies Press.

196 Siu, A. L., Bibbins-Domingo, K., Grossman, D. C., Baumann, L. C., Davidson, K. W., Ebell, M., ... & US Preventive Services Task Force. (2016). Screening for depression in adults: US Preventive Services Task Force recommendation statement. *JAMA*, *315*(4), 380–387.

197 Dennis, C. L., & Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database of Systematic Reviews*, *2*.

preventing depression during the perinatal period.[198] However, findings from several recent large-scale trials have observed no preventative benefits.[199,200,201] Part of the challenge is a lack of validated measures for identifying specific risks for developing postnatal depression.[202]

Targeted indicated interventions

While findings involving the prevention of mental health problems are equivocal, there is clear evidence showing that various **psychotherapies** are effective at reducing problematic mental health symptoms once a psychological illness has occurred. These therapies include CBT, psychodynamic therapy and interpersonal therapy. We describe the nature and efficacy of each of these treatments in detail in our review, *What works to enhance the Healthy Child Programme*.[203]

It is worth noting that online versions of many evidence-based psychotherapeutic interventions now exist, with studies showing that **digitally offered therapies** may be as effective as those offered in person in some instances. However, there are many caveats to this conclusion, depending on the nature of the illness and the type of therapy offered.[204,205] For instance, digitally offered CBT shows promise in treating various anxieties and depression. There is also evidence that various forms of self-administered CBT could be beneficial for individuals with mild to moderate mental health problems.[206] However, the effectiveness of digitally offered therapies for more complex mental health problems is yet to be established.

There is consistent evidence supporting the use of **pharmaceutical treatments** for more serious mental health problems, including various psychoses, severe anxieties (including severe forms of PTSD) and clinical depression.[207,208] These treatments must be prescribed by a psychiatrist or GP, and the dosage must be carefully monitored, particularly when offered to mothers who are pregnant or breastfeeding.[209]

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198 Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., ... & US Preventive Services Task Force. (2019). Interventions to prevent perinatal depression: US Preventive Services Task Force recommendation statement. *JAMA*, *321*(6), 580–587.

199 Ammerman, R. T., Altaye, M., Putnam, F. W., Teeters, A. R., Zou, Y., & Van Ginkel, J. B. (2015). Depression improvement and parenting in low-income mothers in home visiting. *Archives of Women's Mental Health*, *18*(3), 555–563.

200 Cooper, P. J., De Pascalis, L., Woolgar, M., Romaniuk, H., & Murray, L. (2015). Attempting to prevent postnatal depression by targeting the mother–infant relationship: A randomised controlled trial. *Primary Health Care Research & Development*, *16*(04), 383–397.

201 Morrell, C. J., Sutcliffe, P., Booth, A., Stevens, J., Scope, A., Stevenson, M., … & Stewart-Brown, S. (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.

202 Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet*, *384*(9956), 1775–1788.

203 Asmussen, K., & Brims, L. (2018). *What works to enhance 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

204 Thomas, N., McDonald, C., de Boer, K., Brand, R. M., Nedeljkovic, M., & Seabrook, L. (2021). Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*(3), 854–883.

205 Smith, K., Moller, N., Cooper, M., Gabriel, L., Roddy, J., & Sheehy, R. (2022). Video counselling and psychotherapy: A critical commentary on the evidence base. *Counselling and Psychotherapy Research*, *22*(1), 92–97.

206 Luo, C., Sanger, N., Singhal, N., Pattrick, K., Shams, I., Shahid, H., ... & Samaan, Z. (2020). A comparison of electronically-delivered and face to face cognitive behavioural therapies in depressive disorders: A systematic review and meta-analysis. *EClinicalMedicine*, *24*, 100442.

207 Baldwin, D. S., Anderson, I. M., Nutt, D. J., Allgulander, C., Bandelow, B., den Boer, J. A., ... & Malizia, A. (2014). Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology. *Journal of Psychopharmacology*, *28*(5), 403–439.

208 Barth, M., Kriston, L., Klostermann, S., Barbui, C., Cipriani, A., & Linde, K. (2016). Efficacy of selective serotonin reuptake inhibitors and adverse events: Meta-regression and mediation analysis of placebo-controlled trials. *The British Journal of Psychiatry*, *208*(2), 114–119.

209 Kittel-Schneider, S., Felice, E., Buhagiar, R., Lambregtse-van den Berg, M., Wilson, C. A., Banjac Baljak, V., ... & Lupattelli, A. (2022). Treatment of peripartum depression with antidepressants and other psychotropic medications: A synthesis of clinical practice guidelines in Europe. *International Journal of Environmental Research and Public Health*, *19*(4), 1973.

The extent to which therapeutic and pharmacological 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 or pharmaceutical treatments, these positive outcomes are not consistent across all studies.[210,211]

Interestingly, the **Incredible Years Basic** programme has evidence of improving child outcomes when offered to clinically depressed mothers.[212] Several evaluations have also observed reductions in parents' self-reported symptoms of depression, although these are not observed consistently in all rigorous evaluations of the programme.[213,214,215]

Here, this intervention is available to local areas through Improving Access to Psychological Therapies (IAPT) and may be appropriate for parents where there are specific mental health concerns. However, the extent to which it is a sufficient response for families where a child in need or child protection plan assessment has been made has not been explicitly tested.

Child protection concerns

Child-Parent Psychotherapy (CPP), **Infant-Parent Psychotherapy (IPP)** and **Child First** 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.

CPP was developed specifically for parents suffering from depression, anxiety or trauma and who have a child under the age of 6.[216] It is delivered to the parent and child through weekly sessions over a 12-month period. During these sessions, parents receive psychodynamic support for their mental health needs as well as advice for supporting their child during interaction play session. CPP has evidence of reducing symptoms of trauma in parents and children, and of improving children's behaviour.

IPP is a derivation of CPP with a specific focus on mothers with infants. It has been successfully offered to mothers identified as depressed, as well as in families where there are specific child protection concerns. IPP has evidence of improving infant attachment security and increasing maternal sensitivity. It does not, however, have evidence of improving mothers' mood or providing other mental health benefits.

Child First combines CPP with additional keyworker support to provide further assistance to the family in addressing practical needs.[217] Both interventions have evidence of reducing clinical-level symptoms of depression in parents and improving the behavioural and

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210 Stein, A., Netsi, E., Lawrence, P. J., Granger, C., Kempton, C., Craske, M. G., ... & Murray, L. (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.

211 Cuijpers, P., Weitz, E., Karyotaki, E., Garber, J., & Andersson, G. (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.

212 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.

213 Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology*, *62*(3), 583–593.

214 Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., Eames, C., & Edwards, R.T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *BMJ*, *334*.

215 Leijten, P., Gardner, F., Landau, S., Harris, V., Mann, J., Hutchings, J., ... & Scott, S. (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.

216 Lieberman, A. F., Ippen, C. G., & Dimmler, M. H. (2018). Child-parent psychotherapy. Assessing and treating youth exposed to traumatic stress. In V. G. Carrion (Ed.). *Assessing and treating youth exposed to traumatic stress.* APA Publishing.

217 Crusto, C., Lowell, L., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S., & Kaufman, J. (2008). Evaluation of a wraparound process for children exposed to family violence. *Best Practices in Mental Health*, *4*, 1–16.

emotional outcomes of children.[218,219,220] More detail about CPP is provided in case example C in chapter 5.

Edge of care

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is currently the only intervention on the EIF Guidebook with level 3 evidence of improving outcomes for children who are at the edge of care on account of issues associated with their parents' mental health problems. MST-CAN involves therapeutic support offered to the parents and child at the same time, meaning that the child must be old enough to actively participate in the intervention. The programme's evidence includes reductions in child neglect and the need for an out-of-home placement, reductions in child behaviour problems, and reductions in symptoms of trauma-related anxiety.[221] More detail about MST-CAN is provided in case example B.

CASE EXAMPLE B: MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT

A single parent living in a deprived area is suffering from depression. They are struggling to hold down a job and therefore struggling financially. The school refers their 10-year-old child to children's social care on suspicion of neglect.

Substantiated neglect

If suspicions of neglect are substantiated, Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is the most suitable EIF Guidebook intervention for meeting this family's needs.

MST-CAN was developed specifically for children where there are substantiated concerns about child abuse and neglect. Referrals typically come from child protection services following concerns involving abuse or neglect occurring within the last 180 days. Child protection first contacts the family to ensure that the family is in agreement with the referral, and then refers the family on to the MST team.

Within 48 hours of acceptance of the referral, the MST-CAN supervisor or the therapist assigned to the case will contact the family to explain the treatment and invite them to participate. When parents agree, a detailed intake assessment begins, which is carried out over a series of visits to the family's home. During these visits, the primary focus is on engaging family members and establishing a collaborative partnership with the MST therapist, child protection services and the family. In some cases, it will become clear that the family is in crisis, so the first priority is to stabilise the family situation. If the child is out of the home at the time of referral, the MST-CAN worker will meet with foster parents or kinship carers to make sure that the child's placement is stabilised until the child can return home.

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218 Lowell, D., Carter, A., Godoy, L., Paulicin, B., & Briggs-Gowan, M. (2011). A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. *Child Development*, *82,* 193–208.

219 Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology*, *14*, 877–908.

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

221 Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology*, *24*(4), 497.

A second aim of the initial sessions is to gain an understanding of the severity of the family's circumstances and the risks associated with the maltreating behaviour. This understanding is gained through meetings with child protection services, as well as meetings with the family. Early in the assessment process, the MST-CAN therapist meets with the parent and child to explain the intervention's philosophies and principles for collaboration. These principles include a primary focus on the family's strengths, with the stated goal of increasing parental responsibility so that child can remain safely with the family. During this time, the therapist also gathers each family member's perceptions of the problems they are confronting and their goals for treatment.

Parent engagement is at the core of MST-CAN's work with each family. For the programme to progress, all family members must be able to work closely with the therapist to agree the problems, set short- and long-term goals, and carry out agreed activities. The therapist delivers these sessions in the family home, to remove any barriers to treatment. Therapists also take on low caseloads, so that they are able to be available to families 24 hours a day.

After the initial sessions, the MST therapist seeks further information from other individuals and organisations involved in the family's case, including the child's school and child protection services. The MST-CAN therapist carefully assesses each of these systems (family, extended family, school, etc) for specific strengths and weaknesses.

Based on these initial assessments, the MST-CAN therapist then consults with their supervisor to understand the 'fit' of the referral behaviours. This includes understanding the severity of the parent's mental health problems and the degree to which they are limiting the parent's capacity to meet the child's needs and represent any specific harm to the child. The MST-CAN therapist will also carefully consider the extent to which other aspects of the family system could be contributing to the neglect. This will include consideration of any contextual factors that might also be influencing the family's social isolation and financial circumstances.

These 'fit' factors, or drivers of the neglect, then become the focus of intervention. For example, if it is confirmed that parent mental health problems are the key driver, these problems and the related contextual factors will become the primary focus of the intervention. The therapeutic response will therefore address problems specific to the parent, child and family, although the family will also be supported to address community-level issues that might also be contributing to the child's risk of neglect.

During the initial meetings, the therapist will also help the child and parent to complete a trauma assessment. This assessment allows the MST-CAN team to determine the extent to which previous and current traumatic events might be contributing to any problematic parent and child mental health symptoms. Parents may additionally be screened for substance misuse problems if there is suspicion this is a contributing issue.

At the beginning of the intervention, the MST-CAN worker and family work collaboratively to identify family-specific goals for positive change. These goals should be clearly linked to parenting behaviours that would be considered abusive and neglectful, with a primary aim of increasing the child's safety. In the short term, it is expected that:

- the parent will no longer abuse or neglect the child
- there will no longer be a need for an out-of-home placement
- the child will live in a safer home environment
- any family crises will be stabilised

- parents will use more effective parenting skills
- family relationships will improve
- the family will have improved their network of informal supports
- the child and parent's mental wellbeing will improve.

A primary goal of MST-CAN is to help all family members to identify support systems within their immediate family, extended family and community, so that they do not need to rely on more formal support from external agencies. Referrals for additional services after the conclusion of the MST programme are carefully planned and limited to those that can accomplish specific, well-defined goals.

When working with families, the therapist is likely to address a variety of problems at the same time. Typical examples of the kind of work MST-CAN therapists do include:

- treatment of the parent's or child's post-traumatic stress disorder (PTSD)
- treatment for anger management and other difficult parental moods
- treatment for substance abuse on the part of the parent or child
- family communication and problem-solving training
- safety planning
- supporting the parents to use effective child behaviour management strategies
- helping the parents to develop appropriate attributions of their child's behaviour.

By the conclusion of the intervention, it is expected that:

- abuse and neglect will be eliminated
- out-of-home placements will be prevented
- there will be improvements in parental mental health functioning
- there will be observable improvements in parenting behaviours.

Therapists typically work with families for an average of six to nine months, and commonly see families around three times a week, although these visits will vary according to the level of need. Therapists are available 24/7 to the family and carry a caseload of three to four families.

The MST-CAN therapist and treatment team are expected to be well informed about research identifying the risks for abuse and neglect, and thus will be able to tailor the intervention to most effectively mitigate these risks. MST therapists are also trained to treat a wide variety of mental health problems experienced by children and adults. The MST programme explicitly helps therapists to adopt a strengths-based approach and recognise the importance of the family's cultural context. All therapists are also required to have core clinical skills, which enable them to foster and maintain parental engagement. Families are also helped with practical needs that may interfere with treatment improvement, such as help with transportation and assistance with financial problems.

If the therapist discovers that they are unable to support the parent's or family's problems, the therapist will work with the family and the wider MST team to find a more suitable, evidence-based treatment for the parent and child. In this case example, this might include NHS support to prescribe pharmaceutical treatments or therapies that are specific to the parent's mental health condition.

Unsubstantiated neglect

If child protection concerns about neglect are not substantiated, it is possible that less intensive support would be sufficient for meeting the parent's and child's needs. However, it is likely that this support would involve a hybrid set of evidence-based treatments aimed at meeting the mental health needs of the parent and child separately. For example, the parent might be referred to NHS services for individual therapy and medication, while the child might receives therapeutic support through child and adolescent mental health services (CAMHS). This might include Trauma-focussed cognitive behavioural therapy (Trauma-focussed CBT), if the child is suffering from trauma (see chapter 5 for more on this intervention).

This hybrid support could be coordinated through a Supporting Families keyworker, who could also design bespoke support to help the family cope with financial issues and other issues that may be exacerbating the parent's mental health problems.

An advantage of this hybrid arrangement is that it is potentially less expensive than the more intensive support offered by MST-CAN. The intensity of MST-CAN may also not be perceived as warranted in the absence of a preidentified and serious child maltreatment risk.

A key disadvantage, however, is that a greater burden is placed on the parent and child to access treatment. Accessing treatment may be particularly challenging when the parent has serious mental health problems. Additionally, the involvement of multiple practitioners has the potential to create 'cracks' through which opportunities to spot key child maltreatment risks can slip. In this respect, there are fewer guarantees that the practitioners assigned to the case will have the skills, qualifications and supervision necessary to meet the family's needs, should they become more complex.

By contrast, the MST-CAN licence requires that all therapists in the MST team meet the job specification of that role to ensure that they are skilled in understanding and meeting the needs of highly vulnerable families and are able to offer intensive mental health support when it is needed.

Interventions table 3

Interventions with evidence of reducing parental mental health problems and supporting children's development

Name	Description	Key features*	Evidence	Workforce
Universal				
Perinatal mental health screening FIND OUT MORE NICE GUIDANCE (CG192): 1.5 RECOGNISING MENTAL HEALTH PROBLEMS IN PREGNANCY AND THE POSTNATAL PERIOD AND REFERRAL	Routine screening of mothers for mental health problems throughout pregnancy and the postpartum period.	Child age: All ages, but particularly during the perinatal period Need: Universal Model: Screening Available in the UK? Yes Evaluated in the UK? No	Consistent evidence from multiple systematic reviews showing between a 2% and 9% reduction in the risk of depression at follow-up (3-5 months) after receiving screening for depression, with or without additional treatment components, compared with usual care. A 34% reduction in remission in depression symptoms when screening leads to referral of CBT.	Midwives and other practitioners involved in delivering perinatal care.
Targeted selected				
Family Nurse Partnership (FNP) FIND OUT MORE FAMILY NURSE PARTNERSHIP ON THE EIF GUIDEBOOK	A preventative home-visiting intervention for first-time adolescent mothers and their children. The programme has three goals: (1) to improve pregnancy health and behaviours; (2) to improve child health and development by helping parents provide responsible and competent care; and (3) to improve the mother's economic self-sufficiency. Mothers enrol in the programme early in their pregnancy and receive visits from a family nurse on a weekly basis before, and for the first six weeks after the birth of their child. Visits then continue fortnightly until three months before the child's second birthday when visits become monthly in preparation for the programme ending. 64 visits in total are scheduled. During these visits, mothers learn about their young child's health and development, and receive support for their own wellbeing.	Child age: Antenatal to 2 years Need: Selected Model: Home-visiting Available in the UK? Yes Evaluated in the UK? Yes	Level 4 evidence of improving a variety of child and maternal outcomes from multiple RCTs conducted in North America, Europe and the UK. This includes evidence of improving maternal self-esteem in two studies, but no specific evidence of preventing or reducing maternal mental health problems.	Nurses, midwives or health visitors trained in the FNP model.

* Information on interventions as being available or evaluated in the UK is based on desk research at the time of publication, and may be subject to change. Please check with intervention providers for further detail on availability and past evaluations.

Name	Description	Key features	Evidence	Workforce
Targeted indicated				
Antidepressants and other pharmaceutical treatments for treating various psychological disorders	A variety of medications are available for the treatment of depression, anxiety and various forms of psychoses. All must be prescribed by a GP or similarly qualified medical doctor. Not all drugs are appropriate for pregnant or lactating mothers, so particular care must be provided for patients with these characteristics.	Target group: Adults Need: Indicated Model: Pharmaceutical treatment Available in the UK? Yes Evaluated in the UK? Yes	Level 4 evidence of improving the negative symptoms associated with a variety of diagnosed mental health problems.	GP or psychiatrist.
Cognitive behavioural therapy (CBT) (for mental health) FIND OUT MORE NICE GUIDANCE (CG90): TREATMENT FOR MILD TO MODERATE DEPRESSION	A well-evidenced therapeutic technique typically offered to adults experiencing mild to moderate symptoms of depression or anxiety. Adults are taught cognitive strategies for breaking down problems and worries into smaller components to minimise feelings of helplessness and hopelessness and increase a sense of efficacy. Common CBT strategies include methods for managing their moods and intrusive thoughts, relaxation techniques, and strategies for reframing negative situations. The length of CBT can vary, depending on the length of the problem, although most versions are of short duration. Some can also be self-administered, depending on the severity of the mental health problem.	Target group: Adults Need: Indicated Model: Individual therapy Available in the UK? Yes Evaluated in the UK? No	Consistent evidence from multiple systematic reviews showing reductions in symptoms of depression and anxiety are reported in adults, with studies also showing improvements in child mental wellbeing.	Originally developed to be delivered by clinical psychologists, but clinicians with lower qualifications have now successfully administered it and some versions can be self-administered.
Incredible Years Preschool Basic FIND OUT MORE INCREDIBLE YEARS PRESCHOOL BASIC ON THE EIF GUIDEBOOK	A group parenting programme where parents learn strategies for interacting positively with their child and discouraging unwanted behaviour through mediated video vignettes, problem-solving exercises and structured practice activities.	Child age: 3–6 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? Yes	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. Additionally, one UK study shows reductions in symptoms of depression, as reported by clinically depressed mothers participating in a UK trial.	Delivered by two IY co-leaders with QCF-7/8 qualifications who may be a psychologist, social worker, nurse or physician.
Interpersonal therapy FIND OUT MORE NICE GUIDANCE (CG90): DEPRESSION IN ADULTS: RECOGNITION AND MANAGEMENT	IPT provides adults with strategies for improving their relationships with others and managing difficult life events. Hour-long therapeutic sessions take place every one or two weeks, involving between 10 and 20 sessions.	Target group: Adults Need: Indicated Model: Individual therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 3 short-term evidence of improving maternal mood. The treatment effect may be enhanced if combined with antidepressants.	Traditionally delivered by clinical psychologists but has been shown to be effective when delivered by other health professionals.

Name	Description	Key features	Evidence	Workforce
Psychodynamic therapy FIND OUT MORE NICE GUIDANCE (CG90): DEPRESSION IN ADULTS: RECOGNITION AND MANAGEMENT	Psychodynamic therapy makes use of Freudian principles to help individuals consider how episodes occurring in their past may be negatively impacting their current moods and behaviour. Traditional psychodynamic therapy may involve multiple sessions during the week, lasting for a year or longer, although shorter versions also exist.	Target group: Adults Need: Indicated Model: Individual therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 4 evidence, comparable to CBT, of reducing problematic mental health symptoms. There is also evidence suggesting that psychodynamic therapy is superior to CBT or other short therapies in reducing rates of remission, when delivered to individuals over longer periods of time.	Clinical psychologists.
Child protection concerns				
Child First FIND OUT MORE CHILD FIRST ON THE EIF GUIDEBOOK	A 12-month home visiting intervention combining Child-Parent Psychotherapy with other forms of social support to reduce the risk of child maltreatment in vulnerable families with young children.	Child age: 6–36 months Need: Indicated Model: Individual home visiting Available in the UK? No Evaluated in the UK? No	Level 3 evidence of four-fold reductions in child behavioural problems and a two-fold reduction in reports of child maltreatment at a three-year follow-up. Also, a three-fold reduction in parenting stress and four-fold reduction in symptoms of psychopathology at a 12-month follow-up.	Delivered by one clinician with QCF-7/8 level qualifications and one care coordinator with QCF-6 level qualifications.
Child-Parent Psychotherapy (CPP) FIND OUT MORE CHILD-PARENT PSYCHOTHERAPY ON THE EIF GUIDEBOOK	A therapeutic intervention targeting mothers and preschool children who may have experienced trauma or abuse (such as domestic abuse) or are otherwise at risk of behavioural and emotional problems.	Child age: 3–6 years Need: Indicated Model: Individual parent/child therapy Available in the UK? No Evaluated in the UK? No	Level 3+ evidence of improving child behaviour (depending on the study). Parent benefits include reductions in trauma-symptoms and symptoms of depression.	QCF-7/8 level clinical psychologist or social worker.
Infant-Parent Psychotherapy FIND OUT MORE INFANT-PARENT PSYCHOTHERAPY ON THE EIF GUIDEBOOK	A modification of Child-Parent Psychotherapy for at-risk mothers with an infant.	Child age: 0–24 months Need: Indicated Model: Individual parent/child therapy Available in the UK? No Evaluated in the UK? No	Level 3+ evidence of increasing infant attachment security and improving maternal sensitivity.	QCF-7/8 level clinical psychologist or social worker.
Edge of care				
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) FIND OUT MORE MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT ON THE EIF GUIDEBOOK	An intensive treatment for families who have recently been reported to child protection services. A key aim of the intervention is to help families assume greater responsibility for their behaviours and actively work to resolve serious family issues.	Child age: 6–17 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of reduced neglect, psychological aggression, minor and severe assault, non-violent discipline, symptoms of PTSD, dissociative symptoms, internalising symptoms, total behaviour problems and increased placement stability post-intervention.	Delivered jointly by a social worker/psychologist and key worker.

5. Interventions with evidence of preventing children's exposure to domestic abuse and related trauma

KEY POINTS

- Domestic abuse is a broad term applied to violent and threatening behaviours occurring within the context of a romantic relationship.
- There is a gender imbalance in perpetrators and victims, as female victims outnumber males three to one.
- Domestic abuse is highly traumatic for survivors and children who witness it. Studies show that witnessing domestic abuse can be as traumatic as being a direct victim of it.
- Multiple theories have been developed to explain why domestic abuse occurs. Each is supported by evidence, and each may imply a different intervention response. There is therefore no 'core' intervention model or evidence-based theory of change for preventing or stopping domestic abuse.
- Very few interventions targeting domestic abuse have been rigorously tested, particularly when it comes to improving child outcomes. We view this to be a serious gap in the evidence base.

WHAT WORKS

- Healthy relationship advice offered to adolescents through secondary schools has evidence of preventing dating violence during adolescence and the risk of later domestic abuse.
- Relationship advice for couples not experiencing domestic abuse has evidence of keeping violence from occurring within the couple relationship.
- Domestic abuse screening during pregnancy, leading to evidence-based support and advice, has evidence of protecting mothers from further exposure to domestic abuse.
- Therapeutic support offered to the mother and child in parallel has evidence of reducing domestic abuse-related trauma, and re-exposure to domestic abuse. Child First and GenerationPMTO are examples of two therapeutic interventions with evidence of reducing trauma in mothers and children who have experienced or witnessed domestic abuse.

WHAT IS LESS LIKELY TO WORK

- There is currently little robust evidence showing that work with perpetrators, including individual or group-based work involving CBT, anger management therapy or advice based on the Duluth model, reduces the risk of domestic abuse recidivism.
- To date, few robust studies have evaluated the extent to which children benefit from support offered to perpetrators.

5.1 Characteristics

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.[222] Historically, the term 'domestic' has been applied to violence occurring between cohabitating or separated couples, as well as violence occurring between parents and children, while the term 'intimate' can be applied to couples in a romantic relationship who may be cohabitating or living separately. The term 'spousal' is reserved for violence occurring between married couples.[223] More recently, the term dating violence has been developed to refer to abuse and violence occurring between young people under the age of 18.

Over the past 40 years, these broad definitions have undergone further refinement to capture differences in the severity of the violence and power-based dynamics between perpetrators and survivors of abuse.[224] Many scholars view these distinctions as important, as differing forms of domestic and intimate partner violence may benefit from different responses and prevention or intervention efforts.[225,226,227]

- **Domestic battery** typically refers to acts of severe physical violence perpetrated by men against their cohabitating female partners, requiring a legal response.
- **Coercive control** pertains to controlling behaviours that may or may not include physical harm but are used to intimidate or manipulate a romantic partner.
- **Intimate terrorism** is not characterised by physical violence, but still imposes strict control over an intimate partner through emotional abuse, manipulating children, isolation, threats, intimidation, economic abuse, and blaming.
- **Situational violence** refers to the violence used interchangeably between romantic partners in a heated dispute that has gone out of control.
- **Violence resistance** is used to describe violent or aggressive behaviour used by a victim (most typically a female) to resist physical or mental acts of violence.
- **Dating violence** refers to violence and abuse occurring between young people under the age of 18.

Within the UK, domestic abuse is defined within the 2021 Domestic Abuse Act 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.[228] These behaviours include:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour

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

223 Breiding, M., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. R. (2015). *Intimate partner violence surveillance: Uniform definitions and recommended data elements*. National Center for Injury Prevention and Control.

224 Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review*, *46*(3), 476–499.

225 Capaldi, D. M., & Kim, H. K. (2007). Typological approaches to violence in couples: A critique and alternative conceptual approach. *Clinical Psychology Review*, *27*(3), 253–265.

226 Johnson, M. P. (2010). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Northeastern University Press.

227 Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical Psychology Review*, *31*(7), 1145–1155.

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

- economic abuse
- psychological, emotional or other abuse.

Domestic abuse is now considered to involve a distinct set of family dynamics involving power imbalances and coercive control, at levels not present in normal couple conflict.[229,230] These factors preclude the couple's ability to work cooperatively in most standard forms of couples and family therapy, including those described in earlier chapters of this review.[231] In fact, studies show that some standard forms of couples therapy can *elevate* the risk of serious violence in relationships where coercive control exists.[232] For this reason, couples are ineligible for the family conflict interventions described in chapter 3 if behaviours falling within the definition of domestic abuse are present.

Regardless of definition, domestic abuse is strongly predictive of a wide variety of negative outcomes for victims (also widely referred to as survivors).[233,234] These include:

- serious mental health problems, especially post-traumatic stress disorder (PTSD), depression and suicidality
- problematic substance misuse, which in turn increases the risk of a variety of life-threatening diseases
- debilitating injuries, which may interfere with an individual's employment status
- death: between 80 and 100 men and women per year are killed or murdered as a result of a domestic abuse incident involving a current or ex-partner.

Children who are exposed to domestic abuse are also at significantly greater risk of poor outcomes in comparison to those who are not exposed to it.[235,236] In fact, the negative impact of witnessing family violence is comparable to that of being a direct recipient of it. On average, witnessing domestic abuse in childhood more than doubles the risk of a serious adult mental health problem and triples the risk of being either a victim or perpetrator of domestic abuse.[237,238,239] Domestic abuse also often interferes with the caregivers' ability to respond sensitively to their children and can increase the risk of child abuse and neglect.[240,241] However, it should be stressed that this is not always the case and this risk is influenced by a variety of parental and contextual factors.

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229 Johnson, M. P. (2010). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Northeastern University Press.

230 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.

231 Jacobson, N. S., & Gottman, J. M. (1998). *When men batter women: New insights into ending abusive relationships*. Simon and Schuster.

232 Simpson, L., Gattis, K., Atkins, D., & Christensen, A. (2008) Low level relationship aggression and couple therapy outcomes. *Journal of Family Psychology*, *22*, 102–111.

233 Peterson, C., Kearns, M. C., McIntosh, W. L., Estefan, L. F., Nicolaidis, C., McCollister, K. E., ... & Florence, C. (2018). Lifetime economic burden of intimate partner violence among US adults. *American Journal of Preventive Medicine*, *55*(4), 433–444.

234 Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331–1336.

235 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.

236 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.

237 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.

238 Adams, T. R., Handley, E. D., Manly, J. T., Cicchetti, D., & Toth, S. L. (2019). Intimate partner violence as a mechanism underlying the intergenerational transmission of maltreatment among economically disadvantaged mothers and their adolescent daughters. *Development and Psychopathology*, *31*(1), 83–93.

239 Thornberry, T. P., & Henry, K. L. (2013). Intergenerational continuity in maltreatment. *Journal of Abnormal Child Psychology*, *41*(4), 555–569.

240 Dixon, L., Browne, K., & Hamilton-Giachritsis, C. (2005). Risk factors of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of Child Psychology and Psychiatry*, *46*(1), 47–57.

241 Coe, J. L., Huffhines, L., Gonzalez, D., Seifer, R., & Parade, S. H. (2021). Cascades of risk linking intimate partner violence and adverse childhood experiences to less sensitive caregiving during infancy. *Child Maltreatment*, *26*(4), 409–419.

Prevalence

Within the UK, crime statistics consistently 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.[242] Domestic abuse is also the most common reason why a child is assessed as in need.[243] It is therefore clear that domestic abuse is a serious and pervasive problem that must be prevented and stopped.

Theories of intimate partner violence and domestic abuse

The reasons why domestic abuse occurs are quite varied and complex, encompassing cultural beliefs, community deprivation, family dysfunction and individual characteristics. Each of these reasons is supported by evidence, and each may imply a different intervention response. There is therefore no 'core' intervention model or evidence-based theory of change for preventing or stopping domestic abuse, as there is for the other outcomes covered in this review.[244,245,246]

These theories, and their corresponding intervention responses, are summarised in table 5.1 (from Hyde-Nolan & Juliao[247]). The evidence underpinning interventions informed by these theories will be described in the latter half of this chapter.

TABLE 5.1

Theories of domestic abuse

Name	Theory	Intervention response
Structural		
Feminist perspective	Patriarchal societies foster patriarchal family structures, in which men are expected to have power over women. Crimes such as sexual assault, stalking, marital rape and domestic abuse are typically committed by men against women. Additionally, these behaviours serve to exploit and/or control the sexual and social freedom of women to have a lifestyle of equality both inside and outside the home.	Psychoeducation for both men and women on the rights of women, and enforcing accountability in the recognition of those rights. Examples include the Duluth model used in male perpetrator programmes.
Historical	Violence against more vulnerable groups always exists in societies for economic and social reasons. Women and children are typically more vulnerable, hence more likely to be victims of violence.	Laws and policies aimed at protecting vulnerable and disenfranchised sub-populations.
Cultural	Domestic abuse against women is tolerated through cultural norms. For example, violence against women did not surface as a significant societal problem in western societies until the mid-1970s.	Laws and policies aimed a counteracting cultural values and practices.

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

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

244 Hyde-Nolan, M. E., & Juliao, T. (2011). Theoretical basis for family violence. In R. Fife & S. Schrager (Eds.), *Family violence: What health care providers need to know* (pp. 5–16). Jones and Bartlett.

245 Vigurs, C., Schucan-Bird, K., Quy, K., & Gough, D. (2016). *The impact of domestic violence perpetrator programmes on victim and criminal justice outcomes: A systematic review of reviews of research evidence.* What Works: Crime reduction systematic review series. The College of Policing.

246 Bell, K. M., & Naugle, A. E. (2008). Intimate partner violence theoretical considerations: Moving towards a contextual framework. *Clinical Psychology Review*, *28*(7), 1096–1107.

247 Hyde-Nolan, M. E., & Juliao, T. (2012). Theoretical basis for family violence. In R. Fife & S. Schrager (Eds.), *Family violence: What health care providers need to know* (pp. 5–16). Jones and Bartlett.

Name	Theory	Intervention response
Psychoanalytic		
Object relations	During infancy and early childhood, individuals develop mental representations of themselves and others. Children who were insufficiently nurtured do not develop positive representations of themselves and others, and are therefore more likely to have low self-esteem and greater difficulty regulating their emotions and anger. Unmet needs in childhood result in strong feelings of anger, rage and disappointment. Individuals are therefore more likely to be both needy and demanding in their relationships, resulting in victim or perpetrator behaviours.	Psychodynamic therapy aimed at helping individuals understand how their representations may contribute to feelings of anger and inappropriate responses in order to change behaviours rooted in childhood insecurities.
Attachment	Attachment theory is a form of object relations theory that places a greater emphasis on the quality or security of the attachment relationship developed in the child's early years. A secure attachment allows adults to enter romantic relationships with confidence about themselves and their partner. An insecure attachment increases the likelihood that individuals will fail to develop a trusting relationship with their partner. This lack of trust and attachment insecurities in turn contributes to needy and demanding behaviours. Studies have observed that parents' representations of attachment are predictive of their child's attachment security, hence contributing to theories concerning the intergenerational transmission of conflict and violence.	Psychodynamic therapy aimed at helping individuals to understand how insecure representations of past relationships may be contributing to insecurities and maladaptive behaviours within their current relationships, with the aim of increasing attachment security.
Violence as trauma	Childhood exposure to violence increases the likelihood of anxiety problems, including post-traumatic stress disorder (PTSD) and complex trauma. Children learn to become hypervigilant to trauma-inducing events, disrupting how information is processed and how personal threats are assessed. Some theorise that this results in a psychological numbing, which disturbs historical memory structures. Disturbed memories, in turn, result in a compulsion to repeat the trauma in order to reintegrate and manage memories of abuse, as well as to incorporate abusive experiences into the larger memory structure. Hence, experiences of trauma, either as a victim or perpetrator, are repeated in order to be re-established within memory structures.	Therapy aimed at treating symptoms of trauma and motivations aimed at repeating or perpetuating traumatic experiences.
Social theories		
Control theory	Individuals will naturally behave in aggressive and controlling ways unless there is a disincentive to do so. Societal disincentives include punishment through laws, but also societal trade-offs that increase empathy between individuals and strengthen social bonds. For example, greater social integration and bonding for many individuals represents a suitable trade-off for asserting aggressive control. Principles such as the 'golden rule' exemplify this trade-off. Social control theory applied to domestic abuse assumes that family members (most often the father) will take control within the family system when there is an opportunity to do so, and other family members learn to submit to this control as a form of protection or to maintain bonding. Family aggressors may be willing to relinquish control, however, if aggression is sanctioned or replaced by positive bonds within the family.	Laws and policies aimed at disincentivising antisocial or controlling behaviour and increasing societal bonds. Religious and moral principles are also viewed as a means for controlling violent behaviours.

Name	Theory	Intervention response
Resource theory	Force and violence are 'resources' that can be used to resolve conflicts and gain power if no other resources are available. For example, men with high income and social standing have access to a wide variety of resources with which to control family members, in addition to violence, whereas men with limited or no wealth and resources may resort to physical force or violence more quickly. Negotiation and interpersonal skills are considered resources that are available to some individuals. There is some evidence suggesting that cultural perceptions about male dominance within the family system influence their use of various resources to maintain control. For example, men who adhere to traditional models of male dominance may be more likely to resort to violence as a resource to maintain control within the family system, as this right is viewed as a resource.	Psychoeducation for men about the use of power within family relationships, and strategies for improving interpersonal skills as a non-violent resource.
Exosystem factor theory	Domestic abuse may be triggered by other stresses within the family system. This theory is similar to the family stress model described in chapter 1, in that it assumes that external stressors, such as job loss and financial hardship, reduce the resources (such as money or negotiating skills) available to negotiate power and conflict in the home, thus increasing the use of violence to assert power. Exosystem theory recognises economic hardship as a significant source of stress, but also assumes that many other stresses (such as an extramarital affair, house move, or even significant daily hassles) can also increase the likelihood of conflict. This model also assumes, however, that domestic abuse is only likely to occur if other individual-level risks are in place, such as mental health problems, parents' experience of domestic abuse in their own childhood, patriarchal attitudes, etc.	Strategies aimed at improving the economic circumstances of families; therapies aimed at providing family members with strategies for managing stress and negotiating conflict.
Social isolation theory	Domestic abuse is more likely in families that lack wider social support systems which might be used as a resource for managing conflict and reducing stress within the family system. This assumption is supported by evidence showing that rates of domestic abuse are higher in neighbourhoods marked by higher levels of violence and crime, greater disorganisation, and fewer community supports. Social isolation can also occur in the individual families who are culturally dissimilar to those living in the wider community.	Community-wide strategies aimed at increasing community cohesion, social networks and improved access to resources.
Cognitive/behavioural theories		
Social learning theory	Social learning theory maintains that individuals learn social behaviours by observing how the violent behaviours of others are reinforced. Individuals raised in families where coercive cycles and domestic abuse were tolerated are more likely to repeat these behaviours with their own partners. Social learning theory provides one explanation for the intergenerational transmission of violence that has been observed in many studies. Children who grow up in violent or abusive families may learn violent or abusive behaviours, imitate those behaviours, and then repeat those behaviours in future relationships.	Interventions aimed at reducing violent and coercive family interactions.

Name	Theory	Intervention response
Behavioural genetics	Theories of behavioural genetics assume that some aggressive and violent behaviours have a genetic basis. This assumption is based on genetic studies that have identified three genes associated with a propensity for violence, as well as findings from twin studies suggesting that at least 50% of the variation between individuals is explained by genetic factors. These studies also suggest, however, that genetically based violent dispositions will not express themselves unless other non-inherited risks are in place, such as a history of child maltreatment or substance misuse.	Interventions aimed at identifying individuals who are at genetically at risk and providing them with increased support to prevent the expression of violence.
Reactive aggression	The urge to hurt others can be triggered by strong negative emotions. This theory is based on studies of men who have reacted with rage when they perceive or are faced with actual rejection or abandonment by their spouses. A proportion of men report that when faced with emotional pain, they are overcome with the desire to hurt their partners.	Cognitive interventions aimed at helping individuals to better understand emotional responses and manage them before hurting others.
Learned helplessness	Theories of learned helplessness have been provided to explain why victims of domestic violence continue to stay in abusive relationship. Experiencing repeated beatings or other abuse may lead partners (particularly female partners) to become passive, because they feel that escaping their situation will make their life worse and there is nothing that can be done to avoid the aggression. This may be particularly true when the partner feels that their financial circumstances will become much worse if they leave the relationship.	Empowerment-based interventions providing victims with strategies for overcoming patterns of learned helplessness, resisting abuse, and managing finances and housing in the absence of the abusing partner.
Family system theories		
Family systems theory	Aggressive and maladaptive behaviours of one family member should not be viewed in isolation from interactions and relationships with other family members. In this respect, problematic behaviour is not a result of individual characteristics but a product of the family system.	Interventions informed by family systems theory seek to treat the family as a unit rather than any one individual. Many of the interventions described in previous sections (such as MST) are informed by systems principles. However, these interventions may not be appropriate if levels of domestic abuse are particularly high, so family eligibility must be assessed on a case-by-case level.
Family life-cycle theory	Family life-cycle theory assumes that the family system develops through at least six stages, with specific tasks to be performed at each stage. These stages include: (1) single young adulthood, (2) joining of families (the new couple), (3) families with young children, (4) families with adolescents, (5) adult children leaving the family home, and (6) families with parents in later life. Family life-cycle theory also encompasses important transitions, include parental separation, the birth of a child and the death of a family member. Family transitions and stages are developmentally normal, but also represent stressful periods. This stress occurs because family members often must reorganise themselves to adapt to growth and change in the other family members. This stress can be accompanied by feelings of anger, sadness and loss, thus increasing the risk for violence in some individuals.	A number of interventions have been developed to help family members manage emotions and avoid potentially violent reactions to family transitions, as described in chapter 3. A mother's pregnancy, couple divorce and the reformation of a new family all represent transitions that increase the risk of domestic abuse.

Name	Theory	Intervention response
Cycle of violence theory	Cycle of violence theory is one of the most popular theories of domestic abuse. It observes that there are four stages to the physical and psychological abuse that can occur between intimate partners: (1) tension building, (2) the abuse incident, (3) reconciliation, and (4) a period of calm. This theory assumes that victims are persuaded to remain in violent relationships because reconciliations and periods of calm can convince the victim that the cycle will not happen again.	Interventions to help victims understand the abuse cycle and the factors contributing to it, and to develop strategies for protecting themselves and resisting the cycle. These strategies include exit and safety plans when the abuse is severe.
Microsystem factor theories		
Dependency relations theory	Victims remain in abusive relationships because they are financially dependent on their abuser.	Empowerment-based interventions providing women with strategies for resisting abuse and managing finances and housing in the absence of the abusing partner.
Intrafamilial stress theory	Intrafamilial stress includes factors such as having more children than the parents can afford, overcrowded living conditions, and having children with disabilities. This theory assumes that these situations can place a significant burden on the family system, particularly in terms of time and resources, which may contribute to violent behaviour.	Policies which reduce the stresses on the family situation, including benefits, access to improved housing, and support for a child's disabilities.

Although there is strong variation between these theoretical frameworks and their associated interventions, they share a set of common principles that are worth highlighting:[248]

- Domestic abuse involves patterns of interaction between partners influenced by shared characteristics, behaviours and contextual factors. Although one individual may predominate as the perpetrator and the other the victim, both partners play a role in the maintenance of abuse.
- When coercive control is present, the best evidence suggests that interventions be offered to each partner separately.
- Physical violence within the relationship is not tolerated and should be actively sanctioned.
- Preventing violence or stopping it from reoccurring must be considered a primary aim of the intervention.

For the purposes of this review, improving children's wellbeing should be considered a primary outcome. Not only does domestic abuse dramatically increase the risk of child maltreatment, witnessing it can be as psychologically damaging as being a direct recipient of abuse. For this reason, most countries recognise the witnessing of domestic abuse as a crime which is separate from any crime that may have been committed between the child's parents or other family members. In the UK, the witnessing of domestic abuse is formally recognised as a crime under the 2021 Domestic Abuse Act.[249]

[248] Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior*, *16*(4), 312–318.

[249] See: https://www.legislation.gov.uk/ukpga/2021/17/section/3/enacted

5.2 Key risks

Table 5.2 summarises the more common risks associated with domestic abuse.[250,251] Each of the theoretical frameworks listed in table 5.1 prioritises these risks differently. Below, we briefly describe the risks that are most frequently targeted by domestic abuse interventions.

TABLE 5.2

Risk factors for domestic abuse

Individual-level
Low self-esteem
Low education or income
Young age
Aggressive or delinquent behaviour as a youth
Heavy alcohol and drug use
Depression and suicide attempts
Anger and hostility
Lack of nonviolent social problem-solving skills
Antisocial personality traits and conduct problems
Poor behavioural control and impulsiveness
Traits associated with borderline personality disorder
History of being physically abusive
Having few friends and being isolated from other people
Economic stress (e.g., unemployment)
Emotional dependence and insecurity
Belief in strict gender roles (e.g., male dominance and aggression in relationships)
Desire for power and control in relationships
Hostility towards women
Attitudes accepting or justifying violence and aggression
Witnessing violence between parents as a child
History of experiencing poor parenting as a child
History of experiencing physical discipline as a child
History of physical or emotional abuse in childhood
Family-level
Relationship conflicts including jealousy, possessiveness, tension, divorce or separations
Dominance and control of the relationship by one partner over the other
Stressful family transitions
Work-related stress
Families experiencing economic stress
Unhealthy family relationships and interactions
Association with antisocial and aggressive peers
Parents with less than a high-school education
Community-level
High rates of poverty and limited educational and economic opportunities
High unemployment rates
High rates of violence and crime
Poor community cohesion; lack of 'collective efficacy' (in other words, neighbours willingness to intervene when domestic abuse is evident)
Easy access to drugs and alcohol
Weak community sanctions against domestic abuse
Society-level
Traditional gender norms and gender inequality (for example, the idea that women should stay at home, not enter the workforce and be submissive; or that men should support the family and make decisions)
Cultural norms that support aggression towards others
Societal income inequality
Weak health, educational, economic and social policies or laws

250 Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, *3*(2), 231–280.

251 Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and Violent Behavior*, *10*(1), 65–98.

Individual-level risks

Gender: Studies consistently show that men and women are equally likely to engage in aggressive and violent behaviours within intimate relationships.[252,253] However, men are more likely to initiate violence, use sexual violence and cause severe injury. Violence committed by men is also more likely to be reported. Women, by contrast, are more likely to be victims of violence, but also engage in less harmful violent behaviours.[254]

It is worth noting that violence occurs as frequently in same-sex relationships as it does in heterosexual relationships, meaning that it is not solely caused by gender differences, but by power imbalances within the couple relationship.[255] Findings from the most recent crime survey for England and Wales show that approximately 73% of victims are female and 27% are males.[256]

Age: Abuse within romantic relationships is most common during late adolescence, and then continues in individuals where the other risk factors are present.[257] During the adolescent years, young women and men are equally likely to initiate and engage in violence.[258] Dating violence is highly associated with other problematic adolescent behaviours, including substance misuse, antisocial behaviour, and association with deviant peers. Dating violence in adolescence is considered a key risk for the reoccurrence of violence and abuse in future adult intimate relationships.[259]

Low educational attainment is consistently associated with an increased risk of domestic abuse. This relationship can be explained, in part, by the consistent association between domestic abuse and employment status.[260]

Economic stress and unemployment are interchangeably categorised as individual-level and family-level risks, significantly increasing individuals' reactivity and family members' inability to resolve conflict non-violently. Financial and employment stress are consistently associated with an increased risk for domestic abuse.[261]

Pregnancy: Studies repeatedly show that pregnancy heightens the risk of domestic abuse, with one-third of all female survivors reporting violence occurring for the first time during their pregnancy.[262,263,264]

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252 Dutton, D. G., & Nicholls, T. L. (2005). The gender paradigm in domestic violence research and theory: Part 1 — The conflict of theory and data. *Aggression and Violent Behavior*, *10*(6): 680–714.

253 Straus, M. A. (2011). Gender symmetry and mutuality in perpetration of clinical-level partner violence: Empirical evidence and implications for prevention and treatment. *Aggression and Violent Behavior*, *16*(4), 279–288.

254 Swan, S. C., Gambone, L. J., Caldwell, J. E., Sullivan, T. P., & Snow, D. L. (2008). A review of research on women's use of violence with male intimate partners. *Violence and Victims, 23*(3), 301–314.

255 Baker, N. L., Buick, J. D., Kim, S. R., Moniz, S., & Nava, K. L. (2013). Lessons from examining same-sex intimate partner violence. *Sex Roles, 69*(3), 182–192.

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

257 Johnson, W. L., Giordano, P. C., Manning, W. D., & Longmore, M. A. (2015). The age–IPV curve: Changes in the perpetration of intimate partner violence during adolescence and young adulthood. *Journal of Youth and Adolescence*, *44*(3), 708–726.

258 Mulford, C., & Giordano, P. C. (2008). Teen dating violence: A closer look at adolescent romantic relationships. *National Institute of Justice Journal*, *261*(1), 31–40.

259 Vagi, K. J., Rothman, E. F., Latzman, N. E., Tharp, A. T., Hall, D. M., & Breiding, M. J. (2013). Beyond correlates: A review of risk and protective factors for adolescent dating violence perpetration. *Journal of Youth and Adolescence*, *42*(4), 633–649.

260 Matjasko, J. L., Niolon, P. H., & Valle, L. A. (2013). The role of economic factors and economic support in preventing and escaping from intimate partner violence. *Journal of Policy Analysis and Management*, *32*(1), 122.

261 Cano, A., & Vivian, D. (2003). Are life stressors associated with marital violence? *Journal of Family Psychology*, *17*(3), 302.

262 Johnson, J. K., Haider, F., Ellis, K., Hay, D. M., & Lindow, S. W. (2003). The prevalence of domestic violence in pregnant women. *BJOG: An International Journal of Obstetrics and Gynaecology*, *110*(3), 272–275.

263 Bowen, E., Heron, J., Waylen, A., Wolke, D., & ALSPAC Study Team. (2005). Domestic violence risk during and after pregnancy: Findings from a British longitudinal study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *112*(8), 1083–1089.

264 Mojahed, A., Alaidarous, N., Kopp, M., Pogarell, A., Thiel, F., & Garthus-Niegel, S. (2021). Prevalence of intimate partner violence among intimate partners during the perinatal period: A narrative literature review. *Frontiers in Psychiatry*, *12*, 61.

A history of child maltreatment or the witnessing of domestic abuse is consistently associated with an increased likelihood of either perpetuating or being a victim of domestic abuse, even when other common risks are statistically controlled.[265,266,267]

Antisocial behaviour in adolescence and an association with antisocial peers is one of the strongest predictors of dating violence and abuse occurring within future relationships.[268,269]

Alcohol and drug use: Substance misuse is commonly assumed to be a primary risk for domestic abuse, although recent studies observe that this relationship is attenuated by other individual and contextual risk factors, including family income and gender.[270,271]

Mental health problems and domestic abuse are strongly correlated. Studies show that symptoms of depression and anxiety may be caused by domestic abuse, but also increase the risk of domestic abuse occurring – for both perpetrators and victims.[272]

Hostile attitudes based on sex or gender: Hostile male attitudes towards women are consistently associated with an increased risk of male-perpetrated domestic abuse at the population level.[273]

Family-level risks

Stressful life events involving changes in the life-cycle of a family (such as the birth of child or death of a close family member) can introduce stress into the family system, increasing the risk of violence. Family transitions that are particularly known to increase the risk of violence include a mother's pregnancy, couple divorce, and the reformation of a new family.[274,275]

Low family income remains one of the strongest predictors of domestic abuse in comparison to all other risks covered in this section.[276]

Work-related stress is an established risk for domestic abuse.[277] Studies show that difficulties with work/life balance and job insecurity not only directly reduce parents' ability to engage in non-violent conflict resolution, but also increase the likelihood of mental health

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265 Costa, B. M., Kaestle, C. E., Walker, A., Curtis, A., Day, A., Toumbourou, J. W., & Miller, P. (2015). Longitudinal predictors of domestic violence perpetration and victimization: A systematic review. *Aggression and Violent Behavior*, *24*, 261–272.

266 Dixon, L., Browne, K., & Hamilton-Giachritsis, C. (2005). Risk factors of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of Child Psychology and Psychiatry*, *46*(1), 47–57.

267 Widom, C. S., Czaja, S., & Dutton, M. A. (2014). Child abuse and neglect and intimate partner violence victimization and perpetration: A prospective investigation. *Child Abuse & Neglect*, *38*(4), 650–663.

268 Foshee, V. A., Reyes, H. L. M., Ennett, S. T., Suchindran, C., Mathias, J. P., Karriker-Jaffe, K. J., ... & Benefield, T. S. (2011). Risk and protective factors distinguishing profiles of adolescent peer and dating violence perpetration. *Journal of Adolescent Health*, *48*(4), 344–350.

269 Capaldi, D. M., Dishion, T. J., Stoolmiller, M., & Yoerger, K. (2001). Aggression toward female partners by at-risk young men: The contribution of male adolescent friendships. *Developmental Psychology*, *37*(1), 61–73.

270 Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, *3*(2), 231–280.

271 Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy*, *65*, 8–23.

272 Spencer, C., Mallory, A. B., Cafferky, B. M., Kimmes, J. G., Beck, A. R., & Stith, S. M. (2019). Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychology of Violence*, *9*(1), 1.

273 Flood, M., & Pease, B. (2009). Factors influencing attitudes to violence against women. *Trauma, Violence, & Abuse*, *10*(2), 125–142.

274 Schumacher, J. A., Coffey, S. F., Norris, F. H., Tracy, M., Clements, K., & Galea, S. (2010). Intimate partner violence and Hurricane Katrina: Predictors and associated mental health outcomes. *Violence and Victims*, *25*(5), 588–603.

275 Evans, M. L., Lindauer, M., & Farrell, M. E. (2020). A pandemic within a pandemic – Intimate partner violence during Covid-19. *New England Journal of Medicine*, *383*(24), 2302–2304.

276 Schneider, D., Harknett, K., & McLanahan, S. (2016). Intimate partner violence in the great recession. *Demography*, *53*(2), 471–505.

277 Roberts, A. L., McLaughlin, K. A., Conron, K. J., & Koenen, K. C. (2011). Adulthood stressors, history of childhood adversity, and risk of perpetration of intimate partner violence. *American Journal of Preventive Medicine*, *40*(2), 128–138.

problems and substance misuse occurring, which in turn increase the risk of behaviours that would be viewed as domestic abuse.[278]

Community-level risks

There is a high degree of overlap between the community-level risks known to contribute to other forms of family conflict (see chapters 2 and 3) and those contributing to domestic abuse. These risks include **a lack of community cohesion**, **high levels of community crime**, **poor housing availability**, **poor transportation links** and **higher levels of social isolation**.[279,280] Studies show that when these risks are reduced, rates of community violence, child maltreatment and domestic abuse are observed at the population level.[281,282] There is also evidence showing that the formal recognition of domestic abuse as a crime is associated with a decrease in population-level rates of domestic abuse.[283]

Societal and cultural risks

Studies show that the prevalence of domestic abuse is consistently associated with beliefs and cultural norms regarding acceptable patriarchal behaviour. While the world average is 30%, rates of domestic abuse typically range between 23 and 27% in North America, Europe and western Pacific countries, and 33 and 37% in Asian and African countries.[284] These differences may be due, in part, to differences in definition and reporting practices. Many scholars agree, however, that they are underpinned by variations in attitudes about the use of violence towards women and children.[285]

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

A growing number of interventions targeting adolescents have good evidence of preventing and reducing dating violence and abuse. By comparison, 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.[286,287]

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278 Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, *3*(2), 231–280.

279 Gracia, E., López-Quílez, A., Marco, M., & Lila, M. (2018). Neighborhood characteristics and violence behind closed doors: The spatial overlap of child maltreatment and intimate partner violence. *PLoS One*, *13*(6), e0198684.

280 Pinchevsky, G. M., & Wright, E. M. (2012). The impact of neighborhoods on intimate partner violence and victimization. *Trauma, Violence, & Abuse*, *13*(2), 112–132.

281 Morris, M. C., Marco, M., Maguire-Jack, K., Kouros, C. D., Bailey, B., Ruiz, E., & Im, W. (2019). Connecting child maltreatment risk with crime and neighborhood disadvantage across time and place: A Bayesian spatiotemporal analysis. *Child Maltreatment*, *24*(2), 181–192.

282 Gracia, E., López-Quílez, A., Marco, M., & Lila, M. (2018). Neighborhood characteristics and violence behind closed doors: The spatial overlap of child maltreatment and intimate partner violence. *PLoS One*, *13*(6), e0198684.

283 Counts, D. A., Brown, J. K., & Campbell, J. C. (2019). *Sanctions and sanctuary: Cultural perspectives on the beating of wives*. Routledge.

284 World Health Organization. (2021). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*.

285 Montesanti, S. R., & Thurston, W. E. (2015). Mapping the role of structural and interpersonal violence in the lives of women: Implications for public health interventions and policy. *BMC Women's Health*, *15*(1), 1–13.

286 World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*.

287 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.

In this section, we consider the evidence underpinning preventive strategies, as well as the evidence for more targeted activities aimed at stopping domestic abuse once it has occurred (see also interventions table 4). We also consider the extent to which activities have evidence of improving children's wellbeing, especially those who have experienced trauma after witnessing domestic abuse.

Universal support

Antenatal domestic abuse screening, healthy relationship training for young people and healthy relationship training for parents are three examples of intervention activities that have causal evidence of preventing behaviours associated with domestic abuse.

Antenatal domestic abuse screening

Antenatal domestic abuse screening involves routinely screening mothers for domestic abuse as part of their antenatal care. Previously, this practice was considered controversial, because mothers are often reluctant to disclose experiences of domestic abuse to healthcare providers and effective interventions were not previously available. However, there are now several validated measures with sufficient sensitivity and specificity to detect domestic abuse during a mother's pregnancy. As a result, the US Preventive Services Task Force and other public health bodies now actively recommend that universal domestic abuse screening be implemented with mothers during pregnancy.[288,289]

Studies show that these measures are reliable at identifying domestic abuse if administered anonymously to mothers via an electronic tablet.[290] Studies additionally show that domestic abuse can be stopped in some cases if mothers identified as experiencing domestic abuse are provided with evidence-based support (as described below).

Healthy relationship education for adolescents

Healthy relationship education for young people is a second primary prevention strategy strongly advocated by public health organisations for reducing the prevalence of domestic abuse.[291] It is typically delivered through schools to encourage healthy attitudes based on sex or gender, and to provide young people with skills to identify and resist violent and coercive dating behaviours.[292] Examples of these skills include non-violent conflict resolution, improved communication strategies and methods for resisting sexual coercion and violence. Effective healthy relationship training not only provides young people with information about positive relationship skills but offers opportunities to 'practise' them through school plays and peer-led education.

Safe Dates, **Me & You** and **Dating Matters** are three examples of whole-school, healthy relationship programmes that can be offered to children between the age of 11 and 14. All three offer 'multi-technology' curriculums (combining teacher-led, peer-led and computer-based activities) to help young people recognise abusive dating behaviours and develop strategies for avoiding and reducing them. Me & You and Dating Matters also include group meetings for parents that occur at regular intervals throughout the school year.

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288 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.

289 Warren-Gash, C., Bartley, A., Bayly, J., Dutey-Magni, P., Edwards, S., Madge, S., ... & Swarbrick, H. (2016). Outcomes of domestic violence screening at an acute London trust: Are there missed opportunities for intervention? *BMJ Open*, *6*(1), e009069.

290 Kiely, M., El-Mohandes, A. A., El-Khorazaty, M. N., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized trial. *Obstetrics and Gynecology*, *115*(2 Pt 1), 273.

291 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.

292 World Health Organization. (2019). *RESPECT women: Preventing violence against women*.

Safe Dates, Me & You and Dating Matters all have level 3 evidence of preventing dating violence and victimisation.[293,294,295] More information about the evidence underpinning Me & You and Dating Matters can be found in our recent review, *Adolescent mental health: A systematic review on the effectiveness of school-based interventions.*[296]

Healthy relationship advice for couples

Several interventions offering healthy relationship advice to parents at key family transitions has been shown to prevent violence from escalating within the couple relationship. These interventions include **Family Foundations** and **School Children and their Families**, as described in chapter 3.

In particular, Family Foundations has evidence from several evaluations of reducing reports of violence between parents and between parents and children.[297] However, it must be emphasised that these benefits have only been observed in families where coercive control is not already present; otherwise, families would be ineligible for the programme. Hence, healthy relationship advice for couples should not be viewed as an appropriate response to domestic abuse when it has occurred, but may provide benefits at the population level to prevent it from occurring.

Targeted selected interventions

Home visiting

Home visiting interventions are often recommended as potentially effective for preventing domestic abuse in vulnerable populations. This is primarily due to evidence from the **Family Nurse Partnership** programme showing that FNP mothers were less likely to enter or remain in an abusive relationship in comparison to mothers not participating in FNP.[298] However, it is worth noting that FNP does not have evidence of reducing the risk of domestic abuse in the UK, with 40% of mothers in both groups reporting experiences of abuse.[299]

Targeted indicated interventions for children and parents exposed to domestic abuse

In this section, we describe the evidence underpinning activities delivered to families once domestic abuse has occurred. Many of these activities have been identified as effective in previous UK reviews, including the National Institute for Health and Care Excellence's (NICE)

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293 Peskin, M. F., Markham, C. M., Shegog, R., Baumler, E. R., Addy, R. C., Temple, J. R., ... & Tortolero Emery, S. R. (2019). Adolescent dating violence prevention program for early adolescents: The Me & You randomized controlled trial, 2014–2015. *American Journal of Public Health*, *109*(10), 1419–1428.

294 DeGue, S., Niolon, P. H., Estefan, L. F., Tracy, A. J., Le, V. D., Vivolo-Kantor, A. M., Little, T. D., Latzman, N. E., Tharp, A., Lang, K. M., & Taylor, B. (2020). Effects of Dating Matters® on sexual violence and sexual harassment outcomes among middle school youth: A cluster-randomized controlled trial. *Prevention Science*, *22*(2), 175–185.

295 Foshee, V. A., Bauman, K. E., Arriaga, X. B., Helms, R. W., Koch, G. G., & Linder, G. F. (1998). An evaluation of Safe Dates, an adolescent dating violence prevention program. *American Journal of Public Health*, *88*, 45–50.

296 Clarke, A., Sorgenfrei, M., Mulcahy, J., Davey, P., Freidrich, C., & McBride, T. (2021). *Adolescent mental health: A systematic review on the effectiveness of school-based interventions*. Early Intervention Foundation. Available: https://www.eif.org.uk/report/adolescent-mental-health-a-systematic-review-on-the-effectiveness-of-school-based-interventions

297 Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: Effects on coparenting, parenting, family violence, and parent and child adjustment. *Prevention Science*, *17*(6), 751–764.

298 Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., Isacks, K., Sheff, K., & Henderson, C. R. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics*, *114,* 1560–1568.

299 Robling, M., Bekkers, M. J., Bell, K., Butler, C. C., Cannings-John, R., Channon, S., ... & Torgerson, D. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): A pragmatic randomised controlled trial. *The Lancet*, *387*(10014), 146–155.

2013 review of interventions to identify, prevent, reduce and respond to domestic abuse[300] and the National Institute for Health's 2016 IMPROVE evidence synthesis.[301]

It is worth noting that the interventions described here are offered to perpetrators and victims separately. These activities include (1) 'empowerment' interventions offered to pregnant mothers identified as being at risk during a routine antenatal check-up; (2) individual therapy offered to mothers who have witnessed domestic abuse; (3) individual therapy offered to children who have witnessed domestic abuse; (4) parallel therapies offered to mothers and children at the same time; (5) shelters and supportive housing; (6) interventions offered to perpetrators of domestic abuse; and (7) laws and legal sanctions.

Empowerment advice during pregnancy

Two US-based demonstration projects involving the use of 'empowerment' advice during pregnancy have RCT evidence of reducing maternal reports of domestic abuse before and after the baby was born.

In the first project, mothers were identified as experiencing domestic abuse through anonymous screening at their antenatal clinic. Mothers then attended six additional sessions (coinciding with their routine check-ups) delivered by masters-level clinical psychologists. During these sessions, mothers received 'empowerment' advice (also referred to as advocacy advice) based on the Dutton model, providing information about behaviours constituting abuse and violence, and strategies for assessing risk and developing a safety plan. In this instance, mothers additionally received smoking cessation advice and support for managing symptoms of depression (when indicated). The study observed significant reductions in participants reports of violence during their pregnancy and the 12 months after the child was born. Additional benefits included reductions in the likelihood of a preterm birth, maternal reports of smoking and symptoms of depression.[302]

In the second project, Dutton empowerment advice was offered to mothers receiving a home visiting services (such as FNP, as well as other models) who were identified as experiencing domestic abuse. This advice was provided to mothers in three sessions occurring prior to the birth of their child, followed by three sessions occurring after the birth. Practitioners providing this advice represented a range of helping professions, including nurses and lay home visitors. The study observed that rates of domestic abuse reduced more rapidly among those receiving the advice in comparison to those not receiving it, although reports of domestic abuse decreased for both groups.[303]

It is worth noting that while the second project was also successful in reducing rates of domestic abuse, these reductions were not as strong as those observed in the first study. Key differences included the fact that the first project was delivered in a clinical setting by masters-level or higher social workers/psychologists. It is also worth noting that study refusal rates were high in the second study. Programme attrition is common for domestic abuse interventions and is a primary reason why many suffer from a lack of evidence.[304]

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

301 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.

302 Kiely, M., El-Mohandes, A. A., El-Khorazaty, M. N., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized trial. *Obstetrics and Gynecology*, *115*(2 Pt 1), 273.

303 Sharps, P. W., Bullock, L. F., Campbell, J. C., Alhusen, J. L., Ghazarian, S. R., Bhandari, S. S., & Schminkey, D. L. (2016). Domestic violence enhanced perinatal home visits: The DOVE randomized clinical trial. *Journal of Women's Health*, *25*(11), 1129–1138.

304 Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., ... & Feder, G. (2016). Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical. *Campbell Systematic Reviews*, *2*.

Therapeutic support for mothers exposed to domestic abuse

Therapeutic support offered to mothers who have experienced domestic violence includes the therapies described in chapter 4, including CBT. CBT particularly shows promise in reducing symptoms of depression and PTSD in female survivors of domestic abuse, with one study also observing a reduced risk of revictimisation.[305,306] The extent to which therapeutic interventions offered to victims provide benefits for children, however, remains untested.

Parenting support for families exposed to domestic abuse

Four parenting interventions listed on the EIF guidebook have causal evidence of improving child outcomes when offered to mothers and children exposed to domestic abuse. The first of these is **Child-Parent Psychotherapy (CPP)** which combines therapeutic support for the mother's symptoms of trauma with parenting advice to support the needs of the child.

A primary aim of CPP is to stop the intergenerational transmission of family violence by helping the custodial parent to understand how it is negatively impacting the child. Therapists accomplish this by forming a strong therapeutic alliance at the start of the intervention, which then creates the context in which parents are better able to fully attend to their child's needs.

CPP is delivered by masters-level or higher clinical psychologists or social workers to parents and children individually through weekly sessions over the course of 26–52 weeks.[307] The mother and child attend weekly sessions at a clinic, although the intervention can also be delivered in the home or a women's shelter.

CPP is offered as an intervention of choice in US child welfare settings, and has established evidence of reducing both the mother and child's symptoms of trauma, improving child behavioural outcomes and increased satisfaction in the mother's future romantic relationships.[308]

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. Child First also has US evidence of reducing parental symptoms of trauma, improving children's behaviour and reducing child maltreatment risk.[309] Child First was developed specifically for families where domestic abuse and parental substance misuse exist. Further details about the Child First and CPP programmes are provided in case example C below.

GenerationPMTO is another example of an intervention with causal evidence of improving child and parent outcomes when parents have experienced domestic abuse and/or children have witnessed it. GenerationPMTO places a stronger emphasis on behaviours aimed at resisting coercive family cycles in comparison to CPP, although GenerationPMTO also emphasises the importance of the therapeutic alliance for creating the context in which parents are willing to reflect on behaviours and implement change. GenerationPMTO is typically delivered by masters-level or higher psychologists/social workers in the family home, but has also been successfully delivered in women's shelters.

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305 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.

306 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.

307 Lieberman, A., Gosh-Ippen, C. & van Horn, P. (2019). *Don't hit my mommy!: A manual for Child-Parent Psychotherapy with young witnesses of family violence.* Zero to three.

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

309 Crusto, C., Lowell, L., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S., & Kaufman, J. (2008). Evaluation of a wraparound process for children exposed to family violence. *Best Practices in Mental Health*, *4,* 1–16.

Generation PMTO has consistent evidence of improving a variety of child and parent outcomes from multiple studies conducted in the US, Norway and the Netherlands. While it has consistent evidence of reducing the custodial parent's (typically the mother's) symptoms of trauma and improving child behavioural outcomes, the extent to which it reduces the parent's future involvement in abusive relationships has not been explicitly tested.[310]

The **Incredible Years** programme has been successfully adapted for use in shelters for mother and child victims of abuse.[311] The extent to which IY reduces symptoms of trauma or reduces mothers' future involvement in violent relationships has not been explicitly tested, however. Studies also show that IY's model requires some adaptation and lengthening to allow sufficient time for the therapist to develop a strong therapeutic alliance with vulnerable mothers and help mothers better understand the attachment needs of their child.

Parent-Child Interaction Therapy (PCIT) is a PMT intervention with causal evidence of improving child and parent outcomes when offered to families living in shelters on account of domestic abuse. PCIT is informed by the same social learning principles described in chapter 2, aimed at reducing coercive cycles between parents and children. It is delivered by masters-level or higher psychologists, who work individually with parents to increase their sensitivity and provide them with strategies for reducing unwanted child behaviour. This advice is provided via an electronic 'bug in the ear', which allows the practitioner to unobtrusively coach parents while watching them interact with the child through a one-way mirror. This method requires that parents attend clinics where one-way mirrors are available, although the intervention has recently been modified to be delivered in temporary housing shelters.

A recent trial comparing PCIT to an abbreviated version of CPP observed that both interventions were effective at reducing the trauma symptoms of the mother and child. However, PCIT was superior in improving child behavioural outcomes in comparison to CPP.[312] CPP was originally developed for infants and children aged 5 and younger, whereas PCIT's target population includes school-aged children. PCIT may therefore be a preferred choice for families with older children.

Project Support is a final example of a parenting intervention with evidence of reducing child behavioural problems, improving maternal wellbeing and reducing contact with IPV perpetrators when delivered to survivors of domestic abuse during their transition from domestic abuse shelters to supportive housing.[313,314] Project Support is offered to mothers and children at the time they are making this transition. Mothers receive therapeutic support to overcome symptoms of trauma and PMT (as described in chapter 2) for improving their relationship with their child and managing difficult child behaviour. It is delivered by masters-level therapists via 90-minute sessions occurring once a week for an average period of 20 weeks. Project Support's evidence includes reductions in families' contact with domestic abuse perpetrators and improvements in child behavioural problems.

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310 Gewirtz, A. H., DeGarmo, D. S., Lee, S., Morrell, N., & August, G. (2015). Two-year outcomes of the Early Risers prevention trial with formerly homeless families residing in supportive housing. *Journal of Family Psychology*, *29*, 242–252.

311 Rogers, K. C., Bobich, M., & Heppell, P. (2016). The impact of implementing an 'incredible years' group within a family living unit in a transitional living shelter: The case of 'Cathy'. *Pragmatic Case Studies in Psychotherapy*, *12*(2), 65–112.

312 Graziano, P. A., Spiegel, J. A., & Arcia, E. (2020). Early assessment and intervention for families experiencing homelessness: A randomized trial comparing two parenting programs. *medRxiv*. Advance online publication.

313 Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. (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*, 705–717.

314 Jouriles, E. N., Rosenfield, D., McDonald, R., Vu, N. L., Rancher, C., & Mueller, V. (2018). Children exposed to intimate partner violence: Conduct problems, interventions, and partner contact with the child. *Journal of Clinical Child & Adolescent Psychology*, *47*(3), 397–409.

Therapeutic support for children who have witnessed domestic violence

Witnessing domestic violence is highly distressing for children regardless of whether they are direct recipients of it. **Trauma-focussed CBT** (TF-CBT) provides children with cognitive strategies aimed at managing negative emotions and beliefs stemming from highly distressing or abusive experiences. TF-CBT is delivered by clinical psychologists via 12–18 sessions with children individually or children and their parents together. TF-CBT has level 3 evidence of reducing trauma symptoms in children who have witnessed domestic violence or experienced other forms of abuse and neglect.[315]

Shelters and supportive housing

As described at the beginning of this chapter, many women stay in abusive relationships because they cannot afford to leave.[316] Additionally, studies show that a woman's attempt to leave an unsafe relationship can increase the risk of further, more severe violence and even death in some circumstances.[317] For this reason, safe housing options are necessary to ensure that mothers and children remain safe after leaving an abusive partner.

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.[318] Specifically, the review observed that supportive housing was consistently effective in improving mothers' self-reported mental health, self-confidence and intention to leave unsafe relationships. There is also evidence showing that supportive housing can improve children's behaviour and psychological wellbeing when mothers receive effective parenting support as described in the previous sections.[319,320,321,322] However, the extent to which supportive housing reduces the risk of further violence by the original perpetrator, or a new perpetrator, remains unclear.

Work with perpetrators

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. These interventions include 'batterer' programmes based on the Duluth model, which are informed by feminist theories of domestic abuse, as well as CBT approaches aimed at helping perpetrators to manage their moods, temper and potential triggers for violent behaviour.[323,324]

The findings underpinning interventions offered to perpetrators exclusively are mixed, with some studies showing modest improvements in perpetrators' self-reported behaviours

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315 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.

316 World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*.

317 Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse*, *21*(3), 527–540.

318 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*.

319 Haskett, M. E., Loehman, J., & Burkhart, K. (2016). Parenting interventions in shelter settings: A qualitative systematic review of the literature. *Child & Family Social Work, 21*(3), 272–282.

320 Latzman, N. E., Casanueva, C., Brinton, J., & Forman-Hoffman, V. L. (2019). The promotion of well-being among children exposed to intimate partner violence: A systematic review of interventions. *Campbell Systematic Reviews*, *15*(3).

321 Austin, A. E., Shanahan, M. E., Barrios, Y. V., & Macy, R. J. (2019). A systematic review of interventions for women parenting in the context of intimate partner violence. *Trauma, Violence, & Abuse*, *20*(4), 498–519.

322 Anderson, K., & Van Ee, E. (2018). Mothers and children exposed to intimate partner violence: A review of treatment interventions. *International Journal of Environmental Research and Public Health*, *15*(9), 1955.

323 Phillips, R., Kelly, L., & Westmarland, N. (2013). *Domestic violence perpetrator programmes: An historical overview*. Discussion paper. London Metropolitan University and Durham University.

324 Hamilton, L., Koehler, J. A., & Lösel, F. A. (2013). Domestic violence perpetrator programs in Europe, part I: A survey of current practice. *International Journal of Offender Therapy and Comparative Criminology*, *57*(10), 1189–1205.

and attitudes.[325,326,327,328,329,330,331] However, studies also show that changes in perpetrators' attitudes are not always mirrored by changes in their behaviour, with the most rigorously conducted studies showing no improvements in reoffending rates.[332] Studies also rarely consider the impact of these interventions on children's wellbeing.[333]

For these reasons, the current consensus among domestic abuse scholars 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.[334] 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.[335,336]

Nevertheless, some researchers argue that work with perpetrators could potentially reduce domestic violence if care is taken in determining the degree of risk individual perpetrators pose to their partners and children.[337,338] From this perspective, some have argued that couples therapy may be beneficial in instances where the violence has been judged to be situational, or there is minimal use of coercive control.[339,340] For example, reductions in domestic violence have been reported by couples attending behavioural couples therapy for substance misuse, as we describe in chapter 6.[341]

However, it is worth highlighting that this perspective is controversial, particularly because it assumes that therapists have the instruments and skills to accurately assess the nature of the domestic abuse and the level of threat that exists. While some individual therapists may

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325 Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, *23*(8), 1023–1053.

326 Akoensi, T. D., Koehler, J. A., Lösel, F., & Humphreys, D. K. (2013). Domestic violence perpetrator programs in Europe, part II: A systematic review of the state of evidence. *International Journal of Offender therapy and Comparative Criminology*, *57*(10), 1206–1225.

327 Travers, Á., McDonagh, T., Cunningham, T., Armour, C., & Hansen, M. (2021). The effectiveness of interventions to prevent recidivism in perpetrators of intimate partner violence: A systematic review and meta-analysis. *Clinical Psychology Review, 84*, 101974.

328 Papalia, N., Spivak, B., Daffern, M., & Ogloff, J. R. (2019). A meta-analytic review of the efficacy of psychological treatments for violent offenders in correctional and forensic mental health settings. *Clinical Psychology: Science and Practice*, *26*(2), e12282.

329 Santirso, F. A., Gilchrist, G., Lila, M., & Gracia, E. (2020). Motivational strategies in interventions for intimate partner violence offenders: A systematic review and meta-analysis of randomized controlled trials. *Psychosocial Intervention*, *29*(3), 175–190.

330 Cheng, S. Y., Davis, M., Jonson-Reid, M., & Yaeger, L. (2021). Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma, Violence, & Abuse*, *22*(3), 496–511.

331 Karakurt, G., Koç, E., Çetinsaya, E. E., Ayluçtarhan, Z., & Bolen, S. (2019). Meta-analysis and systematic review for the treatment of perpetrators of intimate partner violence. *Neuroscience & Biobehavioral Reviews*, *105*, 220–230.

332 Nesset, M. B., Lara-Cabrera, M. L., Dalsbø, T. K., Pedersen, S. A., Bjørngaard, J. H., & Palmstierna, T. (2019). Cognitive behavioural group therapy for male perpetrators of intimate partner violence: A systematic review. *BMC Psychiatry*, *19*(1), 1–13.

333 Alderson, S., Westmarland, N., & Kelly, L. (2013). The need for accountability to, and support for, children of men on domestic violence perpetrator programmes. *Child Abuse Review*, *22*(3), 182–193.

334 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.

335 Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., ... & Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse*, *7*(4), 355–460.

336 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, polices, and practices*. National Center for Injury Prevention and Control.

337 Travers, Á., McDonagh, T., Cunningham, T., Armour, C., & Hansen, M. (2021). The effectiveness of interventions to prevent recidivism in perpetrators of intimate partner violence: A systematic review and meta-analysis. *Clinical Psychology Review*, *84*, 101974.

338 Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review*, *73,* 101752.

339 Karakurt, G., Whiting, K., Van Esch, C., Bolen, S. D., & Calabrese, J. R. (2016). Couples therapy for intimate partner violence: A systematic review and meta-analysis. *Journal of Marital and Family Therapy*, *42*(4), 567–583.

340 Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior*, *16*(4), 312–318.

341 Fals-Stewart, W., Klostermann, K., & Clinton-Sherrod, M. (2009). Substance abuse and intimate partner violence. In K. D. O'Leary and E. M. Woodin (Eds.), *Psychological and physical aggression in couples: Causes and interventions* (pp. 251–269). American Psychological Association.

feel that they are sufficiently experienced to assess domestic violence risk, there is still not enough evidence to recommend any specific assessment tool as having adequate levels of sensitivity and specificity to detect risk. Nor is there a specific model of couples therapy that has been tested with sufficient rigour to recommend as an effective response to domestic abuse – with the exception of behavioural couples therapy, which has evidence of reducing violence in couples where substance abuse is an issue, as covered in the next chapter.

Most importantly, we still know very little about how children benefit from interventions offered to perpetrators or couples experiencing domestic abuse. Hence, it is possible that child outcomes may remain poor, even when parents report improvements in the couple relationship.

The fact that interventions involving perpetrators (including those offered to perpetrators individually, in groups and as part of couples therapy) currently lack evidence for reducing domestic violence recidivism[342,343] leads us to conclude that new theories of change and intervention models around changing perpetrator behaviour are needed. Until models exist that have been shown to be effective, perpetrator programmes should not be relied upon as a primary means of keeping children and survivors safe, particularly in situations where the perpetrator exerts high levels of coercive control. In order to meet these safety objectives, current evidence would suggest resources might be best directed towards direct work with survivors of domestic abuse and their children. As described above, these interventions have consistent evidence of improving children's behaviour and reducing symptoms of trauma.

Legal sanctions and protection orders

There is some evidence to support the use of laws and sanctions to deter and denounce IPV, although laws are often difficult to evaluate rigorously.[344,345,346] In particular, there is consistent and convincing evidence showing that laws leading to the arrest of domestic abuse offenders may reduce rates at the community level, suggesting that laws may have a significant preventive effect.[347]

However, there is little evidence showing that incarceration and the escalation of sanctions is effective at stopping domestic abuse once it has occurred, suggesting that it is an ineffective form of treatment.[348]

Edge of care

MST, TFCO-Adolescent and FFT are three interventions listed on the EIF Guidebook with evidence of improving child outcomes when offered to families who have experienced domestic abuse. For this reason, they are endorsed by the US Centers for Disease Control and other international public health bodies as a means for preventing the intergenerational transmission of violence through adolescents with a history of offending. MST, FFT and TFCO-Adolescent are all informed by family systems and social learning theories, and seek

342 Barlow, J., & Schrader-MacMillan, A. (2017). *Improving the effectiveness of the child protection system: A review of literature*. Early Intervention Foundation. https://www.eif.org.uk/report/improving-the-effectiveness-of-the-child-protection-system-a-review-of-literature

343 Guy, J. (2014). *Early intervention in domestic violence and abuse*. Early Intervention Foundation. https://www.eif.org.uk/report/early-intervention-in-domestic-violence-and-abuse

344 Robinson, P. H. (2002). The role of deterrence in the formulation of criminal law rules: At its worst when doing its best. *Georgetown Law Journal*, *91*, 949.

345 Braga, A. A., Weisburd, D., & Turchan, B. (2019). Focused deterrence strategies effects on crime: A systematic review. *Campbell Systematic Reviews*, *15*(3).

346 See: https://www.college.police.uk/research/what-works-policing-reduce-crime/what-stops-people-offending

347 Garner, J. H., Maxwell, C. D., & Lee, J. (2021). The specific deterrent effects of criminal sanctions for intimate partner violence: A meta-analysis. *Journal of Criminal Law and Criminology*, *111*, 227.

348 Maxwell, C. D., & Garner, J. H. (2012). The crime control effects of criminal sanctions for intimate partner violence. *Partner Abuse*, *3*(4), 469–500.

to provide families with non-aggressive alternatives for resolving disputes and stopping the escalation of violence.

It should be noted, however, that none of these three interventions 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. If domestic violence is ongoing, TFCO-Adolescent may be the only evidence-based alternative. This is because the child is removed from the home to live with foster parents until the family situation has stabilised and it has been clearly established that the custodial parent can sensitively care for the child.

CASE EXAMPLE C: CHILD FIRST AND CPP

A mother is subjected to domestic abuse by her partner. While she is pregnant with their second child, the abuse against the mother escalates and the perpetrator's behaviour becomes increasingly coercive and violent. The perpetrator is alcohol-dependent.

Child First represents the most comprehensive approach for meeting the needs of mothers experiencing domestic abuse, as it was developed specifically for families where domestic abuse and substance misuse are an issue.

In this example, the mother's need for additional support would first be identified through routine domestic abuse screening occurring at her antenatal checks. The mother is then referred to the Child First team, who scrutinise her needs and risks with validated screening tools. These tools might include the Trauma-Event Screening Inventory — Parent Report Revised (TESI-PRR), which is a 24-item parent-report tool aimed at assessing the child's exposure to domestic violence.

Once eligibility for Child First is verified, the mother and her children are assigned a Child First clinician and care coordinator. The clinician would likely be a masters-level or higher psychologist or social worker and the care coordinator would have at least a bachelors qualification in a helping profession. The role of the therapist is to provide the mother, her child and the baby with therapeutic support through the CPP model, while the care coordinator supports the family's practical needs by designing a 'wrap around' package of care involving other child and family services. In this example, this system of care would include efforts to stabilise the family, which might include supportive temporary housing, if there was no other means of separating the parents.

During the first visit, the clinician and care coordinator attend together to meet the family and establish a positive working relationship. This typically involves toys, songs and games to engage the parent and children. At this time, the care coordinator or therapist will use motivational interviewing techniques to help the mother identify strengths within the family system and goals for positive change. These goals will then inform the package of care that is coordinated for the family, such as support for transportation, as well as involvement from other early years services. The care coordinator is expected to be the primary contact for these other services and should be supported to have good professional connections with all of them.

A primary goal of the care coordinator is to increase parents' capacity to access these services on their own and achieve their self-identified goals with minimal assistance. As such, where possible, care coordinators 'scaffold' and coach parents to utilise this support, rather than doing it for them.

After the first session, the clinician visits the family on a weekly basis to provide CPP over the period of a year. This approach was developed explicitly to stop the intergenerational transmission of family violence by helping vulnerable parents to develop a positive and supportive relationship with their child. When domestic violence is an issue, CPP also aims to reduce symptoms of trauma occurring in the victimised parent and child.

The parent and child are routinely present during each visit, although sessions may be conducted individually with parents during the initial or 'foundational' phase to ensure that sensitive issues are addressed privately.

After the foundational phase is completed, the clinician specifically supports parent–child interaction through play sessions that:

- provide parents with advice about normal developmental challenges and expectations
- help parents to understand the unique processing abilities of their child
- help parents to understand the impact of trauma on their child and how this might be expressed in their behaviour
- help parents to reflect on the meaning and feelings motivating a child's behaviour
- facilitate new and appropriate parental responses to child behavioural challenges
- promote the parent's reflection on the psychodynamic relationship between their own feelings and history, and their response to the child.

Child First and CPP were developed specifically to improve child outcomes, although parental benefits, including reductions in parents' symptoms of trauma, are also primary goals of the programme. CPP also has evidence of improving the quality of the survivor's future intimate relationships.[349]

While empowerment support might also have been considered as an alternative to Child First with CPP, it would have been inadequate in this instance because there is an older child who has likely witnessed domestic violence. Child First with CPP is therefore the most comprehensive response for addressing the needs of the parent and child survivors of abuse.

[349] Peltz, J. S., Rogge, R. D., Rogosch, F. A., Cicchetti, D., & Toth, S. L. (2015). The benefits of child-parent psychotherapy to marital satisfaction. *Families, Systems, & Health*, *33*(4), 372.

Interventions table 4

Interventions with evidence of preventing domestic abuse, reducing its re-occurrence and treating abuse-related trauma

Name	Description	Key features*	Evidence	Workforce
Universal prevention				
Dating Matters FIND OUT MORE NIOLON, P. H. ET AL. (2019) AN RCT OF DATING MATTERS... AMERICAN JOURNAL OF PREVENTIVE MEDICINE, 57(1), 13–23	A school-based intervention teaching 11–14-year-olds healthy relationship skills before they start dating. It also provides advice on stopping behaviours that increase the risk of dating violence, including substance misuse and sexual risk-taking.	Child age: 11–14 years Need: Universal Model: School Available in the UK? No Evaluated in the UK? No	The equivalent of level 3 evidence showing significant reductions in teen dating violence perpetration, victimisation and negative conflict resolution strategies.	Teachers/pupils/ computer.
Family Foundations FIND OUT MORE FAMILY FOUNDATIONS ON THE EIF GUIDEBOOK	A group-based programme for couples expecting their first child. Couples learn strategies for enhancing communication, resolving conflict and sharing of childcare duties.	Child age: Perinatal Need: Universal Model: Group Available in the UK? Yes Evaluated in the UK? No	Level 4 evidence of reduced parental reports of conflict and violence, as reported by both parents on the Conflict Tactics Scale, prior to their first child's birth and at the child's first birthday. *Individuals participating in Family Foundations are ineligible if domestic abuse is present, but participation in the intervention may provide a preventative effect.*	Practitioners trained in the programme model with at least QCF-6 level qualifications or higher. In this context, both male and female healthcare providers.
Me & You FIND OUT MORE PESKIN, M. F. ET AL. (2019) ADOLESCENT DATING VIOLENCE PREVENTION PROGRAM FOR EARLY ADOLESCENTS... AMERICAN JOURNAL OF PUBLIC HEALTH, 109(10), 1419–1428	A whole-school approach for school pupils between the ages of 11 and 12 to promote healthy relationships and address unhealthy relationship behaviour (emotional, physical, sexual, cyber). It combines direct work to pupils with group with advice offered to parents. The student component comprises 12 25-minute sessions. The parent component comprises three parent–child take-home activities and two parent newsletters. The whole-school component comprises a two-day teacher training and one school newsletter (delivered during lesson one).	Child age: 11–12 years Need: Universal Model: School Available in the UK? No Evaluated in the UK? No	The equivalent of level 3 evidence of reduced rates of dating violence perpetration. This included reductions in physical DV perpetration, psychological DV perpetration, threatening DV perpetration and victimisation, and sexual DV victimisation.	Teachers/pupils/ computer.
Safe Dates FIND OUT MORE SAFE DATES ON THE BLUEPRINTS REGISTRY	A 10-session dating abuse prevention programme to raise students' awareness of what constitutes healthy and abusive dating relationships, as well as the causes and consequences of dating abuse.	Child age: 12–14 years Need: Universal Model: School Available in the UK? No Evaluated in the UK? No	The equivalent of level 3 evidence showing significant reductions (56–92%) in self-reported physical, serious physical, and sexual dating violence perpetration and victimisation.	Teachers/pupils.

* Information on interventions as being available or evaluated in the UK is based on desk research at the time of publication, and may be subject to change. Please check with intervention providers for further detail on availability and past evaluations.

Name	Description	Key features	Evidence	Workforce
Schoolchildren & their Families (Parents as Partners) FIND OUT MORE SCHOOLCHILDREN & THEIR FAMILIES ON THE EIF GUIDEBOOK	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.	Child age: Entry to kindergarten/reception Need: Universal Model: Group Available in the UK? Yes Evaluated in the UK? Not known	Level 3 evidence of improved parenting behaviours, parental couple communication and satisfaction. *Individuals participating in Schoolchildren and their Families are ineligible if domestic abuse is present, but participation in the intervention may provide a preventative effect.*	Two practitioners trained in the Schoolchildren and their Families' model with QCF-7/8 level qualifications.
Screening for domestic abuse FIND OUT MORE FELTNER, C. ET AL. (2018). SCREENING FOR INTIMATE PARTNER VIOLENCE, ELDER ABUSE, AND ABUSE OF VULNERABLE ADULTS... JAMA, 320(16), 1688–1701	Universal screening for domestic abuse during the mother's pregnancy, leading to evidence-based treatments. Studies suggest screening may be particularly useful in preventing domestic abuse during pregnancy when conducted anonymously via a tablet during routine pregnancy check-ups.	Child age: Antenatal Need: Universal Model: Screening Available in the UK? No Evaluated in the UK? No	Consistent evidence from multiple systematic reviews showing between 60 and 96% sensitivity and specificity in identifying domestic abuse during a mother's pregnancy.	Health providers.
Targeted selected				
Family Nurse Partnership (FNP) FIND OUT MORE FAMILY NURSE PARTNERSHIP ON THE EIF GUIDEBOOK	A preventative home-visiting intervention for first-time adolescent mothers and their children. The programme has three goals: (1) to improve pregnancy health and behaviours; (2) to improve child health and development by helping parents provide responsible and competent care; and (3) to improve the mother's economic self-sufficiency. Mothers enrol in the programme early in their pregnancy and receive visits from a family nurse on a weekly basis before, and for the first six weeks after the birth of their child. Visits then continue fortnightly until three months before the child's second birthday when visits become monthly in preparation for the programme ending. 64 visits in total are scheduled. During these visits, mothers learn about their young child's health and development, and receive support for their own wellbeing.	Child age: Antenatal to 2 years Need: Selected Model: Home-visiting Available in the UK? Yes Evaluated in the UK? Yes	Level 4 evidence of reducing mothers' involvement in violent relationships during the course of the intervention and in long-term follow-ups – although these benefits were not observed in the most recent UK trial.	Nurses, midwives or health visitors trained in the FNP model.

Name	Description	Key features	Evidence	Workforce
Targeted indicated				
Antenatal 'empowerment' advice for mothers identified at risk of domestic abuse during pregnancy FIND OUT MORE KIELY, M. ET AL. (2010). AN INTEGRATED INTERVENTION TO REDUCE INTIMATE PARTNER VIOLENCE... OBSTETRICS AND GYNECOLOGY, 115(2-1), 273.	Mothers identified as experiencing domestic abuse through antenatal screening are offered 'empowerment' advice involving recognising abuse/coercion in relationships and developing a safety plan.	Child age: Perinatal Need: Indicated Model: Individual Available in the UK? No Evaluated in the UK? No	The equivalent of level 3 evidence of improved birth outcomes and reducing the likelihood of mothers' involvement in violent relationships.	Clinical psychologists.
Cognitive behavioural therapy (CBT) (for victims/ survivors) FIND OUT MORE NICE GUIDANCE (CG90): TREATMENT FOR MILD TO MODERATE DEPRESSION	A well-evidenced therapeutic technique typically offered to adults experiencing mild to moderate symptoms of depression or anxiety. Adults are taught cognitive strategies for breaking down problems and worries into smaller components to minimise feelings of helplessness and hopelessness and increase a sense of efficacy. Common CBT strategies include methods for managing their moods and intrusive thoughts, relaxation techniques, and strategies for reframing negative situations. The length of CBT can vary, depending on the length of the problem, although most versions are of short duration. Some can also be self-administered, depending on the severity of the mental health problem.	Target group: Adults Need: Indicated Model: Individual therapy Available in the UK? Not known Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews showing reductions in symptoms of depression, anxiety and trauma in mothers who have been exposed to domestic abuse.	Clinical psychologists.
Incredible Years Preschool Basic FIND OUT MORE INCREDIBLE YEARS PRESCHOOL BASIC ON THE EIF GUIDEBOOK	A group parenting programme where parents learn strategies for interacting positively with their child and discouraging unwanted behaviour through mediated video vignettes, problem-solving exercises and structured practice activities.	Child age: 3–6 years Need: Indicated Model: Group Available in the UK? Yes Evaluated in the UK? Yes	Level 3 evidence of improving child behavioural outcomes when offered to mothers exposed to domestic abuse.	Delivered by two IY co-leaders with QCF-7/8 level qualifications, who may be a psychologist, social worker, nurse or physician.

Name	Description	Key features	Evidence	Workforce
Child protection concerns				
Child First FIND OUT MORE CHILD FIRST ON THE EIF GUIDEBOOK	A 12-month home visiting intervention combining Child-Parent Psychotherapy with other forms of social support to reduce the risk of child maltreatment in vulnerable families with young children.	Child age: 6–36 months Need: Indicated Model: Individual home visiting Available in the UK? No Evaluated in the UK? No	Level 3 evidence of four-fold reductions in child behavioural problems and a two-fold reduction in reports of child maltreatment at a three-year follow-up. Also, a three-fold reduction in parenting stress and four-fold reduction in symptoms of psychopathology at a 12-month follow-up.	Delivered by one clinician with QCF-7/8 level qualifications and one care coordinator with QCF-6 level qualifications.
Child-Parent Psychotherapy (CPP) FIND OUT MORE CHILD-PARENT PSYCHOTHERAPY ON THE EIF GUIDEBOOK	A therapeutic intervention targeting mothers and preschool children who may have experienced trauma or abuse (such as domestic abuse) or are otherwise at risk of behavioural and emotional problems.	Child age: 3–6 years Need: Indicated Model: Individual parent/ child therapy Available in the UK? No Evaluated in the UK? No	Level 3+ evidence of small to moderate improvements in child behaviour (depending on the study). Parent benefits include reductions in trauma-symptoms and symptoms of depression.	QCF-7/8 level clinical psychologist or social worker.
GenerationPMTO FIND OUT MORE GENERATIONPMTO ON THE EIF GUIDEBOOK	An intervention that teaches parents effective family management skills to reduce antisocial and problematic child behaviour. Promoting school success is also a factor that is woven into the programme throughout relevant components. The length of GenerationPMTO is determined by each family's needs. The number of sessions provided in parent groups ranges from six to 14; in clinical samples the mean number of individual treatment sessions is 25.	Child age: 3–18 years Need: Indicated Model: Group or individual Available in the UK? No Evaluated in the UK? No	Level 4 evidence of improving a wide variety of child outcomes, including reductions in antisocial behaviour, and reduced symptoms of trauma in parents and children.	Qualified GenerationPMTO practitioners with a minimum of QCF-6 level qualifications, preferably QCF-7/8.
Parent-Child Interaction Therapy FIND OUT MORE PARENT-CHILD INTERACTION THERAPY ON THE BLUEPRINTS REGISTRY	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. Parents must achieve mastery in the first phase to proceed to the second.	Child age: 3–12 years Need: Indicated Model: Group Available in the UK? No Evaluated in the UK? No	Level 4 evidence of improving children's behavioural outcomes. This evidence includes studies conducted with highly vulnerable populations, including mothers living in homeless shelters.	Clinical psychologists or social workers with QCF-7/8 level qualifications.
Project Support FIND OUT MORE JOURILES, E. N. ET AL. (2009). REDUCING CONDUCT PROBLEMS AMONG CHILDREN EXPOSED TO INTIMATE PARTNER VIOLENCE... JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY, 77(4), 705.	Combines parent management training with therapeutic support to mothers. It is delivered by QC- 7/8 level therapists via 90-minute sessions occurring once a week for an average period of 20 weeks over an eight-month period.	Child age: 4–9 years Need: Indicated Model: Individual Available in the UK? No Evaluated in the UK? No	Level 3 evidence of reduced child behavioural problems and reduced contact with domestic abuse perpetrators.	Trained therapists with QCF-7/8 level qualifications.

Name	Description	Key features	Evidence	Workforce
Trauma-focused CBT FIND OUT MORE TRAUMA-FOCUSED CBT ON THE EIF GUIDEBOOK	Individuals learn cognitive strategies for managing negative emotions and beliefs stemming from highly distressing and/or abusive experiences.	Child age: 3–18 years Need: Indicated Model: Individual Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence from multiple studies suggesting reductions moderate to strong reductions in symptoms of PTSD, anxiety and depression.	Mental health professional with QCF-7/8 level qualifications.
Edge of care				
Functional Family Therapy FIND OUT MORE FUNCTIONAL FAMILY THERAPY ON THE EIF GUIDEBOOK	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 (i.e. antisocial behaviour and substance abuse).	Child age: 10–18 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 3+ evidence from multiple studies of reducing substance misuse in teenagers. However, these benefits were not replicated in the only UK trial.	Clinical psychologists or social workers with QCF-7/8 level qualifications.
Multisystemic Therapy FIND OUT MORE MULTISYSTEMIC THERAPY ON THE EIF GUIDEBOOK	An intervention for families with a young person aged 12–17 who is at risk of going into care due to serious antisocial and/or offending behaviour.	Child age: 12–17 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 4+ evidence from multiple, internationally conducted studies, including a US evaluation demonstrating reduced youth offending, antisocial behaviour and psychiatric symptomology, including findings involving 14- and 22-year follow-ups. MST has UK evidence consistent with these findings, although its most recent UK evaluation could not confirm that MST was superior to standard youth justice practice.	MST therapist/practitioner with QCF-6 level qualifications.
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) FIND OUT MORE MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT ON THE EIF GUIDEBOOK	An intensive treatment for families who have recently been reported to child protection services. A key aim of the intervention is to help families assume greater responsibility for their behaviours and actively work to resolve serious family issues.	Child age: 6–17 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of reduced neglect, psychological aggression, minor and severe assault, non-violent discipline, symptoms of PTSD, dissociative symptoms, internalising symptoms, total behaviour problems and increased placement stability post-intervention.	Delivered jointly by a social worker/ psychologist and key worker.
Treatment Foster Care Oregon – Adolescent (TFCO-A) FIND OUT MORE TREATMENT FOSTER CARE OREGON ADOLESCENT ON THE EIF GUIDEBOOK	A programme for young people displaying delinquent behaviour in foster placements or residential placements. These young people are placed in a 'treatment foster family' trained in the TFCO-A model with the aim of improving a young person's social, emotional and relational skills, and thereby reducing the incidence of more challenging and antisocial behaviours.	Child age: 12–18 years Need: Edge of care Model: Individual & family therapy Available in the UK? Yes Evaluated in the UK? Yes	Level 3+ evidence of reductions in running away from placements and the number of days incarcerated, as well as reduced delinquent behaviour and reduced rates of criminal referrals during the period from placement to one year post-placement.	Social worker with QCF-7/8 level qualifications.

6. Interventions with evidence of preventing and treating dependent and harmful substance misuse

KEY POINTS

- Substance misuse is a diagnosable mental health disorder that is characterised by chronic and heavy use that continues despite clear evidence of harm.
- Problematic parental substance misuse is consistently associated with poor child outcomes, even when it occurs at non-dependent levels.
- Parental misuse problems are a primary reason why children are placed in out-of-home care.

WHAT WORKS

- Interventions that help parents to stop misusing substances and provide parents with effective parenting strategies.
- Examples of interventions of increasing parental abstinence and improving child outcomes include behavioural couples therapy combined with Helping the Non-compliant Child, Parents Under Pressure and Multisystemic Therapy – Building Stronger Families.

WHAT IS LESS LIKELY TO WORK FOR CHILDREN

- Treatments that solely target parental substance misuse.
- Interventions that target parenting in the absence of substance misuse support.

6.1 Characteristics

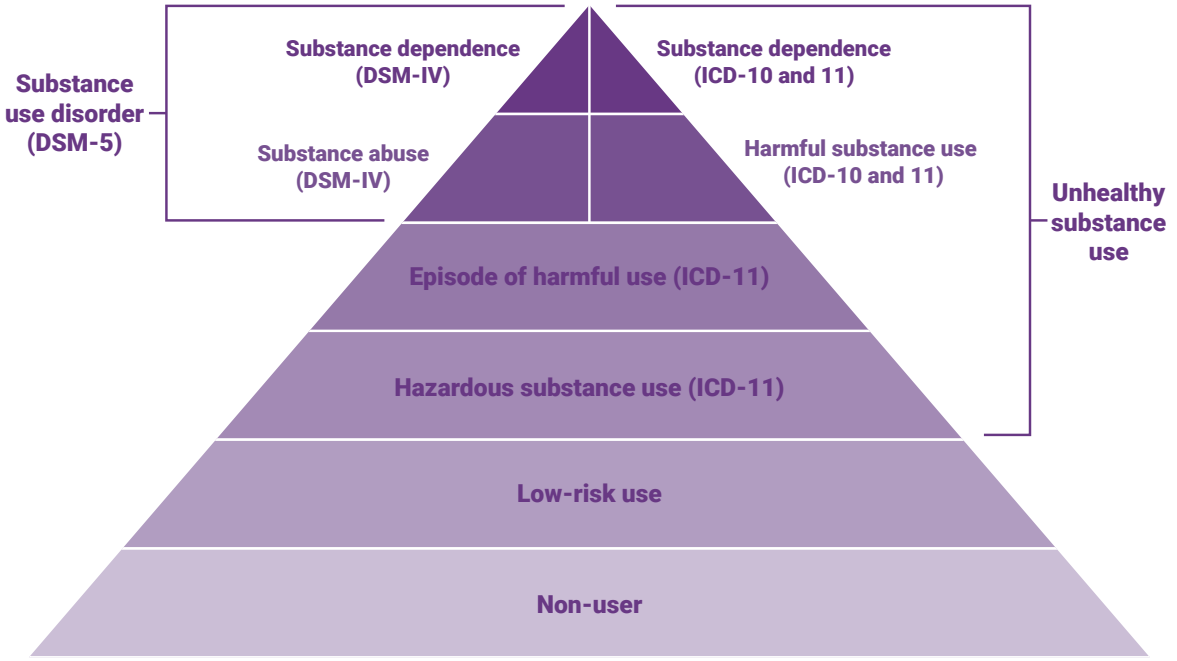
Definition

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.[350] 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 (see figure 6.1).

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

FIGURE 6.1

Spectrum of substance use disorders with respect to the ICD-10/11 and DSM-5 definitions



The International Classification of Diseases and Health Problems (ICD-11) identifies four distinct categories of problematic substance misusing behaviours:[351]

- **Dependence:** A disorder of regulation of substance use arising from repeated or continuous use of alcohol or mind-altering drugs. The characteristic feature is a strong internal drive to use these substances, which is manifested by impaired ability to control use, increasing priority given to use over other activities, and persistence of use despite harm or negative consequences.
- **Harmful use:** A pattern of substance use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. This harm includes the toxic effect of substances on the physical body and systems, as well as harm caused by intoxicated behaviour.
- **Episode of harmful use:** This category encompasses a substance use event that has caused harm to a person's physical or mental health or has resulted in behaviour leading to harm to others. There is no known pattern of substance use, although harm may occur from intoxication, toxic effects on body organs and systems, or from a harmful route of administration. This classification was recently introduced for use in healthcare settings where detailed information on the person's history of substance use may not be available.
- **Hazardous use:** A pattern of substance use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals. The risk may be related to short-term effects of substances or to longer-term cumulative effects on physical or mental health or functioning. Hazardous substance use has not yet reached the level of having caused harm to the physical or mental health of the user or others around the user. The pattern of substance use often persists in spite of the user's awareness of increased risk of harm to themselves or to others.

[351] See: https://www.who.int/standards/classifications/classification-of-diseases

Low levels of substance use typically result in brief periods of mild intoxication that are temporary, pleasurable and manageable for many individuals. However, high levels of intoxication can significantly impair cognitive functioning, and may lead, in some cases, to reckless behaviour, emotional lability, aggression and violence.

Substance use risks becoming problematic when it is frequent and involves high levels of intoxication.[352] High levels of intoxication are typically followed by negative withdrawal symptoms, which – when intoxication episodes are frequent – are then eventually followed by physical cravings. Intoxication–withdrawal–craving cycles can then become increasingly more difficult for some individuals to manage, negatively impacting their job performance and personal relationships.[353]

Harmful and dependent substance use is associated with an increased risk of physical and mental health problems, accidental injury and death. Studies show that at the population level, substance use disorders typically reduce life expectancy by an average of 20 years.[354]

Prevalence

Substance misuse disorders rank among the most prevalent mental health disorders globally. It is currently estimated that 2.2% of the global population have a dependent substance misuse problem, with 1.7% owing to alcohol and 0.5% involving opioid and other harmful drugs.[355]

UK estimates suggest that while approximately 1% of the adult population have a dependent alcohol problem, 16% are believed to drink frequently at hazardous levels. Additionally, of the 1% of adults with a dependent alcohol use problem, it is estimated that less than half are receiving treatment.[356,357]

Parental substance misuse

Reliable estimates of the prevalence of parental substance misuse are difficult to obtain, as studies involving adult populations rarely identify participants as parents.[358] The Children's Commissioner currently estimates that just under 5% of English children live with a parent who engages in harmful or dependent alcohol or drug use.[359] 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.[360]

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

353 Koob, G. F., & Volkow, N. D. (2016). Neurobiology of addiction: A neurocircuitry analysis. *The Lancet Psychiatry*, *3*(8), 760–773.

354 World Health Organization. (2019). *Status report on alcohol consumption, harm and policy responses in 30 European countries*.

355 Degenhardt, L., Charlson, F., Ferrari, A., Santomauro, D., Erskine, H., Mantilla-Herrara, A., ... & Vos, T. (2018). The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Psychiatry*, *5*(12), 987–1012.

356 Pryce, R., Buykx, P., Gray, L., Stone, T., Drummond, C., & Brennan, A. (2017). *Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence. Prevalence, trends and amenability to treatment*. Public Health England.

357 Office for National Statistics. (2021). *Adult substance misuse treatment statistics 2019 to 2020: Report*. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report

358 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.

359 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

360 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.

Studies show that children are negatively impacted by parental substance misuse, even when it does not meet thresholds for dependent use.[361,362,363] 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.[364,365,366] Parental substance misuse is also a key risk for child maltreatment and is a primary reason why children are taken into care.[367] Parental drug or alcohol misuse is consistently implicated in over one-third of serious case reviews.[368]

Parental substance misuse negatively impacts children's development through two distinct pathways.[369] First, parental substance misuse can dramatically reduce a caregiver's capacity to understand and support the child's needs. This inevitably reduces the quality of the parent–child relationship and deprives the child of the psychological and cognitive support necessary for optimal development. Second, parental substance misuse often exposes children to other risks related to the substance misusing behaviour, including domestic violence, parental incarceration, and physical and mental health problems.[370]

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.[371] Parents with persistent substance misuse problems are therefore ineligible for many of the interventions described in other chapters of this review.

Additionally, studies show that children rarely benefit from interventions that target parents' substance misuse problems alone.[372] In this respect, findings from a recent Cochrane review observe 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 (see figure 6.2).[373]

361 Foster, J., Bryant, L., & Brown, K. (2018). *Like sugar for adults: The effect of non-dependent parental drinking on children & families*. UK Institute of Alcohol Studies.

362 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.

363 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.

364 Bryant, L., MacKintosh, A. M., & Bauld, L. (2020). An exploration of the impact of non-dependent parental drinking on children. *Alcohol and Alcoholism*, *55*(1), 121–127.

365 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.

366 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.

367 See: https://www.gov.uk/government/collections/statistics-looked-after-children

368 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

369 Velleman, R., & Templeton, L. J. (2016). Impact of parents' substance misuse on children: An update. *BJPsych Advances*, *22*(2), 108–117.

370 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.

371 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.

372 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.

373 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*.

FIGURE 6.2
Generic theory of change underpinning interventions for parents who misuse substances

Opinions are divided as to 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.[374] The sequencing of treatment is often contingent upon the severity of the parent's problem, 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. For this reason, a variety of treatment options must be considered, including those which place the child in out-of-home care until the parent's substance misuse problems are fully managed.[375]

Total abstinence is a primary goal for many substance dependence treatments.[376] While treatment effectiveness is often measured in terms of reduced alcohol/drug consumption, substance

[374] 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.

[375] 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.

[376] Roerecke M., Gual A., & Rehm J. (2013). Reduction of alcohol consumption and subsequent mortality in alcohol use disorders: Systematic review and meta-analyses. *Journal of Clinical Psychiatry*, *74*, e1181–89.

dependence problems can be difficult to manage until total abstinence is achieved for a period of time. Studies show that the risk of an out-of-home placement remains high when abstinence is not a primary goal for interventions offered to parents with a dependent substance misuse problem.[377]

One reason that abstinence is viewed as a necessary objective is that substance dependence alters the brain's neuro-circuitry, making it difficult for affected users to learn new strategies or behaviours until the physically addictive components of substance misuse are under control.[378] Reductions in substance use are typically not sufficient to reduce these chemical alterations, although neurobiological changes typically reverse themselves within relatively short periods of total abstinence (three to six weeks).

Nevertheless, negative psychological symptoms may persist for months or even years. These symptoms include an impaired ability to manage moods and reflect on behaviours and consequences. Relapse therefore remains an ongoing risk after the physical addiction has been treated.[379,380] When individuals relapse, the neuro-circuitry is once again realtered, in turn making it difficult for individuals to relearn and implement strategies for managing cravings and moods that reinforce their addiction.

For many individuals, full recovery can take months or years to achieve, although significant periods of abstinence can occur between relapse episodes. 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.[381,382]

6.2 Key risks

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.[383] For example, tobacco is a highly addictive substance with strong evidence of negatively impacting young children's health, but is not considered a specific risk for child maltreatment. Opioids, by contrast, are highly addictive and are considered a primary risk for child maltreatment, although there is also evidence showing that being a parent discourages opioid use. Hence, fewer families are negatively impacted by opioid use in comparison to other substances, such as alcohol. While alcohol is less physically addictive than other substances, parents are more likely to use it at dependent/harmful/hazardous levels. From this perspective, parental alcohol use affects a greater number of families and children than opioids, but the negative impact of parental opioid use on child outcomes may be more severe in some cases.

Below, we briefly describe the key risks associated with parental alcohol and opioid misuse, as parental use of both substances is consistently associated with increased child maltreatment risk.

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377 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.

378 Bjornestad, J., McKay, J. R., Berg, H., Moltu, C., & Nesvåg, S. (2020). How often are outcomes other than change in substance use measured? A systematic review of outcome measures in contemporary randomised controlled trials. *Drug and Alcohol Review*, *39*(4), 394–414.

379 Heilig, M., Egli, M., Crabbe, J. C., & Becker, H. C. (2010). Acute withdrawal, protracted abstinence and negative affect in alcoholism: Are they linked? *Addiction Biology*, *15*(2), 169–184.

380 Suchman, N.E., DeCoste, C., Leigh, D., & Borelli, J. (2010). Reflective functioning in mothers with drug use disorders: Implications for dyadic interactions with infants and toddlers. *Attachment & Human Developmen*t, *12*(6), 567–585.

381 Marlatt, G. A., & Witkiewitz, K. (2005). *Relapse prevention for alcohol and drug problems*. Guilford Press.

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

383 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.

Individual-level risks

Heritability: Studies consistently observe there is a strong heritable component to alcohol misuse, with twin studies providing heritability estimates of 40–70%.[384] This heritable component is thought to contribute to the alcohol intolerance observed in those with east Asian heritage (thus reducing the overall risk within these populations), whereas higher levels of alcohol tolerance is believed to increase the risk in northern European populations.[385,386]

Gender: Substance misuse problems (and alcohol in particular) are five times more likely to occur in men than they are in women. However, studies also show that substance misuse problems are increasing among women and that women may be more resistant to treatment.[387,388]

Age of onset: The age at which an individual starts using substances is predictive of whether they will have substance misuse problems in adulthood.[389] Specifically, drinking to drunkenness before the age of 15 dramatically increases the risk of an adult dependency problem.[390,391] Factors which predict early onset alcohol/substance misuse include pressure from peers, low parental monitoring, and having parents who engage in dependent/harmful/hazardous substance misuse.[392]

A history of childhood trauma and/or abuse and neglect: Individuals experiencing high levels of abuse and neglect during childhood are more than twice as likely to have substance misuse problems in adolescence and adulthood.[393,394] This includes individuals who were removed from their homes at one point during their childhood, which is frequently identified as one of the greatest risks.[395]

Mental health problems: Harmful and dependent substance misuse problems are recognised mental health disorders, and it is not uncommon for substance use and mental health problems to co-occur.[396] In this respect, substance misuse problems are considered a feature

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384 Verhulst, B., Neale, M. C, & Kendler, K. S. (2015). The heritability of alcohol use disorders: A meta-analysis of twin and adoption studies. *Psychological Medicine*, *45*, 1061–72.

385 Sloboda, Z., Glantz, M. D., & Tarter, R. E. (2012). Revisiting the concepts of risk and protective factors for understanding the etiology and development of substance use and substance use disorders: Implications for prevention. *Substance Use & Misuse*, *47*(8–9), 944–962.

386 Li, D., Zhao, H., & Gelernter, J. (2012). Strong protective effect of the aldehyde dehydrogenase gene (ALDH2) 504lys (*2) allele against alcoholism and alcohol-induced medical diseases in Asians. *Human Genetics*, *131*, 725–37.

387 Pryce, R., Buykx, P., Gray, L., Stone, T., Drummond, C., & Brennan, A. (2017). *Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence. Prevalence, trends and amenability to treatment*. Public Health England.

388 Degenhardt, L., Charlson, F., Ferrari, A., Santomauro, D., Erskine, H., Mantilla-Herrara, A., ... & Vos, T. (2018). The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Psychiatry*, *5*(12), 987–1012.

389 Jordan, C. J., & Andersen, S. L. (2017). Sensitive periods of substance abuse: Early risk for the transition to dependence. *Developmental Cognitive Neuroscience*, *25*, 29–44.

390 National Institute on Alcohol and Alcohol Abuse (2000). *Developmental processes and mechanisms*.

391 Zucker, R. A., Donovan, J. E., Masten, A. S., Mattson, M. E., & Moss, H. B. (2008). Early developmental processes and the continuity of risk for underage drinking and problem drinking. *Pediatrics*, *121*(4), S252–S272.

392 Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*(1), 64.

393 Cicchetti, D., & Handley, E. D. (2019). Child maltreatment and the development of substance use and disorder. *Neurobiology of Stress*, *10*, 100144.

394 Afifi, T. O., Henriksen, C. A., Asmundson, G. J., & Sareen, J. (2012). Childhood maltreatment and substance use disorders among men and women in a nationally representative sample. *The Canadian Journal of Psychiatry*, *57*(11), 677–686.

395 Meltzer H. (2003). *The mental health of young people looked after by local authorities in England*. H.M.S.O.

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

of some personality disorders and also commonly co-occur with schizophrenia, depression, PTSD and other forms of anxiety.[397,398,399]

Employment status: While there is clear evidence that substance misuse problems increase the risk of unemployment, it is also clear that unemployment increases the risk of substance misuse.[400,401] In this respect, studies observe that substance use often doubles and even triples during periods of unemployment.[402] This increased use, in turn, significantly increases the risk of harmful or dependent misuse problems developing and becoming entrenched.

Family-level risks

Parents' satisfaction with the couple relationship: Studies show that dissatisfaction with the couple relationship commonly co-occurs with addiction problems – although the direction of causality is not always clear.[403,404] However, some studies show that being married may provide a protective effect and that a higher level of couple satisfaction increases the likelihood of a positive treatment outcome.[405]

Domestic violence: Domestic violence is consistently linked to higher levels of dependent/harmful substance misuse problems, although the direction of causality is not always clear, as noted in chapter 5.[406,407]

Religious faith: Studies show that a lack of religious faith is associated with an increased risk of binge drinking behaviours, while practising a religious faith reduces the likelihood of problematic substance use. Studies also show that religious beliefs are consistently associated with improved treatment outcomes.[408]

Community-level risks

Poverty and community disadvantage are consistently associated with increases in substance misuse problems for a variety of complex reasons. For example, individuals with a dependent problem are more likely to live in a disadvantaged community, but it is also clear that living in a disadvantaged community can lower one's resilience to substance misuse.[409]

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397 Rosenström, T., Torvik, F. A., Ystrom, E., Czajkowski, N. O., Gillespie, N. A., Aggen, S. H., ... & Reichborn-Kjennerud, T. (2018). Prediction of alcohol use disorder using personality disorder traits: A twin study. *Addiction*, *113*(1), 15–24.

398 Hall, W., & Farrell, M. (1997). Comorbidity of mental disorders with substance misuse. *The British Journal of Psychiatry*, *171*(1), 4–5.

399 Moss, H. B., Goldstein, R. B., Chen, C. M., & Yi, H. Y. (2015). Patterns of use of other drugs among those with alcohol dependence: Associations with drinking behavior and psychopathology. *Addictive Behaviors*, *50*, 192–198.

400 Henkel, D. (2011). Unemployment and substance use: A review of the literature (1990–2010). *Current Drug Abuse Reviews*, *4*(1), 4–27.

401 Frasquilho, D., Matos, M. G., Salonna, F., Guerreiro, D., Storti, C. C., Gaspar, T., & Caldas-de-Almeida, J. M. (2015). Mental health outcomes in times of economic recession: A systematic literature review. *BMC Public Health*, *16*(1), 1–40.

402 Popovici, I., & French, M. T. (2013). Does unemployment lead to greater alcohol consumption? *Industrial Relations: A Journal of Economy and Society*, *52*(2), 444–466.

403 Testa, M., Crane, C. A., Quigley, B. M., Levitt, A., & Leonard, K. E. (2014). Effects of administered alcohol on intimate partner interactions in a conflict resolution paradigm. *Journal of Studies on Alcohol and Drugs*, *75*(2), 249–258.

404 Heinz, A. J., Wu, J., Witkiewitz, K., Epstein, D. H., & Preston, K. L. (2009). Marriage and relationship closeness as predictors of cocaine and heroin use. *Addictive Behaviors*, *34*(3), 258–263.

405 McKee, L. G., Bonn-Miller, M. O., & Moos, R. H. (2011). Depressive symptoms, friend and partner relationship quality, and posttreatment abstinence. *Journal of Studies on Alcohol and Drugs*, *72*(1), 141–150.

406 Choenni, V., Hammink, A., & van de Mheen, D. (2017). Association between substance use and the perpetration of family violence in industrialized countries: A systematic review. *Trauma, Violence, & Abuse*, *18*(1), 37–50.

407 Gilchrist, G., Radcliffe, P., Noto, A. R., & d'Oliveira, A. F. P. L. (2017). The prevalence and factors associated with ever perpetrating intimate partner violence by men receiving substance use treatment in Brazil and England: A cross-cultural comparison. *Drug and Alcohol Review*, *36*(1), 34–51.

408 Castaldelli-Maia, J. M, & Bhugra, D. (2014). Investigating the interlinkages of alcohol use and misuse, spirituality and culture: Insights from a systematic review. *International Review of Psychiatry*, *26*(3), 352–367.

409 Freisthler, B., & Maguire-Jack, K. (2015). Understanding the interplay between neighborhood structural factors, social processes, and alcohol outlets on child physical abuse. *Child Maltreatment*, *20*(4), 268–277.

Additionally, studies show that living in disadvantaged circumstances often amplifies the negative impact of substance misuse problems. For example, epidemiological studies involving the prevalence of alcohol disorders show that alcohol use contributes to socioeconomic health inequities, with greater harm per litre of alcohol occurring among individuals living in disadvantaged circumstances than those living in more affluent areas.[410,411]

Studies also show that rates of substance misuse problems are directly correlated with **drug and alcohol availability**.[412,413] These substances are often easier to obtain in disadvantaged communities, through the criminal sale of illegal drugs and higher densities of alcohol retailers. Studies show that the density of on- and off-premises alcohol outlets consistently predicts higher rates of substance misuse, community violence and child maltreatment.[414,415] In particular, higher densities of off-premises outlets are associated with increases in reported cases of child physical abuse, while higher densities of bars and pubs predicts increases in physical abuse and child neglect.[416,417]

Societal and cultural risks

Rates of substance misuse problems are highly correlated with societal norms relating to the availability of substances and the permissibility of their use.[418] In this respect, high-income countries with western populations consistently have higher rates of substance misuse in comparison to low-income countries or non-western populations. It is assumed that this increase in prevalence is due to a variety of factors that include heritable characteristics, the availability of drugs and alcohol, and relaxed public attitudes towards their recreational use.[419]

6.3 Interventions with evidence of preventing and stopping parental substance misuse and reducing its negative impact on children

As noted in the previous section, harmful parental substance misuse can create significant problems for children even when it does not reach the thresholds for dependent use. Additionally, substance misuse problems are often deeply entrenched before individuals

410 Degenhardt, L., Charlson, F., Ferrari, A., Santomauro, D., Erskine, H., Mantilla-Herrara, A., ... & Vos, T. (2018). The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet Psychiatry*, *5*(12), 987–1012.

411 World Health Organization. (2019). *Global status report on alcohol and health 2018*.

412 Freisthler, B., & Wolf, J. P. (2016). Testing a social mechanism: Does alcohol outlet density moderate the relationship between levels of alcohol use and child physical abuse? *Violence and Victims*, *31*(6), 1080–1099.

413 Wolf, J. P., Ponicki, W. R., Kepple, N. J., & Gaidus, A. (2016). Are community level prescription opioid overdoses associated with child harm? A spatial analysis of California zip codes, 2001–2011. *Drug and Alcohol Dependence*, *166*, 202–208.

414 Ransome, Y., Luan, H., Shi, X., Duncan, D. T., & Subramanian, S. V. (2019). Alcohol outlet density and area-level heavy drinking are independent risk factors for higher alcohol-related complaints. *Journal of Urban Health*, *96*(6), 889–901.

415 Campbell, C. A., Hahn, R. A., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., ... & Task Force on Community Preventive Services. (2009). The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *American Journal of Preventive Medicine*, *37*(6), 556–569.

416 Morton, C. M., Simmel, C., & Peterson, N. A. (2014). Neighborhood alcohol outlet density and rates of child abuse and neglect: Moderating effects of access to substance abuse services. *Child Abuse & Neglect*, *38*(5), 952–961.

417 Marco, M., Gracia, E., López-Quílez, A., & Freisthler, B. (2019). Child maltreatment and alcohol outlets in Spain: Does the country drinking culture matters? *Child Abuse & Neglect*, *91*, 23–30.

418 Casswell, S., Huckle, T., Wall, M., Parker, K., Chaiyasong, S., Parry, C. D., ... & Piazza, M. (2018). Policy-relevant behaviours predict heavier drinking and mediate the relationship with age, gender and education status: Analysis from the International Alcohol Control Study. *Drug and Alcohol Review*, *37*, S86–S95.

419 Morgenstern, M., Sargent, J. D., Sweeting, H., Faggiano, F., Mathis, F., & Hanewinkel, R. (2014). Favourite alcohol advertisements and binge drinking among adolescents: A cross-cultural cohort study. *Addiction*, *109*(12), 2005–2015.

are willing to accept the need for treatment.[420] For this reason, parental substance misuse problems are difficult to detect and treat, and relapse is a common problem.

Given these challenges, public health bodies encourage countries to implement aggressive preventive substance misuse strategies, to reduce rates of dependent use. For example, the World Health Organization introduced the 'SAFER' initiative in 2011 to help countries developing effective strategies for preventing dependent substance misuse and related deaths.[421] SAFER is an acronym for:

1. **Strengthening** restrictions on alcohol availability
2. **Advancing** and enforcing drink driving counter measures
3. **Facilitating** access to screening, brief interventions and treatment
4. **Enforcing** bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
5. **Raising** prices on alcohol through excise taxes and pricing policies.

Studies consistently show that these five strategies, offered in isolation or in combination, can measurably reduce alcohol/drug consumption and prevent substance misuse-related disease and death at the population level. Strategies 1, 3 and 5 also have specific evidence of reducing family violence and rates of child maltreatment, as we describe in the following sections.

It is worth noting that much of the evidence for public health strategies for preventing substance misuse was gathered between 1995 and 2010, when the strategies were first implemented. Scholars believe that this contributed to marked decreases in drug and alcohol consumption over this period, particularly among adolescents.[422] However, these reductions have ceased since 2010, with some studies showing that harmful levels of alcohol use, in particular, may be on the rise.[423] This is especially true in European countries, where rates of harmful drinking have always been high in comparison to other countries. The WHO attributes these rates to failures in implementing the SAFER strategies.

In the sections below, we consider how strategies 1, 3 and 5, combined with evidence-based treatments, might reduce substance misusing behaviours and decrease the prevalence of child maltreatment (see also interventions table 5).

Universal support

Taxation and minimum unit pricing of alcohol

Studies consistently show that raising the price of alcohol through taxation or minimum unit pricing reliably reduces rates of harmful drinking and alcohol-related deaths.[424] Studies have also convincingly linked alcohol taxation policies to reductions in community violence, interpersonal violence, domestic abuse and child maltreatment. For example, a modest (10%) increase in beer prices (through taxation) is associated with a 2% decrease in child abuse.[425]

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420 Rehm, J., Allamani, A., Della Vedova, R., Elekes, Z., Jakubczyk, A., Landsmane, I., ... & Wojnar, M. (2015). General practitioners recognizing alcohol dependence: A large cross-sectional study in 6 European countries. *The Annals of Family Medicine*, *13*(1), 28–32.

421 See: https://www.who.int/initiatives/SAFER

422 Looze, M. D., Raaijmakers, Q., Bogt, T. T., Bendtsen, P., Farhat, T., Ferreira, M., ... & Pickett, W. (2015). Decreases in adolescent weekly alcohol use in Europe and North America: Evidence from 28 countries from 2002 to 2010. *The European Journal of Public Health*, *25*(2), 69–72.

423 World Health Organization. (2019). *Status report on alcohol consumption. Harm and policy responses in 30 European Countries*.

424 Chisholm, D., Moro, D., Bertram, M., Pretorius, C., Gmel, G., Shield, K., & Rehm, J. (2018). Are the 'best buys' for alcohol control still valid? An update on the comparative cost-effectiveness of alcohol control strategies at the global level. *Journal of Studies on Alcohol and Drugs*, *79*(4), 514–522.

425 Casswell, S., Huckle, T., Wall, M., Parker, K., Chaiyasong, S., Parry, C. D., ... & Piazza, M. (2018). Policy-relevant behaviours predict heavier drinking and mediate the relationship with age, gender and education status: Analysis from the International Alcohol Control Study. *Drug and Alcohol Review*, *37,* S86–S95.

Population-wide drug and alcohol screening

Biomarkers of dependent substance misuse exist for most substances (including alcohol, opioids and cannabis), although the thresholds indicating problematic use are typically high.[426] This makes it difficult to diagnose problematic levels of substance misuse that are not yet detectable through biomarkers.

There is extensive evidence from a range of countries that screening tools, coupled with simple advice from healthcare workers, can prevent problematic drinking from escalating among individuals who are not severely dependent.[427] Examples of these screening measures include the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C), whereby health providers ask a series of questions regarding the nature of alcohol use during routine care.[428] Responses to these questions are then either followed by brief advice about harmful levels of use, or a referral to a specialist substance misuse service for a full assessment if warranted.[429]

Universal screening practices are associated with increased rates of safe drinking (in other words, within the recommended limits), with one study showing increases of 14% among young adults.[430] While this effect is modest, it is nevertheless useful for reducing harmful and dependent rates of drinking at the population level. The impact of universal screening is more dramatic among pregnant women, with studies showing that brief advice more than doubles the rates of abstinence during pregnancy.[431]

The extent to which alcohol screening during pregnancy reduces rates of child maltreatment has not been specifically tested, however. Nevertheless, screening, leading to treatment of harmful/dependent alcohol use is recommended as a promising strategy for reducing rates of foetal alcohol syndrome.[432] Universal screening also has the potential to reduce rates of child abuse and neglect if it increases access to the evidence-based treatments described in later parts of this chapter.

Targeted selected interventions

Reducing alcohol-outlet density in high-risk communities

As mentioned previously, rates of harmful drug and alcohol use increase when these substances are easier to access through the sale of illegal drugs or high densities of on- and off-premises alcohol outlets. The density of on- and off-premises alcohol outlets also parallels rates of child abuse and neglect.[433]

Studies consistently show that rates of abuse and neglect can be reduced by regulating outlet density, particularly in areas where rates of child maltreatment are high. For example, one US-

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426 Barrio, P., Wurst, F. M., & Gual, A. (2018). New alcohol biomarkers. New challenges. *Alcohol and Alcoholism*, *53*, 762–63.

427 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 and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*, *320*(18), 1899–1909.

428 Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., Bradley, K. A., & Ambulatory Care Quality Improvement Project. (1998). The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. *Archives of Internal Medicine*, *158*(16), 1789–1795.

429 National Institute for Health and Clinical Excellence. (2011). *Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence*.

430 Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D., & Humphreys, K. (2012). Drug policy and the public good: Evidence for effective interventions. *The Lancet*, *379*(9810), 71–83.

431 World Health Organization. (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf;jsessionid=528480BDEF513AE9130A22E5EB1C182E?sequence=1

432 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 and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*, *320*(18), 1899–1909.

433 Campbell, C. A., Hahn, R. A., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., ... & Task Force on Community Preventive Services. (2009). The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *American Journal of Preventive Medicine*, *37*(6), 556–569.

based study observed that modest reductions in outlet density (involving the removal of one outlet per 1,000 persons) reduced the prevalence of physical abuse towards children by 4%.[434]

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. In this section, we discuss the evidence underpinning interventions targeting adults with substance misuse problems, regardless of whether they are parents. While many of these treatments have evidence for improving adult outcomes, it is important to emphasise that their benefits to children remain untested.[435] As we have already noted, it is unlikely that these interventions are sufficient for providing benefits for children, as they do not specifically address the parenting impairments that frequently co-occur with parental substance misuse problems.[436]

Twelve-step facilitation interventions (TSFIs)

Twelve-step facilitation interventions (TSFIs) are perhaps the most widely implemented therapeutic response to adult substance misuse problems. TSFIs originate from the original Alcoholics Anonymous model developed by Bill Wilson in 1935. The aim of the model was to help addicted individuals maintain sobriety by working through 12 steps, which first acknowledged their powerlessness over alcohol and then provided strategies for addressing personal failings and increasing spirituality. The model is not aligned to any specific religion but is informed by Wilson's own religious beliefs, which he believed assisted his personal recovery.[437]

Wilson's original model was intended as a group-based intervention that was maintained by volunteers who were also recovering alcoholics. The aim of the group was to remove the stigma associated with alcohol addiction as members worked through the 12 steps. Members also received sponsorship from recovered alcoholics who provided individual support for managing cravings and negative emotions as they tried to achieve total abstinence. A primary aim of the model was to provide a sense of belonging in order to reduce the feelings of shame, guilt and loneliness that are common among dependent substance users. It is also thought that recovered members offer hope to those still struggling with addiction, as living examples that addictions can be overcome.

The model proved to be relatively popular and had over 2 million members by the mid-1950s. Narcotics Anonymous was then also established to meet the needs of individuals addicted to heroin and other addictive substances.

While the original AA model was not manualised, manuals have since been developed to inform its delivery in various settings. For example, the Minnesota (or Hazelden) model was developed in the 1950s to ensure consistent delivery of AA within in-patient detoxification and long-term rehabilitation units.[438] Various forms of cognitive behavioural therapy (CBT) have also been developed to augment the original AA model or to provide an alternative set of 12 steps for individuals who might resist AA because of its spiritual components.[439]

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434 Markowitz, S., & Grossman, M. (1998). Alcohol regulation and domestic violence towards children. *Contemporary Economic Policy*, *16*(3), 309–320.

435 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.

436 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*.

437 Gross, M. (2010). Alcoholics Anonymous: Still sober after 75 years. *American Journal of Public Health*, *100*(12), 2361–2363.

438 Anderson, D. J., McGovern, J. P., & DuPont, R. L. (1999). The origins of the Minnesota model of addiction treatment: A first person account. *Journal of Addictive Diseases*, *18*(1), 107–114.

439 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*.

The evidence underpinning AA and other 12-step models has a history of controversy. This is because the AA organisation originally resisted rigorous evaluation, and there was some evidence suggesting the model had the potential to cause harm.[440] However, a 2020 Cochrane review concluded that TSFIs, based on the original AA model, are effective for increasing total abstinence, and that effectiveness is enhanced when the programme is manualised or offered through clinical support.[441]

The review also observed that treatment outcomes improved when there was active clinical referral and management, and attendance was explicitly 'prescribed', rather than offered to clients as a choice. Additionally, 12-step attendees were more likely to achieve total abstinence in comparison to individuals participating in other evidence-based treatments, including CBT.

It is worth noting that studies also show that the effectiveness of TSFIs can be enhanced by augmenting it with motivational interviewing.[442] Motivational interviewing is a brief, goal-focused form of therapy aimed at helping individuals overcome ambivalence towards positive behaviour change. Motivational interviewing has strong evidence of helping individuals to overcome substance dependency by increasing their engagement in 12-step interventions. However, motivational interviewing is not a standalone intervention, meaning that it does not have evidence of improving child or parent outcomes in the absence of TSFIs or other evidence-based support.[443]

It should be emphasised that TSFIs, with or without motivational interviewing, are not a 'cure' for substance misuse problems. Failure rates remain high and recovery periods can be long, marked by frequent episodes of relapse. Nevertheless, there is convincing evidence that TSFIs are effective in comparison to no treatment at all and other established therapies.

Cognitive behavioural therapy

Studies show that cognitive behavioural therapy is effective for helping individuals to manage substance use problems, with specific evidence of reducing use and increasing rates of abstinence.[444]

CBT provides individuals with strategies for managing cravings and the negative emotions that often occur during periods of withdrawal.[445] It does not include a spiritual component, so is viewed by some as preferrable to TSFIs for individuals who may resist the religious character of the AA/NA philosophy. However, recent studies have verified that TSFIs are equally effective for religious and non-religious participants and achieve superior outcomes in comparison to CBT. Researchers speculate that the fellowship elements of TSFI models may be an active ingredient in helping individuals to maintain abstinence over time.

Pharmaceutical treatments

Pharmaceutical treatments are increasingly prescribed to help individuals to overcome alcohol use problems. These treatments include acamprosate, which facilitates the

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440 Emrick, C. D., & Beresford, T. P. (2016). Contemporary negative assessments of alcoholics anonymous: A response. *Alcoholism Treatment Quarterly*, *34*(4), 463–471.

441 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*.

442 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.

443 Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy*, *37*(2), 129–140.

444 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.

445 McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics*, *33*(3), 511–525.

detoxification process by mitigating the symptoms of the withdrawal.[446,447] Acamprosate is therefore used at initial stages of substance misuse treatment but is not viewed as suitable for helping individuals to achieve abstinence.

Disulfiram is also sometimes prescribed as a short-term measure to stop individuals from drinking. Disulfiram does this by making individuals extremely ill (by inducing vomiting and diarrhoea) within 10 minutes of drinking alcohol. Disulfiram is therefore considered an effective method for stopping substance misuse in the short term. However, it does not reduce symptoms of cravings, so it is common for individuals to relapse after they stop using the drug.

Nalmefene and naltrexone are opioid antagonists that assist addiction recovery by inhibiting the short-term positive effects, or 'high', experienced when individuals drink alcohol or use opiates. The absence of this high reduces the individual's desire for the substance and facilitates the management of cravings. It does not, however, provide individuals with strategies for managing the difficult emotions that occur during periods of withdrawal, so is generally not considered to be adequate in the absence of other therapies.

Collectively, pharmaceutical treatments are considered useful for reducing substance misuse problems when combined with other treatments. However, the effects of pharmaceutical treatments are modest and comparable to those achieved by TFSIs and other forms of therapy.[448]

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. In this section, we describe the evidence underpinning three interventions identified by other What Works clearinghouses as having causal evidence. However, the evidence underpinning these interventions has not yet undergone assessment for the EIF Guidebook.

Behavioural couples therapy combined with the Helping the Noncompliant Child parenting programme

As described previously, CBT has consistent evidence of helping individuals to manage the cravings and difficult thoughts that frequently occur when recovering from substance misuse problems. Behavioural couples therapy (BCT) incorporates CBT strategies to help couples to manage conflict and improve communication.[449] BCT was originally developed to support couples where one partner was suffering from depression, but some of its strongest impacts have been observed when it is offered to couples where one or both partners have a substance misuse problem.[450]

BCT typically begins at the point when one partner seeks help for an addiction. In the early phases of treatment, the couple is introduced to the 'recovery contract', which provides the couple with a framework within which they reward each other for recovery efforts. Progress is then monitored by a clinical psychologist, who meets with the couple on a weekly basis for a period of three to six months. Each partner with a substance misuse problem also receives additional CBT support through individual therapy.[451]

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

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

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

449 Fischer, D. J., & Fink, B. C. (2014). Clinical processes in behavioral couples therapy. *Psychotherapy*, *51*(1), 11.

450 McCrady, B. S., Wilson, A. D., Muñoz, R. E., Fink, B. C., Fokas, K., & Borders, A. (2016). Alcohol-focused behavioral couple therapy. *Family Process*, *55*(3), 443–459.

451 O'Farrell, T. J., & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse*. Guilford Press.

BCT has consistent RCT evidence of reducing levels of substance use, increasing rates of abstinence and improving couple relationship satisfaction.[452] BCT additionally has evidence of reducing child maltreatment risk when combined with the Helping the Noncompliant Child (HNC) parenting intervention.[453] HNC is a 12-week PMT intervention (see chapter 2) providing individual parents or couples with strategies for discouraging negative child behaviour and reducing coercive family interactions. It is listed on the EIF Guidebook with level 3 evidence of improving child outcomes.[454] Further information about HNC and its evidence is provided in interventions table 1.

Parents Under Pressure

Parents Under Pressure (PUP) is an intervention for parents with a child aged 30 months or younger. It primarily targets mothers receiving methadone maintenance for heroin addiction but has also been used with fathers and mothers struggling with alcohol misuse problems. The programme includes specific therapeutic components to help parents to better regulate their emotions, manage stressful environments and respond more sensitively to the needs of their child. The programme is delivered by a licensed psychologist to parents individually in their homes via 10 1.5-hour sessions (called 'modules') that take place weekly over a 10–12-week period. Additional case management may also occur alongside the module sessions, depending upon the parents' needs.[455]

The first module begins by exploring the parent's view of themselves as a parent, and encourages them to identify personal parenting strengths and positive child behaviours. Additional modules are then consecutively introduced and remain as themes that are reinforced in each subsequent session. Daily, child-focused playtimes are scheduled to improve the parent–child relationship, and mindfulness techniques are taught to help mothers learn how to better regulate their emotions. The programme additionally aims to improve social networks by helping families to reconnect to their local community.

The PUP programme has evidence from two RCTs (one completed in the UK) demonstrating reductions in parental substance misuse behaviours, improvements in the parent–child relationship, and reduced child maltreatment risk.[456,457] Further detail about Parents Under Pressure is provided in case example D.

Families Facing the Future

Families Facing the Future (FFF) is a programme for parents who have a child between the age of 5 and 12 and are undergoing methadone treatment. The programme begins with a five-hour retreat (attended by the entire family), followed by twice-weekly 90-minute training sessions attended by the substance misusing parents and their children for 16 weeks. These training sessions cover positive family management strategies based on social learning principles, including the use of positive and negative reinforcement, appropriate monitoring and limit-setting, methods for managing antisocial behaviour, and improving family communication.

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452 McCrady, B. S., Wilson, A. D., Muñoz, R. E., Fink, B. C., Fokas, K., & Borders, A. (2016). Alcohol-focused behavioral couple therapy. *Family Process*, *55*(3), 443–459.

453 Lam, W. K., Fals-Stewart, W., & Kelley, M. L. (2008). Effects of parent skills training with behavioral couples therapy for alcoholism on children: A randomized clinical pilot trial. *Addictive Behaviors*, *33*(8), 1076–1080.

454 Dawe S, Harnett P. J. (2007). Reducing child abuse potential in methadone-maintained parents: Results from a randomised controlled trial. *Journal of Substance Misuse Treatment*, *32*, 381–390.

455 Harnett, P. H., Dawe, S. (2012). The contribution of mindfulness-based therapies for children and families and proposed conceptual integration. *Child and Adolescent Mental Health*, *17* (4), 195–208.

456 Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*, *32*(4), 381–390.

457 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 and Alcohol Dependence*, *194*, 184–194.

The intervention's strongest evidence comes from a single RCT which observed short-term improvements in parents' use of cocaine and the implementation of family routines. However, the study's most interesting findings were observed 15 years later, when significant decreases in substance misuse behaviours were observed among the sons of the FFF family participants.[458]

Edge of care

Parental substance misuse frequently poses a strong risk to children's welfare, and in many cases children will need to be temporarily removed from parental care until their substance misuse problems are fully under control. Factors which inform out-of-home placement include the severity of parents' substance misuse problem, the extent to which one or both parents are struggling with addiction issues, and the child's age, with younger children being at greater risk of serious harm.[459]

The EIF Guidebook currently does not list any interventions with evidence for improving child outcomes where one or both parent has a substance misuse problem. However, Multisystemic Therapy – Building Stronger Families (MST-BST) has recently published results from a rigorously conducted RCT, as described below.

Multisystemic Therapy – Building Stronger Families (MST-BST)

MST-BST combines the core components of the MST-CAN programme (see case example B) with reinforcement-based treatment (RBT) for substance misuse. RBT is an integrative approach to case management (based on the community reinforcement approach) which uses motivational interviewing to help adults to develop and adhere to a plan aimed at achieving total abstinence from drugs and alcohol.[460] This plan typically includes CBT support combined with voucher incentives to help adults maintain abstinence from illegal drugs and alcohol. Children are also offered Trauma-focussed CBT if they are experiencing symptoms of trauma, and parents receive couples therapy.

Families are enrolled in the programme after undergoing a rigorous safety planning assessment. If the misuse involves physical dependency, treatment begins with a short-term inpatient detoxification, followed by medically assisted treatment. All family members then participate in the MST-CAN programme, while parents also attend a two-hour weekly relapse prevention group. Couples therapy and TF-CBT are also available if needed.

The intervention includes at least three urine drug screens (UDS) that are conducted in the home. The results of these screens are then fed back to parents through discussions which chart the UDS outcomes, reinforce the original behavioural contract, and include relapse prevention planning when necessary. A variety of rewards are provided when UDS tests are negative, such as ceremonies, peer and family praise, and small monetary vouchers.

Additionally, all family members engage in maltreatment clarification/healing activities to prevent blame of the child for involvement with child protection services, and to address other unhelpful thinking by the parents contributing to child maltreatment. The clarification/healing process culminates in a formal family meeting in which the caregiver takes responsibility for the substance misuse and maltreatment, and extends an apology to the children and other family members.

MST-BST has recently undergone a rigorous RCT, observing reductions in parent-reports of substance misuse and improvements in child-reports of neglectful parenting behaviours

458 Haggerty, K. P., Skinner, M., Fleming, C. B., Gainey, R. R., & Catalano, R. F. (2008). Long-term effects of the Focus on Families project on substance use disorders among children of parents in methadone treatment. *Addiction*, *103*(12), 2008–2016.

459 Brown, R., & Ward, H. (2012). *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*. The Childhood Wellbeing Research Center.

460 Fazzino, T. L., Bjorlie, K., & Lejuez, C. W. (2019). A systematic review of reinforcement-based interventions for substance use: Efficacy, mechanisms of action, and moderators of treatment effects. *Journal of Substance Abuse Treatment*, *104*, 83–96.

18 months after initial referral.[461] The intervention also observed reductions in out-of-home placements, although these were not statistically significant from those observed in the comparison group. This may be because the follow-up period was initially short (nine months) and the comparison group was also receiving a comprehensive package of community-based support and case management.

CASE EXAMPLE D: PARENTS UNDER PRESSURE

A parent was abused as a child and is care-experienced. They have previously had a child taken into care. They now have a second child aged 2. They have previously suffered with drug addiction and have relapsed. The parent argues frequently with their partner.

Before treatment can be determined, a detailed family assessment must take place to understand the current risks to the child. Given the child's age and the parent's previous history, out-of-home placement should be strongly considered. Studies consistently show that young children with a substance misusing parent are particularly vulnerable, and so out-of-home care may be the best option until one or both parents can achieve abstinence for a substantial period of time.[462] In this example, the history of the child previously taken into care should also be carefully scrutinised.

If it is determined that the child can remain safe while under the parents' care, then the PUP intervention may be an option. Parents are not eligible for the programme, however, if there is evidence of domestic abuse, and the child must be 30 months or younger.

As described above, PUP is delivered through 12 modules that provide parents with strategies for managing and overcoming their substance misuse problems, dealing with stressful life situations, and engaging positively with their child. The parents' 'capacity for change' is assessed and closely monitored as they complete each module.[463]

An assessment of capacity-to-change includes:

- Carrying out a cross-sectional assessment of the parents' current functioning, using validated measures and the practitioner's professional judgment.
- Specifying with the parent a set of achievable targets for change. The Goal Attainment Scale was developed specifically to help the practitioner and parent identify small, achievable goals that the parent can then work towards within the course of the PUP intervention.
- Implementing an intervention with proven efficacy with parents of similar characteristics – in this case, the PUP intervention.
- Objective measurement of progress over time, including evaluation of the parents' willingness to engage and cooperate with the intervention and the extent to which targets were achieved. Studies show that behaviours involving disguised compliance are more frequent in cases where child maltreatment is a risk.[464]

461 Schaeffer, C. M., Swenson, C. C., & Powell, J. S. (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*, 105379.

462 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.

463 Harnett, P. H. (2007). A procedure for assessing parents' capacity for change in child protection cases. *Children and Youth Services Review*, *29*(9), 1179–1188.

464 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. & Black, J. (2009). *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005–07*. Department for Children, Schools and Families.

If there is evidence that the parent is achieving small goals leading to behaviour change, it may then be safe for the child to remain with the parents. However, as mentioned previously, overcoming substance misuse problems is challenging for many individuals, and capacity for change may not be achieved within the course of the PUP treatment or within a timeframe that is safe for a very young child. In these instances, practitioners must be prepared to conclude that the child will need to be removed from the parents' care until their substance misuse problems are fully managed and it is clear they are able to participate in and benefit from parenting support.

Interventions table 5

Interventions with evidence of preventing and treating parental substance misuse and improving child outcomes

Name	Description	Key features*	Evidence	Workforce
Universal prevention				
Screening and advice during pregnancy FIND OUT MORE NICE GUIDANCE (CG192): ANTENATAL AND POSTNATAL MENTAL HEALTH: CLINICAL MANAGEMENT AND SERVICE GUIDANCE FIND OUT MORE NICE GUIDANCE (CG115): ALCOHOL-USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING (HIGH-RISK DRINKING) AND ALCOHOL DEPENDENCE	Universal screening for substance misuse with the AUDIT-C during a mother's pregnancy, leading to evidence-based treatments and detoxification when necessary. Current NICE guidelines recommend that pregnant mothers be asked about their alcohol and substance use on a regular basis and advised not to drink. Practitioners are also encouraged to use the AUDIT-C to screen for problematic alcohol use if is it suspected.	Child age: All ages Need: Universal Model: Screening Available in the UK? Yes Evaluated in the UK? Not known	The equivalent of level 3 evidence of reducing problematic alcohol use in the general population, and increasing total abstinence during pregnancy among non-misusing mothers. Promising evidence of reducing foetal alcohol syndrome in mothers where there is a known risk.	Healthcare providers.
Taxation and minimum unit pricing of alcohol FIND OUT MORE BONIFACE, S. ET AL. (2017). EVIDENCE FOR THE EFFECTIVENESS OF MINIMUM PRICING OF ALCOHOL... BMJ OPEN, 7(5), E013497	Taxes and laws aimed at limiting alcohol and cigarette consumption by increasing its cost.	Child age: All ages Need: Universal Model: Taxation & pricing strategies Available in the UK? Yes Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews showing that taxation reduces alcohol consumption in casual users and heavy drinkers.	National policies.

* Information on interventions as being available or evaluated in the UK is based on desk research at the time of publication, and may be subject to change. Please check with intervention providers for further detail on availability and past evaluations.

Name	Description	Key features	Evidence	Workforce
Targeted selected				
Reducing alcohol outlet density at the neighbourhood level FIND OUT MORE CAMPBELL, C. A. ET AL. (2009). THE EFFECTIVENESS OF LIMITING ALCOHOL OUTLET DENSITY... AMERICAN JOURNAL OF PREVENTIVE MEDICINE, 37(6), 556–569	Restrictions on alcohol outlet density in residential neighbourhoods with high levels of domestic abuse, child abuse and neglect.	Child age: All ages Need: Selected Model: Off-licence availability Available in the UK? Not known Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews showing reductions in child maltreatment after restrictions are introduced.	Local policies based on community data.
Targeted indicated				
Adult treatments				
Cognitive behavioural therapy (CBT) (for substance misuse) FIND OUT MORE NICE GUIDANCE (CG115): ALCOHOL-USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING (HIGH-RISK DRINKING) AND ALCOHOL DEPENDENCE	Cognitive behavioural therapy for substance misuse helps to manage cravings as well as negative moods and emotions leading to substance misuse.	Target group: Adults Need: Indicated Model: Individual therapy Available in the UK? Yes Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews showing reductions in substance misuse, although recent evidence suggests this may not be as strong as 12-step programmes.	Originally developed to be delivered by a clinical psychologist, but clinicians with lower qualifications have now successfully administered it and some versions can be self-administered.
Detoxification FIND OUT MORE NICE GUIDANCE (CG115): ALCOHOL-USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING (HIGH-RISK DRINKING) AND ALCOHOL DEPENDENCE	In-patient care to reduce alcohol/opiate intake to reduce life-threatening withdrawal symptoms.	Target group: Addicted adolescents and adults Need: Indicated Model: In-patient care Available in the UK? Yes Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews of reducing alcohol/substance misuse in the short-term; less effective as a long-term solution for reducing relapse.	Healthcare providers/ substance misuse specialists.

Name	Description	Key features	Evidence	Workforce
Pharmaceutical treatments FIND OUT MORE NICE GUIDANCE (CG115): ALCOHOL-USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING (HIGH-RISK DRINKING) AND ALCOHOL DEPENDENCE	Drugs that either reduce substance misuse cravings, limit the effects of alcohol or cause gastrointestinal illness when alcohol is used.	Target group: 18+ Need: Indicated Model: Prescription Available in the UK? Yes Evaluated in the UK? Not known	Growing RCT and systematic review evidence showing that pharmaceutical treatments are highly effective for some individuals.	GP or psychiatrist.
Twelve-step facilitated interventions (TSFIs) FIND OUT MORE KELLY, J. F. ET AL. (2020). ALCOHOLICS ANONYMOUS AND OTHER 12-STEP PROGRAMS FOR ALCOHOL USE DISORDER. COCHRANE DATABASE OF SYSTEMATIC REVIEWS, (3)	Individuals attend group sessions as needed (potentially daily) and are assigned a mentor to work through 12 steps aimed at achieving total abstinence from alcohol and other substances.	Target group: Addicted adults Need: Indicated Model: Group based with individual support Available in the UK? Yes Evaluated in the UK? Not known	Robust evidence from several recent RCTs, summarised in a recent Cochrane review.	Healthcare combined with voluntary support.
TSFIs combined with motivational interviewing FIND OUT MORE KELLY, J. F. ET AL. (2020). ALCOHOLICS ANONYMOUS AND OTHER 12-STEP PROGRAMS FOR ALCOHOL USE DISORDER. COCHRANE DATABASE OF SYSTEMATIC REVIEWS, (3) FIND OUT MORE MOTIVATIONAL INTERVIEWING ON THE TITLE IV-E PREVENTION SERVICES CLEARINGHOUSE	Motivational interviewing is combined with 12-step treatments to increase motivation and attendance.	Target group: Addicted adults Need: Indicated Model: Individual Available in the UK? Yes Evaluated in the UK? Not known	Consistent evidence from multiple systematic reviews showing that motivational interviewing increases retention and adherence in 12-step programmes. The evidence for motivational interviewing is in combination with other treatments, so is not a standalone treatment.	Specialist trained healthcare providers or keyworkers.

Name	Description	Key features	Evidence	Workforce
Treatments for parents and families				
Behavioural couples therapy for alcohol and substance misuse FIND OUT MORE NICE GUIDANCE (CG115): ALCOHOL-USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING (HIGH-RISK DRINKING) AND ALCOHOL DEPENDENCE	Behavioural couples therapy is only suitable if the couple is in a cohabitating relationship and only one partner has a substance misuse problem. Couples attend 12 to 20 weekly sessions where they learn strategies for improving communication and reducing conflict. A key element is that the non-misusing partner learns how to reinforce non-misusing behaviours. Behavioural couples can be combined with the Helping the Noncompliant Child parenting intervention (see interventions table 1).	Child age: All ages Need: Indicated Model: Couples therapy Available in the UK? Not known Evaluated in the UK? No	Level 3 evidence of long-term reductions in substance misuse and related problems, improved couple communication and satisfaction. Improvements in child wellbeing and behaviour when the programme is combined with parenting intervention.	Clinical psychologists or social workers with a substance misuse specialty.
Child First FIND OUT MORE CHILD FIRST ON THE EIF GUIDEBOOK	A 12-month home visiting intervention combining Child-Parent Psychotherapy with other forms of social support to reduce the risk of child maltreatment in vulnerable families with young children.	Child age: 6–36 months Need: Indicated Model: Individual home visiting Available in the UK? No Evaluated in the UK? No	Child First does not have specific evidence of reducing substance misusing behaviours. It has level 3 evidence of four-fold reductions in child behavioural problems and a two-fold reduction in reports of child maltreatment at a three-year follow-up. Also, a three-fold reduction in parenting stress and four-fold reduction in symptoms of psychopathology at a 12-month follow-up.	Delivered by one clinician with QCF-7/8 level qualifications and one care coordinator with QCF-6 level qualifications.
Families Facing the Future (FFF) FIND OUT MORE FAMILIES FACING THE FUTURE ON THE TITLE IV-E PREVENTION SERVICES CLEARINGHOUSE	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.	Child age: All ages Need: Indicated Model: Group and individual therapy combined with methadone treatment Available in the UK? Yes Evaluated in the UK? Yes	Level 3 evidence of reducing parental substance misusing behaviours. Impact on child wellbeing is less well established.	Case managers must have a master's degree as well as training in chemical dependency and parenting.
Parents Under Pressure (PUP) FIND OUT MORE BARLOW, J. ET AL. (2019). A RANDOMIZED CONTROLLED TRIAL AND ECONOMIC EVALUATION OF THE PARENTS UNDER PRESSURE PROGRAM FOR PARENTS IN SUBSTANCE ABUSE TREATMENT. DRUG AND ALCOHOL DEPENDENCE, 194, 184–194	Parents with a diagnosed substance misuse problem attend a 12-module programme aimed at reducing their substance misusing behaviours and improving parenting practices.	Child age: Up to 30 months Need: Indicated Model: Individual therapy combined with methadone treatment Available in the UK? Yes Evaluated in the UK? Yes	Evidence from two RCTs showing reductions in child abuse potential and substance misusing behaviours.	Methadone treatment overseen by a medical doctor combined with therapy provided by a clinical psychologist/ social worker.

Name	Description	Key features	Evidence	Workforce
Edge of care				
Multisystemic Therapy – Building Stronger Families (MST-BSF) FIND OUT MORE SCHAEFFER, C. M. ET AL. (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, 105379	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.	Child age: 6–17 years Need: Edge of care Model: Individual and family therapy Available in the UK? Yes Evaluated in the UK? No	Level 3 evidence of reducing parent self-reported alcohol and opiate use, and of improving child-reported neglectful parenting.	MST therapist/practitioner with QCF-6 level qualifications.

7. Improving the wellbeing of vulnerable children through a comprehensive public health approach

KEY POINTS

- Child maltreatment is multidetermined by risks existing at the level of the child, family, community and society. Comprehensive public health strategies targeting multiple levels of need are therefore necessary to stop and prevent child abuse and neglect.
- Child safety should remain at the heart of any public health effort aimed at preventing and stopping child maltreatment. However, it is also essential that these efforts support children's wellbeing more generally and reduce the impact of known risks. This means efforts should comprehensively support all domains of child development, especially children's physical, intellectual, self-regulatory, and social and emotional health.
- There is now clear evidence that public health efforts that involve scaling up evidence-based interventions measurably improve children's wellbeing and reduce pressure on the child welfare system. Long-term evaluations of scale-ups implemented in the early 2000s observed reductions in youth crime and repeat child protection cases that are directly associated with the scaling-up of evidence-based interventions. Additionally, there is clear evidence that the benefits from the scale-ups are sustainable over time and can lead to permanent improvements in rates of youth offending and the demand for children's social care services.
- These scale-ups are believed to be effective because they introduce interventions that provide value over and above routine care in terms of content and quality. There is also clear evidence that evidence-based interventions can bring about sustainable, positive changes to the standard of routine care.
- Interventions must fit within local systems, however, to add value that is measurable and sustainable. This fit is determined by the characteristics of the intervention and the wider system in which it will be embedded. Systems will frequently need to make changes to accommodate evidence-based interventions, although these changes often enhance the quality of the overall system.
- System improvements cannot be sustained unless there is a suitably qualified workforce to implement evidence-based interventions. Policies must therefore also be introduced to ensure that a sufficiently qualified workforce is available to ensure that high-quality services will remain available for all families, as and when they need them.

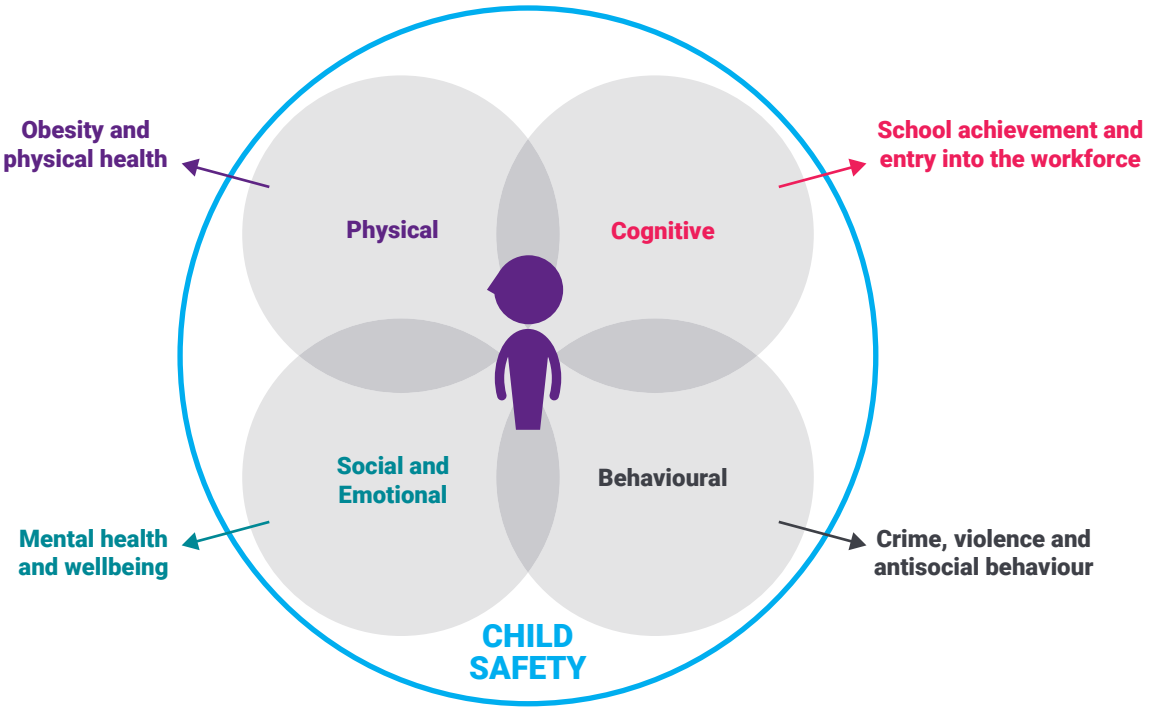
7.1 A focus on child wellbeing

In this report, we have described how child maltreatment is multidetermined by risks at the level of the child or other individual, family, community and society.[465] This means that no single intervention or policy will be sufficient to eradicate child maltreatment entirely, and that comprehensive public health approaches targeting multiple levels of need will always be necessary.[466,467]

A comprehensive public health approach requires system partners to work together to ensure the wellbeing of all children, with a particular focus on the most vulnerable.[468] This starts with a clear focus on child safety, but also targets child wellbeing in other important domains, encompassing children's physical health, cognitive development, self-regulatory capabilities and social and emotional security (see figure 7.1).[469,470]

FIGURE 7.1

Key domains of child wellbeing, underpinned by a focus on child safety



Effective support in each of these domains not only supports children's development from birth to age 18, but also helps to ensure that children will grow into adults who are healthy and happy contributors to society.

[465] Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry*, *56*(1), 96–118.

[466] Gilbert, R., Woodman, J., & Logan, S. (2012). Developing services for a public health approach to child maltreatment. *The International Journal of Children's Rights*, *20*(3), 323–342.

[467] Herrenkohl, T. I., Leeb, R. T., & Higgins, D. (2016). The public health model of child maltreatment prevention. *Trauma, Violence, & Abuse*, *17*(4), 363–365.

[468] Wulczyn, F., Daro, D., Fluke, J., Feldman, S., Glodek, C., & Lifanda, K. (2010). *Adapting a systems approach to child protection: Key concepts and considerations*. UNICEF.

[469] Conti, G., & Heckman, J. J. (2012). *The economics of child well-being* (NBER Working Paper 18466). National Bureau of Economic Research.

[470] Samuels, B. (2015). Reflections: Protective factor frameworks and public policy. In Daro, D., Donnelly, A. D., Huang, A. C., Powell, B. J. (Eds.), *Advances in Child Abuse Prevention Knowledge: The Perspective of New Leadership* (pp. 225–227). Springer.

The support provided through universal services is often adequate to meet the developmental needs of most children. However, highly vulnerable children frequently need additional support that is more intensive and tailored than what universal services can provide. A continuum of support is therefore necessary to keep known problems from getting worse, as well as preventing them from happening in the first place.

7.2 Generating system-wide benefits

There is now clear evidence that when a continuum of evidence-based family interventions is made available at scale, measurable population-wide benefits can be achieved. A case in point is the country of Norway, where a tiered system of evidence-based child and family support has been in place since 1999.[471] Originally set up to reduce pressure on the youth justice and child welfare systems, this continuum includes:

- brief parent management training (PMT) for families identified as needing it through schools or primary healthcare settings
- multi-tiered, school-based support aimed at preventing bullying, reducing problematic behaviour and improving academic attainment
- GenerationPMTO for families experiencing very serious difficulties with their child's behaviour
- MST, MST-CAN, FFT and TFCO-A for families where there is a documented case of child maltreatment or the child is involved in criminal or antisocial behaviour.

A series of RCTs conducted over the past 20 years have verified that Norway's approach consistently provides benefits for vulnerable children and parents. Child benefits include improved behaviour at home and at school, and reductions in youth crime. Parent benefits include reductions in family conflict, increased parenting satisfaction, and reductions in parental stress. Follow-up studies confirm that these benefits are not only sustainable for a year or longer but are replicable in diverse settings and populations.[472,473,474,475,476,477,478,479]

Monitoring data additionally shows that pressure on Norway's child welfare system has been measurably reduced over the past 20 years. For example, monitoring data from Norway's child welfare system in 2020 observed that of the 799 children receiving MST/MST-CAN/FFT/TFCO support, none required an out-of-home placement and only one recipient was involved in a crime. Additionally, 75–100% of children (depending on the region) receiving

471 Biglan, T., & Ogden, T. (2008). The evolution of evidence-based practices. *European Journal of Behavior Analysis*, *9*, 1–15.

472 Hagen, K. A., Ogden, T., & Bjørnebekk, G. (2011). Treatment outcomes and mediators of parent management training: A one-year follow-up of children with conduct problems. *Journal of Clinical Child & Adolescent Psychology*, *40*(2), 165–178.

473 Bjørknes, R., & Manger, T. (2013). Can parent training alter parent practice and reduce conduct problems in ethnic minority children? A randomized controlled trial. *Prevention Science*, *14*(1), 52–63.

474 Ogden, T., & Hagen, K. A. (2008). Treatment effectiveness of Parent Management Training in Norway: A randomized controlled trial of children with conduct problems. *Journal of Consulting and Clinical Psychology*, *76*(4), 607.

475 Akin, B. A., Lang, K., McDonald, T. P., Yan, Y., & Little, T. (2019). Randomized trial of PMTO in foster care: Six-month child well-being outcomes. *Research on Social Work Practice*, *29*(2), 206–222.

476 Akin, B. A., Lang, K., Yan, Y., & McDonald, T. P. (2018). Randomized trial of PMTO in foster care: 12-month child well-being, parenting, and caregiver functioning outcomes. *Children and Youth Services Review, 95*, 49–63.

477 Bjørnebekk, G., Kjøbli, J., & Ogden, T. (2015). Children with conduct problems and co-occurring ADHD: Behavioral improvements following parent management training. *Child & Family Behaviour Therapy*, *37*(1), 1–19.

478 Kjøbli, J., & Ogden, T. (2012). A randomized effectiveness trial of brief parent training in primary care settings. *Prevention Science*, *13*(6), 616–626.

479 Kjøbli, J., & Bjørnebekk, G. (2013). A randomized effectiveness trial of brief parent training: Six-month follow-up. *Research on Social Work Practice*, *23*(6), 603–612.

support remained in school and none were misusing substances throughout the year following treatment.[480,481,482]

Other places where evidence-based interventions have substantially improved the lives of vulnerable children include several US states. In Massachusetts, substantiated cases of child maltreatment significantly decreased once CPP and Trauma-focused CBT were offered through the child welfare system.[483] Similarly, South Carolina saw a drop in child protection cases in counties that were randomly assigned to implement the full continuum of Triple P parenting programmes.[484] Pennsylvania has also witnessed a notable decrease in youth crime and child welfare cases immediately after providing support to communities to select and implement evidence-based family interventions on the basis of local need.[485]

7.3 Evidence-based scale-ups in the UK

Evidence-based interventions have also been introduced at scale in the UK, with varying levels of success. For example, Incredible Years has undergone five UK trials since 2002, each confirming consistent and sometimes dramatic improvements in children's behaviour.[486,487,488,489,490] Findings from monitoring returns further confirm that these benefits are upheld when Incredible Years is offered through routine care, although they also reveal inconsistencies in the quality of Incredible Years' implementation and challenges in collecting monitoring data.[491]

Other findings are also mixed. While the initial trial of Family Nurse Partnership (FNP) did not reduce child maltreatment, it did observe improvements in FNP children's school performance at reception and year 2.[492] By contrast, the first UK trial of Functional Family

480 The Norwegian Centre for Child Behavioural Development. (2020). *Annual report 2020: We follow research into practice*. https://www.nubu.no/english/category28.html

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

482 Keles, S., Taraldsen, K., & Røyrhus Olseth, A. (2021). Identification of Multisystemic Therapy (MST) subgroups with distinct trajectories on ultimate outcomes in Norway. *Research on Child and Adolescent Psychopathology*, *49*(4), 429–442.

483 Bartlett, J. D., Griffin, J. L., Spinazzola, J., Fraser, J. G., Noroña, C. R., Bodian, R., Todd, M., Montagna, C., & Barto, B. (2018). The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma. *Children and Youth Services Review*, *84*, 110–117.

484 Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System population trial. *Prevention Science*, *10*, 1–12.

485 Fagan, A. A., Bumbarger, B. K., Barth, R. P., Bradshaw, C. P., Cooper, B. R., Supplee, L. H., & Walker, D. K. (2019). Scaling up evidence-based interventions in US public systems to prevent behavioral health problems: Challenges and opportunities. *Prevention Science*, *20*(8), 1147–1168.

486 Scott, S., Sylva, K., Doolan, M., Price, J., Jacobs, B., Crook, C., & Landau, S. (2010). Randomised controlled trial of parent groups for child antisocial behaviour targeting multiple risk factors: The SPOKES project. *Journal* of *Child Psychology and Psychiatry*, *51*(1), 48–57.

487 Morpeth, L., Blower, S., Tobin, K., Taylor, R. S., Bywater, T., Edwards, R. T., ... & Berry, V. (2017). The effectiveness of the Incredible Years pre-school parenting programme in the United Kingdom: A pragmatic randomised controlled trial. *Child Care in Practice*, *23*(2), 141–161.

488 Scott, S., Sylva, K., Kallitsoglou, A., Ford, T. (2014). *Which type of parenting programme best improves child behaviour and reading? Follow up of the Helping Children Achieve trial. Final Report*. Nuffield Foundation.

489 Sonuga-Barke, E. J., Barton, J., Daley, D., Hutchings, J., Maishman, T., Raftery, J., ... & Thompson, M. J. (2018). A comparison of the clinical effectiveness and cost of specialised individually delivered parent training for preschool attention-deficit/hyperactivity disorder and a generic, group-based programme: A multi-centre, randomised controlled trial of the New Forest Parenting Programme versus Incredible Years. *European Child & Adolescent Psychiatry*, *27*(6), 797–809.

490 Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, *47*(11), 1123–1132.

491 Wolpert, M., Jacob, J., Napoleone, E., Whale, A., Calderon, A., & Edbrooke-Childs, J. (2016). *Child- and parent-reported outcomes and experience from child and young people's mental health services 2011–2015*. CAMHS Press.

492 Robling, M., Lugg-Widger, F. V., Cannings-John, R., Angel, L., Channon, S., Fitzsimmons, D., ... & Slater, T. (2022). Nurse-led home-visitation programme for first-time mothers in reducing maltreatment and improving child health and development (BB: 2-6): Longer-term outcomes from a randomised cohort using data linkage. *BMJ Open*, *12*(2), e049960.

Therapy (FFT) failed to show any significant benefits for parents or children.[493] While Multisystemic Therapy's (MST) first UK trial observed significant reductions in youth offending, the second did not.[494,495] Findings from the qualitative strand of the second MST UK trial did, nevertheless, observe improvements in young people's attitudes and self-reflection capabilities.

It is worth noting that MST and FFT are both well-liked by practitioners and are typically perceived to add value within their local contexts. It is also important to emphasise that both interventions saw improvements in outcomes for parents and children that were comparable to each other.

7.4 Ensuring significant value-added

A primary reason why evidence-based interventions improve child and family outcomes is because they are significantly better than or different to those offered through 'management as usual'. This value not only involves evidence-based content, but quality assurance (QA) processes that ensure that the intervention is delivered to a high standard and reaches the families who most need it. While management as usual is also often informed by evidence-based content, its benefits tend to be more inconsistent owing to service issues that compromise the quality of delivery, such as overly high caseloads, high staff turnover, insufficient supervision, or inadequate practitioner preservice training.

Many of the interventions described in this report include QA frameworks that have been developed specifically to address these delivery issues. Examples of these frameworks include fidelity monitoring, caseload specification, eligibility requirements, minimum practitioner qualifications, data monitoring, and processes for recruiting and supervising staff.

From this perspective, evidence-based interventions could be viewed as 'plug-ins' that can be added to improve the efficiency and effectiveness of management as usual. When these plug-ins are implemented to a high standard, service quality improves and benefits for children and families are more likely to be achieved. While it is theoretically possible for service quality to improve in the absence of these evidence-based plug-ins, service teams often struggle, for example, because they don't know how to develop QA frameworks themselves or lack sufficient resources.

The training and consultation offered through evidence-based interventions rectifies this situation by increasing practitioners' knowledge about both the evidence-based content and relevant QA systems. In many instances, intervention training also includes information about how to access or create the resources necessary to successfully implement the intervention. However, these resources are typically external to the intervention model, so must be provided by the wider system in which the intervention will be embedded.

493 Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. *Journal of Child Psychology and Psychiatry*, *58*(9), 1023–1032.

494 Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., ... & Goodyer, I. M. (2020). Multisystemic therapy compared with management as usual for adolescents at risk of offending: The START II RCT. *Health Services and Delivery Research*, *8*(23), 1–114.

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

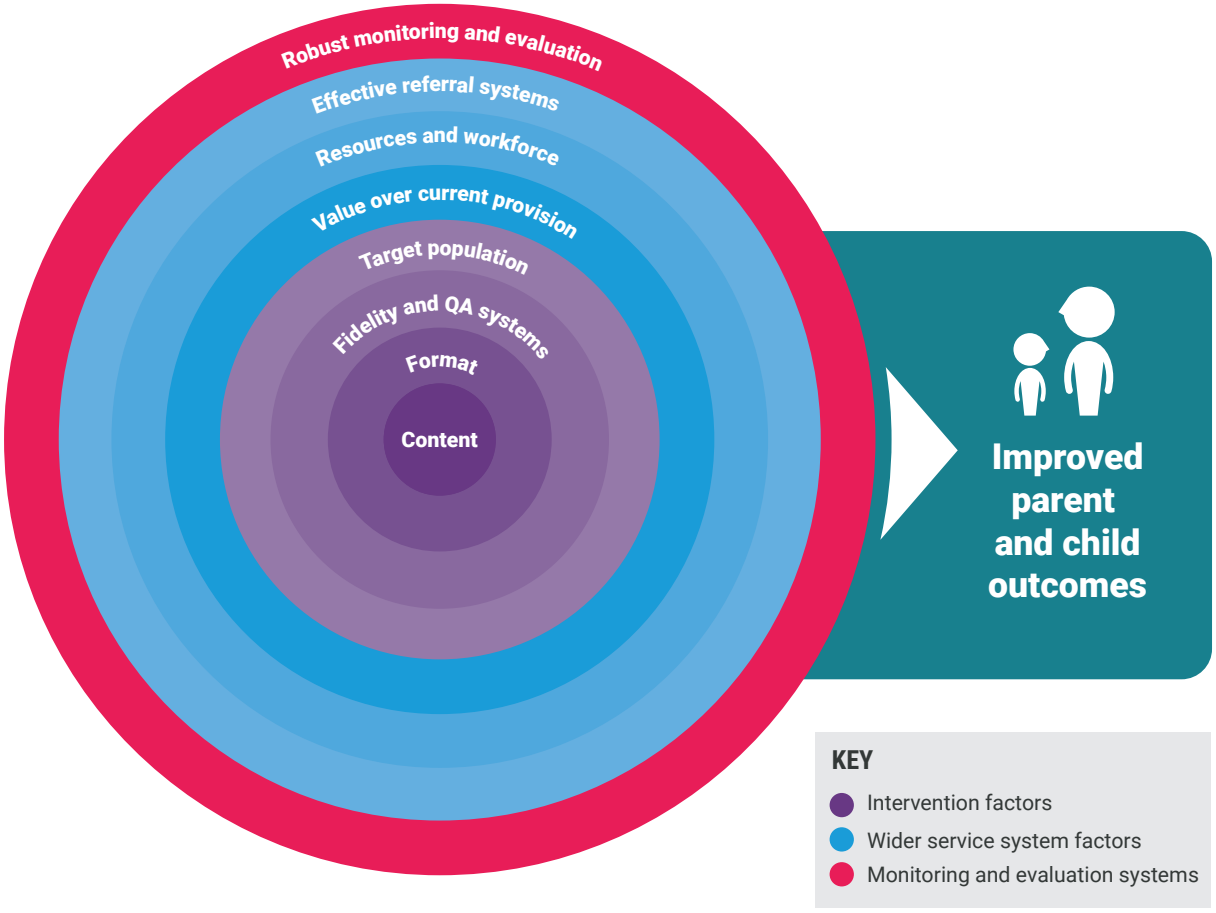
7.5 Determining intervention fit

Evidence that an intervention has 'worked' at one point in time is never a guarantee that it will be effective again. There also needs to be a good fit between the intervention model and the wider service system to ensure that it is needed and can be delivered to a high standard. Selecting and implementing evidence-based interventions so they are effective also requires substantial input from the systems, agencies and practitioners involved in delivering them.

In this section, we identify eight factors[496] which should be considered when determining whether interventions are needed and will fit within the current system (see figure 7.2).

FIGURE 7.2

Factors to consider when determining intervention fit



While an intervention's content, format and QA systems are typically 'bought' into the system, the system often has to make significant adaptations and changes to ensure the intervention will fit and remain effective. These changes will also often result in improvements in service quality. Hence, a poor initial fit does not necessarily mean that an intervention should be rejected, but rather that system-level improvements or 'upgrades' may be required to increase the likelihood of effectiveness.

[496] Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice*, *19*(5), 531–540.

Eight factors to consider when determining fit

1. Evidence-based content

An intervention's content provides the basis of its effectiveness. The interventions described in this review all have content that is informed by a theory of change rooted in scientifically verified observations of child development and family functioning. These theories have then been tested through impact evaluations that are sufficiently rigorous to attribute causality to the intervention model. Most have also undergone further testing to determine effectiveness at scale, including the intervention's fit within diverse settings and populations, and the most appropriate workforce required to deliver it.

Content not only refers to the information support provided to children and families but also to the strategies taught to practitioners to increase family engagement. These strategies include methods for engaging hard-to-reach parents, overcoming resistance, conducting assessments (including eligibility assessment), and developing and maintaining a therapeutic alliance.

This content, including its initial testing and development, is initially 'owned' by the intervention provider. This knowledge is then 'sold' in the form of practitioner training that is purchased by the agencies involved in implementing the intervention.

In many instances, it is expected that those attending this training will have previous knowledge and skills that will facilitate their ability to put the content into practice. Those commissioning the intervention will therefore need to consider whether a sufficiently skilled and qualified workforce is available to attend the training and deliver the intervention as it was intended (see below).

2. Format and dosage

In order to be effective, evidence-based content must be delivered to families in a format that is accessible and sufficiently intensive to produce the outcomes the intervention aims to achieve. An intervention's format therefore determines *how* parents and children will learn new information that will positively change their attitudes and behaviour.

An intervention's format also determines its dosage – in other words, the intensity of the intervention (for example, group or individual), its frequency and overall duration, and its activities for facilitating parental learning (such as homework, role play, video feedback, etc.). An intervention's dosage is fundamentally determined by the needs of the intervention's primary target population.

Intervention developers determine an intervention's format and dosage through feasibility testing and rigorous evaluation. Studies repeatedly show that intervention effectiveness is diminished or lost when the format is modified or dosage is reduced. Examples of dosage modifications known to reduce intervention effectiveness include shortening the length or number of intervention sessions, eliminating content or changing its sequence, replacing one-to-one support with group advice, or failing to monitor family progress. Modifications which limit the practitioner's ability to engage families or form a therapeutic bond also severely diminish the effectiveness of the intervention.

An intervention's format is integral to the delivery of the content. While information about format requirements is purchased through practitioner training, commissioners must consider whether these requirements can be maintained by the agencies that will deliver it.

3. Fidelity and quality assurance

As emphasised above, the efficacy of intervention content is maintained through QA systems that support delivery quality and intervention fidelity. Intervention fidelity is sometimes mischaracterised as slavish adherence to a manual.[497] Although the interventions identified in this review all have a manual, the manual is offered as a reference to inform the practitioner's own judgment. In this respect, fidelity is best viewed as adherence to a set of principles. These principles include the science-based theories underpinning an intervention's content, but also broader principles about establishing positive relationships and delivering services to a high standard. A manual is therefore not an intervention script, but an important intervention QA system.

Examples of other QA systems used by evidence-based child and family interventions include training certification processes, supervision requirements, and systems for monitoring families' progress towards key outcomes. Further information about these systems is provided in the boxed text below.

The interventions identified in this review also all provide advice about QA systems as part of their practitioner training. In some instances, QA advice is additionally provided by the programme developer through ongoing consultation that comes as part of the intervention's licensing requirements.

While licensing requirements can sometimes dramatically increase the 'price' of an intervention, they also provide important QA support that is typically not offered by less expensive interventions. Examples of the kinds of support provided by licensed models include bespoke advice on assessing local need and determining the intervention's reach, advice on effective interagency referral systems, practitioner role specification and recruitment support, post-training supervision, and data management and monitoring software.

These licensing arrangements help to ensure that the host agency is better able to meet the intervention's QA requirements and increase the likelihood that it will be effective when it is delivered. This additional support is particularly necessary when implementing complex interventions that are intended for highly vulnerable families where child maltreatment is an issue.

When licensing arrangements are required as part of the training, the host agency is essentially buying in QA support from the provider. When this support is not provided, the host agency must develop its own QA systems.

QUALITY ASSURANCE SYSTEMS FOR MAINTAINING PROGRAMME FIDELITY

Practitioner selection: Practitioners should not only be selected on the basis of their qualifications but also on their experience and personal characteristics. Many of the more expensive interventions provide guidelines on how to do this.

Rigorous accreditation processes: Rigorous accreditation or certification processes help to ensure that interventions are delivered to a high standard. Examples of rigorous accreditation processes include the scoring of videotapes of practitioners delivering the intervention.

A clearly specified intervention model: Studies suggest that practitioners will have an easier time delivering interventions to a high standard if the model is clearly defined and there are clear learning outcomes linked to specific activities.

[497] Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-based psychotherapy: Advantages and challenges. *Neurotherapeutics*, *14*(3), 537–545.

High quality pre-service training: Practitioners are more likely to learn the training content if there is training is clear and there are hands-on opportunities to practise new skills.

Appropriate levels of supervision: Appropriate levels of supervision are essential for ensuring that interventions are delivered to a high standard and meeting the needs of the participating families. Interventions involving vulnerable families should include both casework supervision and intervention-specific supervision.

Organisational support: Formal recognition at the agency level also incentivises practitioners to deliver the intervention to a high standard. Examples of agency support include appropriate budgetary allowances for staff supervision, manageable caseloads, easy access to the resources required to deliver the intervention, and recognition that the intervention represents important work.

Ongoing consultation: Many interventions offer consultation support. Sometimes this is paid for as needed and in other instances it is included in the training costs. It is particularly common for consultation support to be provided during the initial phases of the intervention's set-up.

Licensing fees: Some of the more expensive interventions require an annual licensing fee that reflects that the intervention is delivered in a way that meets the provider's quality assurance requirements. It is not uncommon for providers to require agencies to collect and provide monitoring data as part of their licensing arrangements to ensure that key conditions are being met and to provide ongoing feedback.

4. Target population specificity

The targeted nature of the interventions described in this review means that one size will never fit all. It is therefore essential that interventions specify who they are for and provide clear eligibility criteria.

The interventions included in this review all have clear eligibility criteria and provide advice on how to assess the needs of families and monitor progress as part of their practitioner training. They also provide advice on how to determine when the intervention may not be working and how to make referrals to external support.

It is, however, the responsibility of the host agency to determine how the eligibility requirements correspond with the needs of the local community and how families will be recruited.

Assessing this fit begins with a robust understanding of local need. Once this is established, commissioners are in a better position to consider whether an intervention is needed and how it will reach the families who most need it. Further advice on how to best determine local need is described in EIF's guide to evaluating early help systems.[498]

5. Determining value-added

Those commissioning and delivering evidence-based interventions must be confident that they are needed and represent value over the current local offer. Otherwise, implementing the intervention will waste time and money. While impact evaluations provide insight into how much value an intervention has provided in the past, this knowledge is not sufficient

[498] Taylor, S., Drayton, E., & McBride, T. (2019). *Evaluating early help: A guide to evaluation of complex local early help systems*. Early Intervention Foundation. https://www.eif.org.uk/resource/evaluating-early-help-a-guide-to-evaluation-of-complex-local-early-help-systems

for determining whether the value will be the same in a new and different setting. This is because an intervention's value is always relative to what is currently available.[499]

Determining value-added requires a solid understanding of an intervention's current evidence base and what it can and cannot achieve, which can be compared to what is available through current provision. The EIF Guidebook and What Works reports provide a starting point for understanding the evidence base, but we encourage commissioners to go deeper than this before commissioning interventions. This means going beyond the Guidebook ratings to consider the extent to which an intervention's intended outcomes represent value from a public health perspective, their implications for long-term child wellbeing, their magnitude of impact, and their relative costs.

Once commissioners feel that they have a solid understanding of what an intervention has and has not achieved, they should then compare this to what is locally available. Local stakeholders will have the best knowledge of their current provision, so are ultimately responsible for this decision. This decision can also be informed by system-mapping exercises that help commissioners to assess the performance of their current offer in terms of reach and achieved outcomes. The strengths and weaknesses identified through this exercise can then be used to determine if the intervention is needed and, if so, how much value it might provide and where in the community it will have its greatest impact. System mapping is also useful for locating resources that can be leveraged to implement the evidence-based models that are ultimately selected.

Further information about conducting effective system mapping exercises can be found in EIF's guide to evaluating early help systems.[500]

6. Resources and workforce

Interventions require substantial resources in the form of money, capital and workforce in order to be set up and sustained over time.

Studies consistently show that workforce availability is a primary reason why interventions succeed or fail.[501] A lack of suitably trained practitioners will significantly undermine the effectiveness of any evidence-based intervention and in some cases even cause harm. For example, a study of practitioners delivering the Incredible Years programme demonstrated positive and often substantial improvements among parents participating in groups delivered by highly skilled practitioners. However, parents attending groups led by those lacking the appropriate skills often demonstrated a decline in parenting skills, suggesting that attending the programme actually made their circumstances worse.[502]

While providers can make recommendations about the qualifications and skills required to deliver an intervention, it is the responsibility of those commissioning and delivering the intervention to determine whether a sufficiently qualified workforce is available.

7. Robust interagency referral systems

It is essential that evidence-based interventions are embedded within a wider system of care that can address family needs as they become apparent. This is particularly true of interventions offered to vulnerable families, where there is a greater risk of child

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499 Sindelar, J. L., & Ball, S. A. (2010). Cost evaluation of evidence-based treatments. *Addiction Science & Clinical Practice*, *5*(2), 44.

500 Taylor, S., Drayton, E., & McBride, T. (2019). *Evaluating early help: A guide to evaluation of complex local early help systems*. Early Intervention Foundation. https://www.eif.org.uk/resource/evaluating-early-help-a-guide-to-evaluation-of-complex-local-early-help-systems

501 Klest, S. K. (2014). Clustering practitioners within service organizations may improve implementation outcomes for evidence-based programs. *Zeitschrift für Psychologie*, *222*, 30–36.

502 Scott, S., Carby, A., & Rendu, A. (2008). *Impact of therapists' skill on effectiveness of parenting groups for child antisocial behavior*. Institute of Psychiatry, Kings College London.

maltreatment.[503] While some children and parents will clearly gain from the interventions described in this review, there will always be cases where an out-of-home placement will be the best option for the child. Thus, good referral systems must be in place to offer families other services if that becomes necessary.[504]

Multiagency responsibilities and referral systems should be established at the time the intervention is set up. Some intervention providers offer consultation support for this as part of the licensing process. However, the quality of interagency relationships and referral systems is fundamentally determined by the quality of policies and support offered through the wider local system.

8. Robust monitoring and evaluation systems for measuring effectiveness

Intervention effectiveness can only be understood if robust systems are in place to assess family progress. These systems include monitoring activities that assess child and parent outcomes on an ongoing basis, as well as more rigorous evaluation arrangements which determine the intervention's impact and the extent to which it is adding value over local provision.

In some cases, programme developers provide detailed advice on how their programme should be monitored, and a few require monitoring data as part of their licensing arrangements. However, good monitoring and evaluation systems are considered essential good practice for the delivery of any family service and are therefore a core responsibility of the host agency. Further information about how to establish robust monitoring systems can be found in EIF's *10 steps for evaluation success* guidance.[505]

[503] The Administration for Children and Families. (2021). *Prevention resource guide*. https://www.childwelfare.gov/pubPDFs/guide_2021.pdf

[504] Ward, H., & Rose, W. (2002). *Approaches to needs assessments in children's services*. Jessica Kingsley.

[505] Asmussen, K., Brims, L., & McBride, T. (2019). *10 steps for evaluation success*. Early Intervention Foundation. https://www.eif.org.uk/resource/10-steps-for-evaluation-success

8. Conclusions and recommendations

This review was commissioned to identify interventions that have evidence of preventing or stopping child maltreatment and its associated risks, and that are sufficiently developed such that they could be included in a local family help offer. We have made the case that a comprehensive public health approach targeting the wellbeing of all children is the best way to improve the lives of the most vulnerable and to prevent child abuse and neglect. Such an approach would offer strong universal support to all children, while retaining a focus on those who are at the greatest risk. This means making support available for a wide range of family needs, including advice offered to all parents on managing normal levels of stress, as well as more intensive support with evidence of keeping serious problems from becoming worse.

Although evidence-based interventions are not a panacea, there is now a strong case that when commissioned in response to a good understanding of local need, they strengthen the offer of support for families. We therefore recommend that commissioners use the information provided in this review to deepen their knowledge of the current evidence base and to use it as a basis for identifying and commissioning interventions that show good potential for supporting the vulnerable families in their communities.

Six key messages stand out from this review:

1. There are a range of interventions with good evidence that could be included in local family help offers

In this review, we have 59 examples of interventions and activities with causal evidence of improving children's wellbeing within five categories of child maltreatment risk (see summary interventions table 6). Collectively, these interventions demonstrate that effective interventions are available to address a wide range of child and family needs and that there is a high level of choice for commissioners. We encourage local commissioners to consider these activities when designing their family help services.

Many of these interventions are already available in the UK, and some have demonstrated consistent and measurable benefits within each of the four nations. However, it is also clear that these interventions are underused and not always delivered to a high standard. We therefore recommend that these interventions are made more widely available, and that work is done to ensure that they reach the families who most need them.

2. Increasing the availability of evidence-based interventions can accelerate improvements in practice

Including evidence-based interventions within the wider service system provides a way of upskilling family support professionals within local teams, through the training generally included as part of an intervention's package.

This training works by increasing practitioners' knowledge of scientifically proven theories of change and provides them with effective methods for engaging vulnerable families, including strengths-based working, shared decision-making, and practices that encourage and motivate positive family change. This training also helps practitioners to empathise with vulnerable families' circumstances and gives them strategies for developing a positive and

respectful working relationship. Additionally, the interventions identified in this review have all undergone extensive user-testing, demonstrating that they are well liked and that families are motivated to remain engaged.

For these reasons, we view these interventions as the 'best bets' for strengthening the consistency and quality of family help services for families with the most serious problems. As set out in chapter 7, it is helpful to think of these interventions less as manualised programmes and more as quality assurance frameworks. While the costs of these interventions may seem high, they offer a direct return on investment through staff training and the intensive implementation support that they typically provide.

3. There are interventions that are currently not available in the UK that could add value to the current system

This report has identified four interventions that are currently not available in the UK but could add considerable value to the family help system. These are highlighted in the interventions summary table below, and include choices that could be offered to families where there are child protection concerns or a child is at the edge of care. All four have been shown to reduce the risk of abuse and neglect and improve the wellbeing of vulnerable children. These interventions are:

Child First is a 12-month intervention providing therapeutic and practical support to highly vulnerable families with a child aged 3 or younger. Its evidence includes improvements in young children's language and behaviour as well as reductions in child maltreatment. Child First is suitable for families where there are multiple risks, including domestic abuse and parental substance misuse.

Parent-child interaction therapy (PCIT) provides intensive and individualised parenting support to highly vulnerable families with a child between the ages of 3 and 12. While the UK already offers a range of effective parent management training interventions, PCIT has particularly strong evidence of reducing symptoms of trauma in mothers and children living in homeless shelters, as well as improving the behaviour of children.

GenerationPMTO is an intensive family intervention that can be offered to vulnerable families with a child between the ages of 3 and 18. Its evidence includes consistent and long-term improvements in children's behaviour, including reductions in involvement with the police 8.5 years after intervention completion. GenerationPMTO also has strong evidence of effectiveness in European countries such as Norway, where it has been shown to provide consistent benefits to vulnerable families for nearly 20 years.

Multisystemic Therapy – Building Stronger Families: Parental substance misuse is a primary reason children are taken into care and is particularly resistant to treatment. Multisystemic Therapy – Building Stronger Families is a new addition to the MST suite (which combines MST with reinforced treatment for substance misuse) with causal evidence of helping parents to abstain from substance misuse and improve child wellbeing.

We believe that making these programmes available would accelerate gains in practice quality in the current system and reduce the need for many children to go into care. We therefore recommend that these interventions be brought to the UK on a pilot basis with national government support and mandate.

4. Increasing the availability of evidence-based interventions is likely to require support for implementation

Even when we have good evidence that an intervention can work, how it is implemented often determines whether or not it produces the expected results. High-quality implementation support is therefore essential for evidence-based interventions to remain effective as they are delivered.

However, implementing evidence-based interventions to a high standard takes time and can be resource-intensive. It relies on capacity within local systems to carry out meaningful analysis of population needs and current system performance, as well as identifying interventions that fit the local context. It also requires that a suitably qualified workforce is available to deliver the interventions, and that resources are available to facilitate effective interagency working, such as data monitoring systems and referral agreements.

This capacity is often hard to find locally and, as is well documented, the current pressures on local authorities are significant. In this challenging context, achieving the scale-up of evidence-based interventions sufficient to achieve population-level improvements would require significant commitment and support from national government.

5. There are still some things we don't know

This review has highlighted some of the limitations of the current evidence base, and areas where UK evidence remains insufficient for guiding practice.

These limitations severely restrict the local system's ability to meet the needs of all vulnerable families. Moving towards a stronger and more comprehensive service offer requires an ambitious programme of research led and coordinated centrally in order to develop, pilot and trial new interventions and tackle some of the most pressing gaps in evidence.

Some of the key evidence gaps identified in this review include:

- **The degree to which children benefit from interventions developed for their parents:** While there is now indicative evidence showing that children can benefit from adult mental health treatments for parents, we are also learning that children are unlikely to benefit from parental substance misuse support that does not include a parenting component. We therefore need to know more about how children do and do not benefit from adult interventions, and rigorously test the ways in which adult support might also be enhanced to support child outcomes.
- **The extent to which the impacts of evidence-based interventions are sustained over time:** In this review, we have identified several interventions with evidence of reducing the need for children to go into care in the short term. However, we still do not know whether they prevent the risk of poor adult outcomes. We therefore need more rigorous long-term studies to consider the impact of effective interventions as children develop.
- **A lack of knowledge of how to support domestic abuse perpetrators in a way that significantly changes their behaviour and reduces the risk of further abuse:** The evidence summarised in this review has highlighted a longstanding lack of evidence underpinning perpetrator programmes and the degree to which survivors and children benefit from these efforts. New theories of change about how to effectively work with perpetrators are needed, which are informed by robust observational evidence regarding family violence and perpetrator characteristics, and which focus on improvements in children and survivors' safety as primary outcomes. These theories of change should then be used to develop new perpetrator interventions that target reductions in family violence and the improved wellbeing of all family members (including adult and child survivors, and perpetrators) as primary outcomes.
- **Improving our ability to adapt and evaluate interventions developed overseas:** On the face of it, some evidence-based interventions imported from overseas have failed to replicate positive results in the UK context. However, as we describe in chapter 7, many of these interventions did improve child outcomes, but not in a way that was measurably better than standard UK care in the short-term. Rigorous, long-term evaluations of imported interventions are needed so that we can fully understand their long-term benefits, and guard against dismantling them in favour of new interventions that have never been tested.

6. Evidence-based interventions will never be enough to reverse the impact of poverty

All parents want the best for their children, and very few actively want to harm them. However, accumulated stress due to the Covid-19 pandemic, job pressures, community disadvantage and a lack of resources can limit parents' ability to engage positively with their children and increase the likelihood of responses that are aggressive, harmful or neglectful.

Long-term economic hardship and poverty are known amplifiers of parent vulnerabilities and direct contributors to family stress. Although the evidence-based interventions described in this review may provide a short-term solution to some specific family problems, they are insufficient to stop the long-term erosion effect of poverty on families' mental and physical wellbeing. For this reason, to be fully effective, new efforts to prevent child maltreatment must also include measures to reduce economic pressure on families, particularly those who are the most vulnerable.

In this review, we have identified research that has convincingly linked economic improvements and community reforms to reductions in child maltreatment at the population level. However, much more needs to be understood about how individual initiatives to reduce financial pressure could reduce the prevalence of specific forms of child maltreatment and improve the life-chances of vulnerable children more generally. We highlight this lack of knowledge as a particular gap in the current evidence base and recommend closing it as a necessary next step towards improving the wellbeing of the county's most vulnerable children.

Summary interventions table 6

Interventions with established evidence of preventing, stopping or reducing the impact of child abuse and neglect and related risks

Level of need	Behaviour management	Family conflict	Parental mental health	Domestic abuse	Parental substance misuse
Universal		• Family Foundations • Schoolchildren & their Families	• Perinatal mental health screening	• Dating Matters • Family Foundations • Me & You • Safe Dates • Schoolchildren & their Families • Screening for domestic abuse	• Screening and advice during pregnancy • Taxation and minimum unit pricing of alcohol
Targeted selected	• Family Check-up for Children • Family Nurse Partnership • ParentChild+ • ParentCorps • Parents as First Teachers • Strengthening Families 10–14 • Triple P Online	• Family Check-up for Children	• Family Nurse Partnership	• Family Nurse Partnership	• Reducing alcohol outlet density at the neighbourhood level
Targeted indicated	• Empowering Parents, Empowering Communities • Helping the Noncompliant Child • Hitkashrut • Incredible Years Preschool Basic • Incredible Years School Age Basic • Resilience Triple P • Triple P Discussion Groups • Triple P Level 4: Group & Standard • Triple P Teen: Group & Standard Level 4	• Enhanced Triple P • Incredible Years Preschool BASIC and ADVANCE *For separating parents* • New Beginnings • Triple P Transitions	• Antidepressants and other pharmaceutical treatments for treating various psychological disorders • Cognitive behavioural therapy (for mental health) • Incredible Years Preschool Basic • Interpersonal Therapy • Psychodynamic Therapy	• Antenatal 'empowerment' advice for mothers identified at risk of domestic abuse during pregnancy • Cognitive behavioural therapy (for victims/survivors) • Incredible Years Preschool Basic	*Adult treatments* • Cognitive behavioural therapy (for substance misuse) • Detoxification • Pharmaceutical treatments • Twelve-step facilitated interventions (TSFIs) • TSFIs combined with motivational interviewing *For parents and families* • Behavioural couples therapy for alcohol and substance misuse • Child First • Families Facing the Future • Parents Under Pressure

Level of need	Behaviour management	Family conflict	Parental mental health	Domestic abuse	Parental substance misuse
Child protection concerns	• Child First • Child-Parent Psychotherapy • GenerationPMTO • Parent-Child Interaction Therapy • Pathways Triple P (Level 5)		• Child First • Child-Parent Psychotherapy • Infant-Parent Psychotherapy	• Child First • Child-Parent Psychotherapy • GenerationPMTO • Parent-Child Interaction Therapy • Project Support • Trauma-focused CBT	
Edge of care	• Functional Family Therapy • Multidimensional Family Therapy • Multisystemic Therapy • Multisystemic Therapy for Child Abuse and Neglect • Multisystemic Therapy for Problem Sexual Behaviour • Treatment Foster Care Oregon – Adolescent		• Multisystemic Therapy for Child Abuse and Neglect	• Functional Family Therapy • Multisystemic Therapy • Multisystemic Therapy Child Abuse and Neglect • Treatment Foster Care Oregon – Adolescent	• Multisystemic Family Therapy – Building Stronger Families