NSW GOVERNMENT Family & Community Services

Review of the evidence for intensive family service models

This review by the Parenting Research Centre and The University of Melbourne identifies interventions for improving outcomes for families with a range of identified vulnerabilities. The findings will help inform the service reformation process.

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Disclaimer

The Parenting Research Centre and The University of Melbourne do not endorse any particular intervention presented here. This review of the evidence drew largely on reliable secondary sources rather than primary sources of evidence. The searches were conducted in early 2015. Readers are advised to consider new evidence arising since the publication of this review when selecting and implementing interventions with vulnerable families.

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Key definitions

These definitions are drawn from several sources, including the project brief for this review (NSW Department of Family and Community Services, 2014), from rapid evidence assessments conducted by the Parenting Research Centre (PRC) and its collaborators (Australian Centre for Posttraumatic Mental Health and Parenting Research Centre, 2013), and from information available from The Child Welfare Information Gateway (www.childwelfare.gov), the NSW Department Families and Community Services (www.community.nsw.gov.au) and the VIC Department of Human Services (www.dhs.vic.gov.au). Other sources are cited in individual definitions where appropriate.

Crisis response	Crisis intervention and response can be an intervention on its own or it can be a component within multiple component models. Crisis response usual provides 24/7 service delivery to families/parents who are at highest risk of out of home placement. Services provision seeks to intervene and stabilise events and circumstances and build effective responses to antecedent and maintaining events.
Domestic violence	The Violence Against Women Specialist Unit of the NSW Attorney General's office uses the legal definition of domestic violence from the NSW Crimes Act 1900 which defines domestic violence as: a personal violence offence committed against a person who has been married to, or had a de facto or intimate personal relationship with, the person who commits the offence. The definition also includes violence against a person living in the same household or residential facility as the offender, a person who is dependent on the paid or unpaid care of the offender, or a person who is a relative of the offender. Personal violence offences (used in the definition of domestic violence) "include but are not limited to: assault, maliciously destroying property, breaching an apprehended violence order (AVO), sexual assault, murder, manslaughter, wounding with intent to do bodily harm, discharging loaded firearms with intent, and malicious wounding or infliction of grievous bodily harm". (p. 23) The Violence Against Women Specialist Unit of the NSW Attorney General's office advises that the term "family violence" is preferred to "domestic violence" by some Indigenous groups. Gendered language is used to refer to perpetrators and victims/survivors. It is acknowledged that domestic violence does exist within same-sex relationships, and that some men apply for AVOs against female partners; however "the overwhelming majority of AVO applications are made by women against their intimate male partners or ex-partners." (p. 2) In practice and in the literature, interventions for reducing harm and addressing trauma from domestic violence are predicated on a female survivor. Source: The Violence Against Women Specialist Unit (2003)
Family preservation	Family preservation interventions and services are intended to avoid placement of children and youth into out-of-home care by ensuring child safety and improving family functioning and parenting practices. Preservation services are short-term and

	family-focused; intensive family preservation services are shorter, more intense, and are generally crisis-focused. Source: Child Welfare Information Gateway (www.childwelfare.gov)
Family support	Family support can be provided by community-based services and agencies that assist and support parents in the role as caregivers. Family support is any intervention which helps parents develop their strengths and resolve problems that could potentially lead to child maltreatment and family disruption. Source: Child Welfare Information Gateway (www.childwelfare.gov)
Intensive case management	Intensive case management services provide intensive support to people with high needs. There is a high level of contact and intense relationship with the young person and their family. Its main aim is to reduce high-risk behaviour and increase stability for the youth, and it includes intensive outreach and support, extended hours of service availability, and after-hours crisis support and intervention. In the NSW context, intensive case management is provided by Intensive Family Support and Intensive Family Preservation services, in which service-providers coordinate services to provide after-hours caseworker support (24 hour availability in the first twelve weeks) and monitor child safety and ROSH. Intensive Family Support/Intensive Family Preservation are Community Services' second-highest and highest-intensity programs. They work with families in crisis, whose children are at high or imminent risk of removal and placement in out-of-home care (OOHC). Source: VIC Department of Human Services (www.dhs.vic.gov.au); NSW Department of Community Services (www.community.nsw.gov.au)
Intensive service models	Intensive service models are "activities, programs, services and interventions designed to alter the behaviour or development of individuals and/or families who show signs of an identified problem, or who exhibit risk factors or vulnerabilities, by providing the resources and skills necessary to combat the identified risks" (NSW Department of Family and Community Services, 2014). However, the scope of interventions included in the review extends beyond intensive service models to include any interventions delivered to children and families at risk or vulnerable for various reasons.
Maltreatment	Maltreatment of children and youth is any non-accidental behaviour by parents and caregivers (or other adults or older adolescents) which is outside generally accepted norms of conduct, and which constitutes a significant risk of causing physical and/or emotional harm to the child or young person. While not accidental, such behaviours need not be intended to cause harm. Maltreatment includes acts of omission (neglect) and commission (abuse). Forms of maltreatment include neglect and any form of abuse: physical, sexual, psychological harm, exploitation, and failure to adequately meet the child's needs. Programs aimed at preventing maltreatment may be available to the general population to prevent maltreatment before it occurs (primary services), or targeted at families at high risk of maltreatment due to, for example, parental substance abuse, parental mental health concerns, intimate partner violence,

	(secondary services), or directed at families in which maltreatment has already occurred (tertiary services). Source: NSW ROSH guidelines; Child Welfare Information Gateway (www.childwelfare.gov); Australian Institute of Family Studies (www3.aifs.gov.au/cfa/publications/what-child-abuse-and-neglect); World Health Organisation (www.who.int/topics/child_abuse/en)
Multicomponent interventions	Reviews of complex multicomponent interventions need special consideration to understand the features, processes and interactions thereof that combine to make up the intervention. There is usually not a shared understanding of what the components in multicomponent interventions are or what terminology should be used. This makes it difficult to identify the components of a given intervention and judge if they are the same as, or different from, other interventions addressing the same outcomes or if there is overlap between some components but not others. Certainly, study authors do not typically report findings by component (or provide a detailed account of all the components of the intervention), or make any attribution as to what proportion of a reported effect is due to a particular component. Interventions can be considered multicomponent if they involve multiple activities for children/youth or multiple activities for families, or if sessions were delivered to families and also to children/youth. Source: Guise et al. (2014)
Outcome	An outcome is defined as a measurable change or benefit to a child or other family member. It may be either an increase in a desired behaviour (for example, improved parenting practice) or a decrease in an undesired behaviour (such as reduced child protection notifications). *Target* outcomes are the outcomes that an intervention aims to prevent, reduce or improve. Outcomes may be focused on the child, parent, whole family or the service providers and system.
Parents with an intellectual disability	Parents with an *intellectual disability* refers to "parents with a diagnosed intellectual impairment, parents who self-identify as having learning difficulties, and parents who are identified by a practitioner as having a cognitive impairment that affects their learning". Source: The Healthy Start network (www.healthystart.net.au)
Placement prevention	Placement prevention refers to services and interventions designed to prevent placement of children and youth into out-of-home care or care outside the family home. Placement prevention programs may operate at varying levels of intensity and support, but have in common the aim of supporting families to prevent problems from escalating and reducing the likelihood of children and youth entering or remaining in out-of-home care. This includes any care provided outside the family home environment including involuntary (where there is a court order requiring a child to live out of their parents' care) or voluntary (where there is no such court order) care. Source: NSW Department of Community Services (www.community.nsw.gov.au)

Reunification/ restoration	Reunification is a planned process intended to return a child safely to their family of origin after a period of out-of-home care, and allowing them to remain there in the long term. Wherever it is in the child or youth's best interest, planning for family reunification is part of planning for children in out-of-home care. Source: Victorian Department of Human Services (www.dhs.vic.gov.au)
Risk of Significant Harm	Risk of significant harm (ROSH) is the threshold for statutory intervention in NSW. It can result from a single act or omission, or cumulative acts or omissions. Assessing ROSH involves determining if circumstances causing concern for the safety, welfare or wellbeing of a child or young person are present to a significant extent. ROSH is assessed against the following broad categories: physical abuse, neglect, sexual abuse, psychological harm, danger to self or others, relinquished care, carer concern, unborn child. ROSH criteria specify when mandatory reporting responsibilities are activated. Source: NSW Department of Community Services (www.community.nsw.gov.au)
Trauma	The word *trauma* has multiple meanings in the scientific literature and in lay terminology. In this review, we use the following definition of trauma: "…experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful—they are also shocking, terrifying, or devastating to the survivor, resulting in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness" (Courtois, 1999).
Trauma-informed care	When addressing an outcome associated with trauma exposure, a *trauma-informed care* approach is often taken. This is "a framework grounded in an understanding and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Oliver, 2010).

1. Executive summary

1.1. Purpose of the review

This review was undertaken by the Parenting Research Centre (PRC) and the University of Melbourne at the request of the NSW Department of Family and Children's Services (FACS). The system of NGO services within FACS is undergoing reform in order to improve practice within services for vulnerable children and families. The purpose of this review is to identify interventions that have been found to be effective for improving outcomes for families with a range of identified vulnerabilities. The findings of this review will help inform the service reformation process.

1.2. Theoretical approach

This review is approached from a social ecology framework which is relevant not only to the general child and family context (Bronfenbrenner, 1979), but has also been translated to the context of child maltreatment (Belsky, 1993), which considers the range of complex and interrelated child, parent, family and community factors that may contribute to placing children at risk of maltreatment and harm (Swenson & Chaffin, 2006).

1.3. Methods

Interventions relevant to this review were systematically searched via:

- four established and authoritative international clearinghouses, and
- previous reviews conducted by the PRC and partner organisations.

Gaps in findings from these searches were identified and additional interventions and updates sought via stakeholder documents, consultation with experts and searches of the academic databases.

Data regarding all interventions and populations identified in the search were extracted and collated. Interventions were then rated using a rigorous rating scheme:

- *Well Supported* interventions demonstrated effect in at least two randomised controlled trials (RCTs) and that effect was maintained at least 12 months after completion of the intervention; and were found to be effective in a meta-analysis conducted as part of a high quality systematic review.
- *Supported* interventions demonstrated effect in two RCTs, maintained at 12-month follow-up (but support from meta-analysis in a high quality systematic review could not be found).
- *Promising* interventions demonstrated effect in at least two RCTs with maintenance of that effect at least six months after the completion of the intervention.
- *Emerging* interventions demonstrated effect in one RCT with maintenance of effect at least six months after intervention completion.

An extensive search was conducted to identify intervention *delivery* and *content components*. These are elements of practice related to how the intervention is

delivered and *what* is delivered to the families. While this type of information is not always reported by intervention developers, identification of intervention components can help shape an understanding of the interventions. Where possible from the information available, delivery and content components of the interventions were identified and drawn together in a *common* components analysis. Pulling these components together provides a picture of what is common across a group of interventions that have been found to be effective, rather than identifying which components themselves are effective.

1.4. Findings: interventions, components and ratings

Forty-five interventions were identified with a rating of Emerging or higher. Two of these interventions were rated Well Supported, 18 interventions were rated Supported, nine were rated Promising, and 16 were rated Emerging. Studies evaluating these interventions involved families with a range of identified vulnerabilities, within community, family, parent, and child socio-ecological factors that may have contributed to maltreatment or risk of harm:

Community factors

- Families with low income or socio-economic status parents.

Family factors

- Families with children or young people exposed to or at risk of maltreatment, including neglect and/or any form of abuse
- Families exposed to domestic or family violence
- Families of children or youth who are at imminent risk of placement in out-of-home care.

Parent factors

- Families where a parent has a substance misuse concern
- Families where a parent has a mental illness
- Families where there is a teenage parent.

Child factors

- Families with children or youth with substance misuse problems or those at risk of this issue
- Families with children or youth with offending behaviours or delinquent, or those at risk of these behaviours
- Families of children or youth with a mental illness
- Families of children or youth at risk of suicide
- Families of children or youth with problematic sexual behaviour, or those at risk of these behaviours.

The 45 interventions included in this review are listed in Table 1, along with their assigned ratings and outcome domains targeted. Extensive details of these interventions are provided in the findings section of this report, grouped under identified vulnerability within community, family, parent and child factors.

Table 1: Interventions included in the review, ratings and outcomes targeted

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Well Supported								
Nurse-Family Partnerships (NFP)	First-time, low-income or adolescent mothers — commences prenatally and continues until the child is two years old.	✓	✓	✓	✓	✓	✓	✓
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Children, and their parents, who are experiencing significant emotional and behavioural problems related to trauma, including maltreatment or vulnerable family circumstances.	✓	✓	✓		✓	✓	
Supported								
Attachment and Biobehavioral Catch-up (ABC)	Caregivers of infants aged 6 months – 2 years who have experienced early adversity, such as due to maltreatment or disruptions in care		✓		✓	✓		
Be Proud! Be Responsible!	At risk, 'minority' youth aged 11 – 19 years. Delivered primarily to African American and Latino adolescents.		✓	✓				
Coping Power	Children aged 5 – 11 at risk of substance misuse.	✓	✓			✓	✓	
DARE to be You	Children aged 2 – 5 years at risk of future substance misuse.	✓	✓			✓	✓	

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Early Risers' "Skills for Success"	Children aged 6 to 12 years who are at high risk of conduct problems, including substance use.		✓			✓	✓	✓
Healthy Families America (Home Visiting for Child Well-Being) (HFA)	Families of children aged 0 – 5 years who are at risk for child maltreatment. Families may be at risk due to mental illness, substance abuse, or parental history of abuse in childhood.	✓	✓	✓	✓	✓	✓	✓
The Incredible Years	Families with children aged 4 – 8 years with behavioural or conduct problems. Also used with children at high risk.	✓	✓			✓	✓	
Multidimensional Family Therapy (MDFT)	Adolescents aged 11 – 18 years with substance use, delinquency, and related behavioural and emotional problems.	✓	✓			✓	✓	✓
Multisystemic Therapy (MST)	Youth aged 12 – 17 years who are serious juvenile offenders with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviours and/or youth involved with the juvenile justice system.		✓			✓	✓	✓
Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)	Youths aged 13 – 17 years who have committed sexual offences and demonstrated other problem behaviours.		✓			✓	✓	✓

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Oregon Model Parent Management Training (PMTO)	Parents of children 2 - 18 years with disruptive behaviours. Versions adapted for children with substance abuse, delinquency, conduct disorder, and child neglect and abuse.		✓		✓	✓	✓	✓
ParentCORPS	Children aged 3 – 6 years in families living in low-income communities.	✓	✓			✓		
Parent-Child Interaction Therapy (PCIT)	Children aged 2 – 7 years with behaviour and parent-child relationship problems. May be conducted with parents or other carers.	✓	✓			✓		
Project Success	Students aged 12 to 18 years who are at high risk for substance abuse due to discipline problems, truancy, poor academic performance, parental substance abuse and negative attitudes toward school.		✓				✓	✓
Project Towards no Drug Abuse	Youth aged 15 – 18 years who are at-risk for drug use and violent behaviour.		✓					
Prolonged Exposure Therapy for Adolescents (PE-A)	Adolescents who have experienced a trauma of any kind. Has also been used with children aged 6 – 12 years.	✓	✓				✓	
SafeCare	Parents of children aged 0 – 5 years at risk for child neglect and/or abuse and/or parents with a history of child maltreatment.	✓	✓	✓	✓	✓		

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Triple P–Standard and Enhanced	Parenting intervention for children with behavioural problems, adapted for use with maltreatment populations and parents with mental illness.	✓	✓		✓	✓		
Promising								
Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	Youth aged 11 – 17 years with drug abuse, and co-existing problems such as conduct problems and depression.	✓	✓	✓		✓	✓	
Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	Adults with drug abuse and dependence, and other problems including family dysfunction, depression, child maltreatment and trauma.		✓	✓	✓	✓	✓	
Brief Strategic Family Therapy (BSFT)	Youth aged 12 – 18 years with substance abuse problems and co-occurring behaviour problems such as conduct problems, risky sexual behaviour and aggressive and violent behaviour.		✓			✓	✓	
Child-Parent Psychotherapy (CPP)	Children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse.	✓	✓	✓		✓	✓	
Functional Family Therapy (FFT)	Youth aged 11 – 18 years with problems such as violent acting-out, conduct disorder, and substance abuse.		✓			✓	✓	✓

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)	Children aged 6 –17 years who are at risk for placement in out-of-home due to serious behavioural problems and co-occurring mental health symptoms.		✓			✓	✓	✓
Parenting With Love and Limits (PLL)	Youth aged 10 – 18 years with severe emotional and behavioural problems and co-occurring problems including domestic violence, alcohol or drug use, depression, suicidal ideation, destruction of property, or chronic truancy.		✓	✓		✓		
Safe Environment for Every Kid Model (SEEK)	Families with children aged 0 – 5 years who are at risk of maltreating behaviours due to parental substance abuse or depression.	✓		✓	✓		✓	
Teaching Kids to Cope (TKC)	Youth aged 12 – 18 years with depressive symptomatology and/or suicidal ideation.		✓	✓				
Emerging								
AVANCE Parent-Child Education Program (PCEP)	Parents with children aged 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education levels.	✓						
Coping and Support Training (CAST)	Youth aged 14 – 19 who have been identified as being at significant risk for suicide.		✓	✓				

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Child FIRST	Children aged 6 months – 3 years with emotional and behaviour problems where the parents are at psychosocial risk due to maltreatment or parental mental illness.	✓	✓	✓	✓	✓		✓
Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Program	Children aged 6 – 12 years with problem sexual behaviours and their parents.		✓			✓		
Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	Parents with significant mood disorders, with children aged 6 years and older.		✓			✓	✓	
Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP)	Children aged 3 to 6 years with a history of maltreatment.	✓	✓	✓	✓	✓		
Community Advocacy Project (CAP)	Survivors of domestic violence and their children.					✓	✓	✓
Early Start	Infants who are at risk of maltreatment due to domestic violence and parental substance misuse	✓	✓	✓	✓	✓	✓	✓

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Family Connections	Children aged 5 – 11 exposed to maltreatment, domestic violence, parental mental illness or parental substance misuse.		✓		✓	✓	✓	✓
Families Facing the Future	Parents receiving methadone treatment and their children aged 5 – 14.	✓	✓	✓		✓	✓	
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents.	✓	✓					
Homebuilders	Families with children aged up to 18 years at imminent risk of placement into, or needing intensive services to return from, residential or group treatment, foster care, or juvenile justice facilities or psychiatric hospitals.	✓	✓		✓	✓	✓	✓
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Children aged 6 –17 years who have been maltreated or who are at risk of maltreatment.	✓	✓	✓	✓	✓		✓
Parent training prevention model (not the name of an intervention, description only)	Parents of children aged 18 months – 4 years who are at risk of maltreatment and have parents who have a low SES status or are disadvantaged.	✓	✓	✓	✓	✓		

Intervention	Population	Outcomes targeted						
		Child development	Child behaviour	Safety and physical well-being	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Parents Under Pressure (PuP)	Families of children aged 2 – 8 years who are at risk of child maltreatment due to problems such as parental substance misuse, mental illness, severe financial stress and family conflict.		✓	✓	✓	✓	✓	
Project Support	Children aged 3 – 8 years who have been exposed or who are at risk of neglect, abuse or domestic violence.		✓		✓	✓		✓

To conduct the common components analysis, interventions involving families with various identified vulnerabilities were grouped, and delivery and content components that were found to be *common* across interventions within these groups were identified. These common components by vulnerability group are reported in the main findings of the report.

This review identified 49 distinct intervention delivery components and 118 content components relating to the 45 included interventions. Box 1 provides a list of the components that were *common* to at least 50% of 45 interventions, regardless of which population they targeted. Four common components were identified. Despite extensive searches to identify components, the high number of interventions included in this analysis and the disparate nature of the interventions created greater variability in the types of components identified, thereby resulting in few components that were common across these interventions.

Box 1. Common components across all interventions included in this review

Intervention delivery

- Sessions were structured

Intervention content

- Parenting education or training or parenting skills
- Child/youth behaviour, behaviour change and behaviour management
- Parent-child relationships, communication and interactions.

1.5. Discussion

This review identified several interventions suitable for families experiencing a range of vulnerabilities. The focus of the review was on interventions that can confidently be considered to be effective, with two interventions found to be Well Supported by the evidence and 18 found to be Supported. A further nine interventions were rated Promising and 16 were rated Emerging.

1.5.1. Analysis of the findings

Interventions included in this review were typically multicomponent and involved multi-problem families. Most centred on families where the child or young person had been maltreated or were at risk of maltreatment. Interventions for families experiencing domestic violence and maltreatment, as well as interventions for adolescent and low-income parents, were more often delivered in the early childhood years. On the other hand, interventions targeting children at risk of removal from their home and risky behaviour were, unsurprisingly, focused on teenagers.

Nearly all of the interventions aimed to improve child behaviour outcomes (*n* =44). Family functioning outcomes, such as relationships between family members, were also frequently targeted (*n* = 36). Just over half of the interventions sought to improve family support network outcomes such as social and community supports (*n* = 25), and child development outcomes (*n* = 24). Further outcomes targeted by these interventions were: safety and physical wellbeing (*n* = 19); maltreatment

prevention (*n* =17); and systems outcomes such as out-of-home care placements and verified investigations (*n* = 17).

Interventions were more often delivered in the home on an individual basis rather than to groups, and involved intervention for parents as well as children. It was not unusual for families to be given the option of intervention location that suited their situation. Interventions typically lasted no more than six months, and although staffing requirements varied between interventions, they were usually delivered by staff who were trained and were receiving ongoing supervision and support.

Interventions for families with young people at imminent risk of removal from the home were found to be the most intensive; not in the duration of the services, but in the high frequency of weekly contact with staff and 24/7 availability of staff.

1.5.2. Gaps in the evidence

Many evaluated interventions were identified and considered for inclusion in this review. Some lacked sufficient rigour in order to determine if they were effective for improving child or parent outcomes and these were not included in this review. The approach adopted in this review was to focus on interventions based on a rigorous rating scale so that we could be more confident in the effectiveness of interventions. Interventions evaluated less rigorously or with limited maintenance of effect may well still work for improving outcomes, but this cannot be determined until further research is available.

This review identified that there are several populations for which limited evidence is available. For example, no interventions rated Emerging or higher were identified that were specifically for parents with intellectual disabilities. There were also few interventions that specifically included families exposed to domestic violence, low income or low socio-economic status (SES) families, and teenage parents, or families of youth with mental health and suicide risks or those at risk of removal to out-of-home care.

1.5.3. Implementation considerations

This review identified a range of effective interventions that may be suitable for FACS services. Identifying these interventions and their common components is the first step in a long implementation process. Considerable details regarding factors to consider when selecting and implementing interventions are presented towards the end of this report. In brief, consideration needs to be given to the following factors:

- Appropriateness of intervention aims and outcomes — do these match intended outcomes for families served?
- Targeted participants — do these match the families served?
- Delivery setting — are there options to suit service needs?
- Host setting — does intervention fit the organisation, and how ready is the organisation?
- Implementation infrastructure — which organisations will be involved in decision-making, administration, planning; what are the roles and collaboration requirements?

- Implementation capacity — who will do the implementation work; what additional competencies are needed for this?
- Costs — what costs are involved; is the intervention cost-effective?
- Accessibility — is the intervention and required support available and suitable?
- Technical assistance — what are the training requirements and available technical assistance?
- Fidelity — what are the requirements to ensure the intervention is delivered effectively to families?
- Data and measurement of effectiveness — how is the intervention monitored and evaluated?
- Language — does it match our client population?

Broadly speaking, FACS services are primarily concerned with interventions for families with children at risk of significant harm (ROSH). Matching intervention populations for the families being supported requires further clarification into more discrete categories; for example, interventions that aim to reduce neglect of children aged from 0 – 5 years, and interventions that prevent out-of-home placement in adolescents with challenging behaviours. The aim of this analysis is to determine what works for whom and when, and if the interventions' effect can be seen across different vulnerability groups that are common in child welfare. Keep in mind that family vulnerabilities are inter-related, and that addressing one outcome, such as parenting skills, may have benefits for other outcomes such as maternal depression and substance use.

While several gaps in population groups were identified, it should be noted that many interventions reported here probably did involve families experiencing a wide range of problems, even if the main focus was on only one or two issues. Many of the interventions may be suited to other vulnerable groups despite the fact that they do not specifically target them. By design, the multicomponent interventions included in this review cater for multi-problem families.

A more pertinent consideration may be to determine not whether the intervention has involved particular populations, but whether it has catered for the varying needs of these groups. Is the material relevant for young parents? Does it consider the learning needs of parents with intellectual disabilities? Does it target relevant outcomes for this group?

Another consideration regarding particular population groups relates to interventions for parents with a mental illness and parents with substance misuse problems. This review sought only to identify interventions relevant to parents with these concerns; interventions for adults outside the family context were not considered. Many additional adult relevant services do exist, however consideration would need to be given to whether these general adult interventions are effective in the context of families and maltreatment.

A central part of the implementation process, regardless of which interventions are selected or if existing interventions are adapted, is the need for clear implementation planning, monitoring and evaluation to be instituted before implementation commences.

1.5.4. Limitations

The scope of interventions and populations included in this review was broad. Time limitations, combined with this breadth of scope, did not allow for a full systematic review. It was not possible given the time constraints to seek further information on interventions from original published studies, from unpublished studies, or by contacting authors and intervention developers. A range of thorough search strategies was implemented to overcome these limitations, and we are confident that this approach has identified the majority of effective interventions that are relevant to intensive family services.

The incomplete reporting of intervention details was another limitation. Intervention details and components were sourced from clearinghouses and past REAs. Further intervention delivery and content components were also sourced from developer websites. Not all details were available for all interventions. While we have endeavoured to extract and analyse all components available, there is no doubt that there are more components involved in most of the interventions included in this review.

1.5.5. Suggestions to consider when using this review

Identifying effective interventions and the common components of these interventions is only a starting point for FACS services. Some potential next steps to consider include:

1. After taking implementation factors into account, assess the fit between the interventions reported here and the FACS service context and families being supported.
2. Assess if further investigation into interventions is required — such as interventions with limited evidence or interventions targeting adults in general rather than parents.
3. Give further consideration to the delivery and content components identified within each intervention and those found to be in common across groups. Note that these have not been identified as ‘effective’ components and there may be interplay between components to be aware of. Consider seeking support that would enable you to understand these nuances before you give thought to matching components to meet the needs of FACS services.
4. Make plans and receive support for implementation and evaluation of all interventions and adaptations. Considerations include the socio-political context, funding structures, and the engagement and involvement of stakeholders at the system level of the implementation context.
5. Consider the socio-ecological system context of the family; child, parent family, community factors that may contribute to maltreatment are inter-related.
6. Consider the availability of new evidence that may support interventions.

2. Background

2.1. Context

Supporting families involved in the child welfare system or child protection services is a complicated matter. Parents and children in these service systems typically have multiple and varying issues or vulnerabilities, they come from different backgrounds, and they have varying family structures, with children of different ages. The families who are coming into contact with family and community services are increasingly living in complex circumstances, experiencing substance misuse, mental health issues, domestic and family violence, and intergenerational disadvantage (NSW Department of Family and Community Services, 2014). Many families who are experiencing these risk factors for child abuse and neglect are also experiencing broader challenges of exclusion and disadvantage, such as poverty and social isolation, homelessness or unstable accommodation, poor child and maternal health, disconnection of young people from families, schools and communities, and they have experienced trauma. Families may be experiencing several of these risk factors (Council of Australian Governments, 2009). They might be familiar to the service systems because of their re-occurring or ongoing concerns. They might present at extreme crisis points or they might be identified at a time when risk is apparent and crisis prevention is the objective.

Regardless of the circumstances of the family, service providers want be able to choose an intervention or suite of interventions that has the highest likelihood of being effective, rather than just respond to emergency situations as they arise.

2.1.1. Theoretical approach to this review

It is helpful in the context of this review to consider how complex family and social systems can affect child outcomes. This review is framed through a socio-ecological lens, which is relevant to all family contexts but is a particularly helpful approach given the complex circumstances of families who are presenting to service providers.

2.1.1.1. Social ecology and child maltreatment

Families are complex structures, existing within even more complex systems and contexts. Bronfenbrenner was the first to propose a theory of the social ecology of human development (1979). This theory describes the inter-relationships of the various people and systems involved in a child's life while emphasising that a child does not exist in isolation from the reciprocal effect of surrounding systems. The effect of these systems on the child increases with the systems' proximity to the child: parents and other family members have the greatest influence, and other systems such as peers, school, community and the wider society, have less — and often less direct — influence. Social ecology theory has been adapted, revised and applied to a range of interventions supporting children and families (Stormshak & Dishion, 2002).

A social ecology approach has since been applied to the conceptualisation of child maltreatment (Belsky, 1993). Just as the various systems relevant to the ecology of human development have influenced each other, child maltreatment is determined by a range of inter-related factors across various social systems in the family context. Understanding the array of problems that families are dealing with and

determining how to address these issues and how to improve the situation for parents and children requires consideration of the entire family context and the influence that different people and groups involved with families have on each other (Belsky, 1993). Taking an ecological view of the risk and protective factors associated with child maltreatment helps us to consider the broader community circumstances affecting the wellbeing of children and young people.

A range of child, parent, family, community and ecological factors may come into play in child maltreatment. While authors who are taking a social ecology perspective stress that children are in no way to be considered at fault in this regard, there are some child factors, such as age, delays or disabilities, temperament and non-compliance, gender, and abuse, that may influence child maltreatment. All these issues can create greater challenges for parents, which may impact parenting and, ultimately, the child (Swenson and Chaffin (2006)).

Other child-related factors may place children at risk, such as substance abuse, offending behaviours, mental illness, and violent and delinquent behaviours. Some of these are typically more prevalent, or at least more developed, in adolescents and may not be associated with increased risk of maltreatment, but they may place young people at risk of significantly poor outcomes and harm. (Swenson & Chaffin, 2006)

Parent-related factors include, but are not limited to: the parent's own history of abuse, parental mental illness or distress, low monitoring of children, and substance abuse. At the family level, some of the factors are: conflict and violence, limited resources and supports, financial hardships, and unemployment. All of these factors, combined with some community factors (e.g. economic disadvantage, low monitoring by adults in community) and ecological factors (e.g. how the different systems — such as relationships between community and family, school and parents — work together), contribute to the determination of child maltreatment. On the other hand, just as negative circumstances within families and beyond can interfere with parenting and increase risk for children, other factors can act as buffers to risk. These can include provision of social services to meet the needs of families, peer relationships for young people, and social supports for parents. The unidirectional influence of the socio-ecological systems can be also positive (Swenson & Chaffin, 2006).

2.1.1.2. Multicomponent interventions for vulnerable families

In addition to the connectedness between systems relevant to the child and to the determination of child maltreatment or risk of harm, there is interplay between interventions delivered to families and within communities. The type of interventions delivered to multi-vulnerability families is typically multicomponent. As such, interventions delivered at one level (e.g. to the parent) impact other levels (e.g. the child) and vice versa. Likewise, interventions delivered to address one vulnerability (e.g. parent mental health) can potentially impact other concerns (e.g. child substance abuse). Multicomponent interventions tend to address the range of systems involved in the socio-ecological structure of a child's life, thereby also possibly having direct or indirect impacts on various vulnerabilities or factors within those systems.

Logically, interventions concerned with preventing or addressing issues of child maltreatment should consider the various systems that form part of the child's world

and determine where interventions are needed. The type of intervention (i.e. does it address neglect?) does not necessarily define the target of the intervention (i.e. is it for the parent?). Instead it determines the contributing factors: the factors that contribute to maltreatment or to children being at risk of harm. These factors vary from family to family, with factors that place children at risk of harm differing across families (Swenson & Chaffin, 2006).

2.2. Purpose of this review

The findings of this review will help inform service selection and identify intervention components as part of the ongoing reformation of intensive family services in NSW. This review was conducted in the context of reviewing intensive services for vulnerable families. Vulnerable children and youth are served by prevention and early intervention services (secondary intervention services), and where these children have also been judged to be at risk of significant harm (ROSH), Child Protection Services (tertiary intervention services) are also involved. As for all NSW children and young people, children at ROSH also benefit from the primary or universal services available to all families (Cassells et al., 2014).

FACS is undertaking a strategic reform of its system of NGO-funded services. The aim of this reform is to establish a more efficient system to deliver locally integrated and flexible service responses, which would enable it to reduce risk and increase safety for vulnerable children living at home.

Measurable objectives of this service reform are to:

- Reduce the rate of children and young people re-reported as being at risk of significant harm
- Increase the number of children and families who receive a face-to-face service response
- Decrease the number of children who enter out-of-home care
- Increase the capacity of the non-government sector to provide support and intervention to high-risk families with complex needs.

It is in this context of seeking to identify further improvements to NGO services for children and young people at ROSH that this review was commissioned, in order to identify effective interventions likely to be of most use for vulnerable families. The review identifies interventions that target a broad range of parent, child and family outcomes, nested within the context of child, parent, family and community factors, often referred to as vulnerabilities, which may contribute to the risk of child maltreatment and harm.

2.3. Scope of this review

This review provides a synthesis of the literature that evaluates interventions that aim to improve outcomes for children where families and children have specific vulnerabilities. These interventions may be service models, programs, approaches, or therapies, but, for ease of use, they are referred to here as interventions. The interventions include, but are not limited to, intensive service delivery for parents and families with children at risk of significant harm (ROSH), with the specific aim of decreasing such risk and/or potential harm.

The target of the interventions included in this review may include children, parents and/or families. Any form of individual or family vulnerability is in scope, however the key parent vulnerabilities of substance abuse, mental health and domestic violence are of particular interest to FACS. Children of all ages are included, and parents include biological parents as well as others acting in the parenting role. Interventions for foster carers and service providers are not in scope.

Several interventions exist to foster family reunification, but FACS' key interest for this review is in *prevention* of removal from home. Interventions solely focused on reunification or restoration of families, once the child has already been removed, are out of scope in this review.

In this review, interventions targeting trauma-related to child maltreatment, and at-risk family situations such as domestic violence, parent substance misuse and parent mental illness, are in scope. Interventions solely focused on other traumatic events such as war trauma or trauma arising from natural disasters are not included. Interventions aimed both at reducing risk of exposure to trauma and at ameliorating the sequelae of trauma are included.

3. Methods

3.1. Overview

The scope of this review is broad, in order to capture the maximum number of interventions that are potentially relevant to FACS services. Considerable research exists on the range of populations, outcomes and interventions of relevance, and this review drew on existing reviews and analyses. These existing sources were updated and consistent ratings of the evidence were applied.

3.2. Identification of interventions

The identification of interventions was a three-part process:

1. To identify relevant interventions that have been evaluated and rated on web-based clearinghouses or in previous reviews by the PRC
2. To identify gaps in populations, interventions and recency of intervention ratings gathered in step 1; and
3. To identify additional interventions and to update interventions in an attempt to fill the gaps identified in step 2.

3.2.1. Interventions rated on clearinghouses and in PRC reviews

This review drew on the analyses of four established, highly used and credible international web-based clearinghouses, and on previous rapid evidence assessments conducted by the PRC and partner organisations to identify relevant interventions (see Box 2). International clearinghouses were used as the initial search point because they combine an emphasis on interventions in widespread use in agencies with evaluations of the evidence supporting those interventions. They are intended to help decision-makers select and implement interventions. Although these clearinghouses are based in the USA, they are not limited to interventions designed and implemented in the USA; they include interventions from anywhere provided they meet selection criteria.

The clearinghouses listed in Box 2 were selected because they met the following criteria, as established in an earlier PRC review (Wade, Macvean, Falkiner, Devine, & Mildon, 2012):

- Provided ratings of child, parent or family programs;
- Specified child, parent or family outcomes and the target population;
- Use experts in the field to rate programs; and
- Used rating scale or systems which have clear criteria for inclusion.

The previous rapid evidence assessments (REAs) were chosen because of their high relevance to this topic, their systematic approach to intervention search and selection, and their use of rating schemes. All interventions under relevant topics areas (see Appendix 1) in the clearinghouses were assessed for inclusion and all interventions in the previous REAs were considered.

Box 2. Clearinghouses and PRC rapid evidence assessments used to identify interventions

International clearinghouses

- California Evidence-Based Clearinghouse (http://www.cebc4cw.org/)
- National Center for Community-Based Child Abuse Prevention (http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory)
- Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices (http://www.samhsa.gov/nrepp)
- Blueprints for Violence Prevention (http://www.blueprintsprograms.com/allPrograms.php)

PRC rapid evidence assessments

- Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013) (http://www.parentingrc.org.au/index.php/resources/supporting-children-exposed-to-trauma-arising-from-abuse-and-neglect)
- Macvean, Mildon, Shlonsky, Devine, Falkiner, Trajanovska and D'Esposito (2013) (http://www.parentingrc.org.au/index.php/resources/evidence-review-an-analysis-of-the-evidence-for-parenting-interventions-for-parents-of-vulnerable-children-aged-up-to-six-years)
- Shlonsky, Kertesz, Macvean, Petrovic, Devine, D'Esposito and Mildon (2013) (http://www.parentingrc.org.au/index.php/resources/evidence-review-analysis-of-the-evidence-for-out-of-home-care).

Interventions reported on the clearinghouses and in the past REAs were in scope if they were about:

- Intensive family services
- Child maltreatment of any form
- Specific family vulnerabilities including but not limited to mental illness, substance abuse, domestic violence
- Prevention of out-of-home placement and homelessness
- Trauma, arising from child maltreatment or at-risk home environments, as opposed to war trauma or natural disasters
- Child vulnerabilities such as substance abuse, self-injurious behaviour, mental illness, sexual behaviours.

The following were out of scope:

- Pharmacological interventions
- Universal interventions where the population was not vulnerable or at risk in some way. One exception was made: all child maltreatment prevention strategies with universal populations were retained due to their high relevance to this review

- Substance abuse treatment interventions where the population was not multi-risk
- Interventions targeting academic achievement. School attendance interventions were included.

3.2.2. Identification of gaps in the evidence

Once identified, interventions were organised into groups according to the demographics of families that had participated in evaluations of the interventions: maltreatment of children and young people, parental substance abuse, parental mental illness, domestic violence, parent low income or low socio-economic status (SES), teenage parenting, trauma, child and youth substance abuse, child and youth offending behaviour or delinquency, child and youth mental illness, child and youth suicide, child and youth sexual behaviour, and children and young people at imminent risk of out-of-home placement. Vulnerability areas, outcomes targeted, and recency of the evidence available on clearinghouses for intervention rating was analysed to determine if there were potential gaps in the coverage of relevant interventions.

3.2.3. Updating the interventions identified

The following documents received from FACS were screened to determine if additional interventions or updates on the already identified interventions could be located:

- Katz and Smyth (2014)
- Kelly and Westmarland (2015)
- NSW Department of Family and Community Services (2013)
- NSW Department of Family and Community Services (undated)

A targeted search was conducted for interventions that had not been rated on clearinghouses since 2011 or earlier. Details of these searches appear in Appendix 1. Targeted searches were conducted for the following interventions (with more details of these interventions provided in the section reporting findings).

- Project Success (2007 onwards)
- DARE to be You (2006 onwards)
- Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk) (2006 onwards)
- ParentCORPS (2011 onwards)
- Multisystemic Therapy — Psychiatric (MST-Psychiatric) (2008 onwards)
- Teaching Kids to Cope (2010 onwards)
- Coping and Support Training (CAST) (2007 onwards)
- Be Proud! Be Responsible! (2007 onwards).

This gap analysis revealed that one parent vulnerability area of key interest to FACS lacked coverage – parents with an intellectual disability. In an attempt to fill this gap, input was sought from expert colleagues in this area and the following documents were screened for suitable interventions:

Reviews

- Wilson, McKenzie, Quayle, and Murray (2013)
- Coren, Hutchfield, Thomae, and Gustafsson (2010)
- Wade, Llewellyn, and Matthews (2008)
- Feldman (1994).

RCTs

- Feldman, Case, and Sparks (1992)
- Keltner, Finn, and Shearer (1995)
- Llewellyn, McConnell, Honey, Mayes, and Russo (2003).

In addition, a search of the academic databases was conducted to top up the Cochrane Library systematic review (Coren et al., 2010) to determine if more recent studies could be found on this topic (see Appendix 1 for search details).

3.3. Data extraction

Information regarding the population, intervention context, dose, content, delivery, outcomes targeted, and costs (where available) were extracted for all included interventions. Further intervention delivery and content components were sourced from intervention developer websites and other clearinghouses. To assist with clarity of reporting, an outcomes framework was used to identify the outcome domains targeted by each intervention. This was adapted from previous REAs (Macvean et al., 2013; Wade et al., 2012) and it appears in Box 3.

3.4. Intervention effectiveness rating

All included interventions were rated according to the scale in Figure 1. Interventions identified through two REAs (Macvean et al., 2013; Shlonsky et al., 2013) had already been rated using this scale. Interventions identified via the clearinghouses and the remaining REA (Australian Centre for Posttraumatic Mental Health and Parenting Research Centre, 2013) were re-rated according to this scale for consistency of reporting. Information from multiple sources was synthesised where applicable. This rating scale uses tight criteria to assess quality based on design rigour, maintenance of effect, replication of effect and, for those rated highest, demonstrated effect in a high quality systematic review and meta-analysis. Use of this scale enables more confident statements about the degree of effect of the reported interventions.

This rating process relies on high quality systematic reviews with meta-analyses in order for interventions to be rated Well Supported. This additional measure takes into account the additional rigour of systematic reviews and ensures that only those interventions with the best available evidence are singled out at the highest rating level. Further information about the rating process can be found in Appendix 1.

Due to the large quantity of interventions on the broad range topics of relevance to this review, the focus of this report is on interventions that can more confidently be considered ‘effective’ as defined earlier: that is, those rated Emerging and higher. All interventions identified that were evaluated in an RCT were considered for inclusion, with those rated Pending appearing in a list in Appendix 1.

Box 3. Outcomes framework used to identify outcome domains targeted by interventions (adapted from Macvean et al. (2013) and Wade et al. (2012))

Child development: normative standards for growth and development; antenatal and infant development (e.g. antenatal and parental smoking and mother's alcohol/drug use, foetal and early childhood exposure to trauma or abuse, birth weight, breastfeeding, immunisation); covers prenatal through to 6 years; overall health; temperament; language and cognitive development (e.g. early childhood brain development, pre-academic skills, approaches to learning, successful in reading, writing, literacy and numeracy, problem-solving and decision-making skills, completion of secondary education, academic achievement, school engagement, attachment and retention, truancy, absenteeism); child adaptive behaviour (e.g. self-care skills, motor skills); parent promotion of child health and development; parent knowledge of child development.

Child behaviour: includes both internalising and externalising behaviour difficulties; problem behaviour; consistent parenting; child behaviour management; positive child behaviour and pro-social behaviour; social and emotional development (e.g. mental health, identity, social competence, self-control, self-esteem, self-efficacy, emotional management and expression, trauma symptoms, coping, emotional intelligence); law-abiding behaviour and underage convictions (particularly for adolescents); risk avoidance and risky behaviour (e.g. youth pregnancy, youth suicide, youth smoking, substance use).

Safety and physical wellbeing: includes optimal physical health and healthy lifestyle (e.g. adequate nutrition, free from preventable disease, sun protection, healthy teeth and gums, healthy weight, free from asthma, adequate exercise and physical activity, healthy adult/parent lifestyle); safety (e.g. safe from injury and harm); stability, material wellbeing and economic security (e.g. ability to pay for essentials, adequate family housing, family income and family social capital); effects of long-term exposure to persistent poverty; basic child care (e.g. bathing, putting baby to bed, clothing, food and nutrition, child self-care, avoidance of neglect)

Child maltreatment prevention: includes prevention of all forms of abuse as well as neglect; reduction of maltreatment; prevention of recurrence of maltreatment.

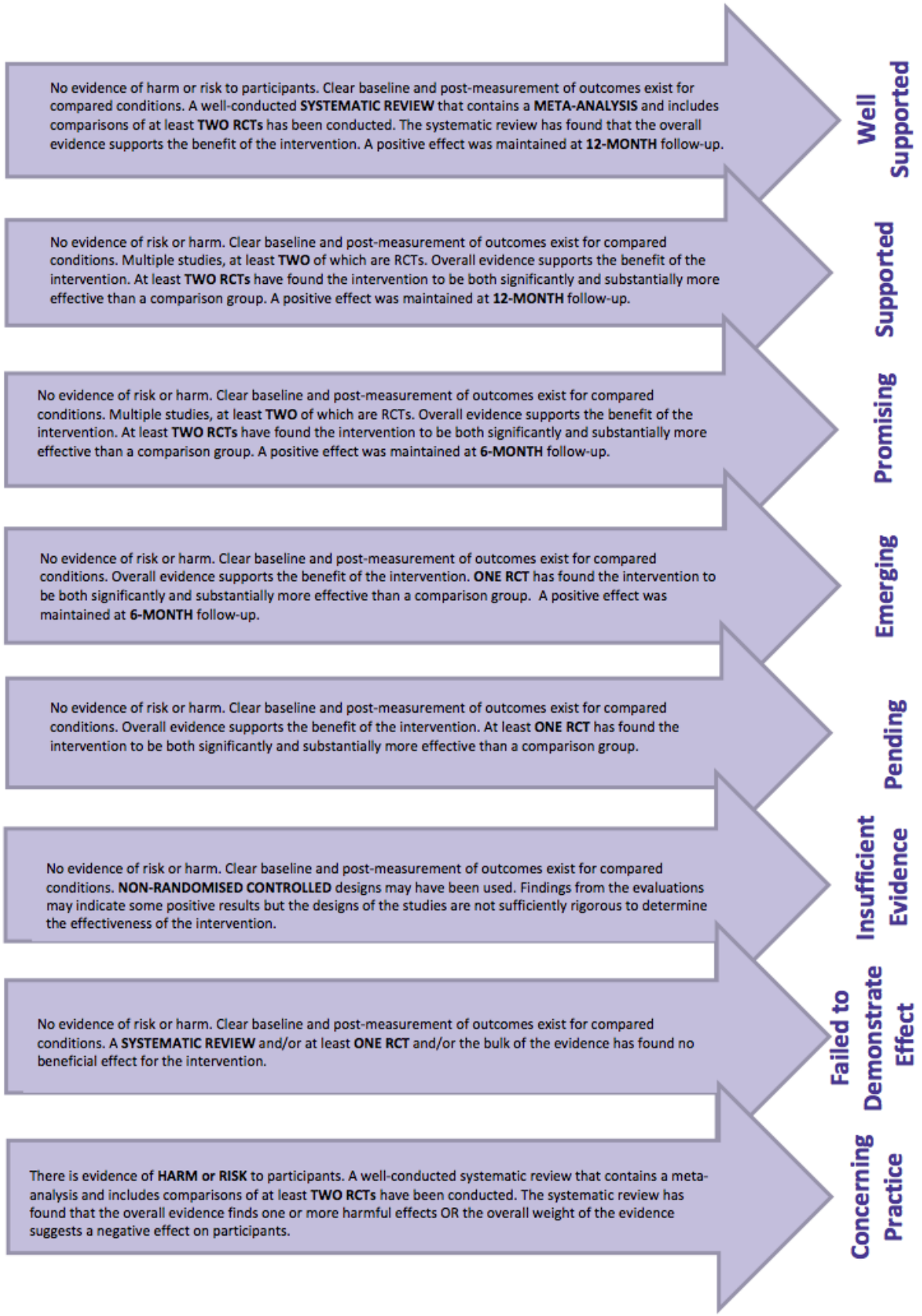
Family functioning: includes parent-child interactions (e.g. positive interactions between parents and children, emotional warmth and responsiveness, absence of hostility); consistency and reliability (e.g. children able to rely on supportive adults, providing guidance, providing adequate boundaries); attachment; stimulating learning and development; the parental relationship and relationships between other family members (e.g. child free from exposure to conflict or family violence, positive family functioning, stability in relationships, connection to primary caregiver, connection to family); good parental mental health.

Support networks: includes social relationships and social support (e.g. connection to school and friends, connection to community, connection to culture); family's community participation; community resources.

Systems outcomes: notification and re-notification to agencies, maltreatment investigations and re-investigation, verified maltreatment investigations and re-investigations, referrals to agencies, presentation to emergency department, help-

seeking behaviour, out-of-home care, length of stay, placement stability, maltreatment in care, placement with family, placement in community, placement with siblings, frequency, duration, and quality of parent visitation, level of restrictiveness of care, family reunification/restoration, adoption, re-entry to care, service utilisation, foster parent recruitment and retention, utilisation of kinship care.

Figure 1: Rating scale used to categorise the effectiveness of the interventions



3.5. Common components analysis

One of the challenges in the process of selecting effective interventions is finding something that suits the context of an organisation and the population. According to Mitchell (2011), the identification of components or elements that are common across interventions may help decrease some of these barriers to implementation of evidence-based practices. Chorpita, Daleiden, and Weisz (2005) defined a “practice element”, also known as a component, as a “discrete clinical technique or strategy” (p.11) that is part of an intervention. This refers to *what* is delivered within an intervention — e.g. the skills that are taught to parents — as well as *how* the intervention is delivered; e.g. modelling ways for parents to interact with children.

While interventions vary in the type of components they use, interventions for families, parents and children typically have some components in common. *Common components* are delivery techniques and intervention content that groups of interventions share. According to Chorpita (2005), common components can be matched to the individual context and target population. The end product of a common components analysis is that you have a picture of *delivery and content components* that are *common* across interventions that have been found to be effective, rather than a picture of effective components.

For the purpose of the common components analysis in this review, ‘effective’ interventions refer to interventions rated Emerging or higher, as defined in Figure 1. That is, the interventions have demonstrated a statistically significant improvement in child, parent, family or system outcomes when compared to a randomly assigned comparison group that did not receive the intervention (i.e. in a randomised controlled trial or RCT). The interventions have also demonstrated that the observed effect maintained for six months after the completion of the intervention.

The common components analysis is dependent on the availability of information about individual intervention delivery and content components. Degree of reporting by intervention developers is variable and the lack of components identified for some interventions in this review may be a reflection of availability of intervention details, as opposed to actual intervention components.

Components involved in each intervention rated Emerging or higher were identified through an extensive search and placed into a matrix (see Appendix 3). Components found to be common across at least 50% of interventions involving children or families with various identified vulnerabilities were collated to form a picture of common components.

Identification of commonly occurring intervention delivery and content components may assist with practice decisions in FACS services.

4. Findings

The systematic search of the clearinghouses identified a considerable number of interventions that were relevant to this topic. Many of these lacked evaluation design rigour (i.e. they were not evaluated in RCTs) in order to determine the effectiveness of the intervention. These interventions would be rated as having *Insufficient Evidence* and are not reported here.

From all sources, this review identified 136 relevant interventions that have been tested in RCTs. The results of these evaluations suggest that these interventions may be of some benefit to families. Ninety-one of these interventions were rated Pending. They have demonstrated effect in an RCT but they have either shown no maintenance of effect or the maintenance period was less than six months after the completion of the intervention. In order to be more confident in the benefit of an intervention, the effect should ideally be observed for a longer period in the absence of the support received by the intervention. A list of the Pending interventions appears in Appendix 1.

The interventions reported here are those that received a rating of Emerging and higher (n = 45) according to the scale in figure 1. These are the interventions that can more confidently be considered 'effective', as they demonstrated effect using a rigorous design (randomised controlled trial or RCT) and this effect was maintained *for at least one child, parent or family outcome* for a minimum of six months after the completion of the intervention. Two of the 45 interventions were rated Well Supported, 18 were rated Supported, nine were rated Promising and 16 were rated Emerging.

The 45 included interventions that were identified via the clearinghouses and the previous REAs. No new interventions rated Emerging or higher were identified through the additional search processes and no new evidence was found that resulted in rating adjustments. Further details regarding these search methods and the results of the additional searches can be found in Appendix 1, and also in the subsection below on parents with an intellectual disability.

Interventions are presented below in the context of child, parent, family and community factors that may determine child harm or maltreatment. As most families involved in these interventions were multi-problem and many of the interventions were multicomponent, most interventions related to more than one factor or identified child or family vulnerability. Many of the interventions involved families that presented with typical child welfare issues such as domestic violence and substance abuse and mental illness, which placed the family at risk of maltreating behaviours.

Interventions are identified as 'involving families' that have particular vulnerabilities for the purpose of consistency, however some may target only children or only parents, rather than parents and children. Interventions targeting more than one identified vulnerability will only be described once. The descriptions provided here have been synthesised from the clearinghouses and the past REAs. Further details of the interventions can be found in Appendix 2. In addition to intervention descriptions, there are subsections indicating *Stated Requirements* for most interventions. Under these headings are aspects of the interventions that, according

to the clearinghouses, are necessary for implementation, as signified by the use of phrases such as ‘must have’ and ‘minimum requirement’.

Features of the interventions appear after descriptions of the interventions. Child/youth age has been categorised into four groups: commencing during the ante-natal period, birth to preschool years (0-5), primary school years (6-12), and adolescence (13+). Intervention duration was categorised into three time frames: less than six months; 6 – 12 months; and longer than 12 months.

At the end of each section summarising the interventions involving the various identified family vulnerabilities, the components that were found to be *common* across at least 50% of these interventions are presented. Details of the components are provided in a matrix in Appendix 3.

In addition, four of the interventions were identified as taking a trauma-informed approach (defined previously); one was rated Well Supported, one Supported, one Promising, and one Emerging. These will be identified throughout the following section, with components of these trauma-informed practices summarised towards the end of this section.

Individual instances of child maltreatment take place within a broader community context. A range of child, parent, family and community factors affect child maltreatment (as discussed above) — those factors should be taken into account when selecting appropriate interventions. The findings of this review will be presented with consideration of the broader ecological context first in the form of community factors, followed by family factors, then parent factors and finally child factors which may be associated with increased risk of harm to children and young people.

4.1. Interventions associated with community factors

4.1.1. Interventions involving families identified as low income/SES

Several of the interventions included in this review may have been evaluated with low income or low SES families, however only five clearly indicated that these populations or communities were targeted (see table 2). Although these populations were targeted, the objective was not typically to improve the economic or social circumstances of the family.

4.1.1.1. Well Supported interventions

One intervention involving low income/SES parents was rated Well Supported: Nurse Family Partnership (NFP).

Nurse Family Partnership (NFP)

Nurse Family Partnership (NFP) is a home visiting intervention for low-income or adolescent, first-time mothers. The intervention commences during the second trimester and continues until the child is two years of age. Delivered by trained and qualified nurses, the intervention targets all of the outcomes in the outcomes framework.

In addition to providing education to parents regarding health behaviour, caring for children and family planning, the home-visiting nurses link parents to services and housing, income and nutritional assistance, and help them to access vocational training and childcare. Individualised service plans are developed in collaboration

with the parents, and parents are provided with problems solving skills and praise. Sessions are structured and last for one hour to 1.5 hours, with a total of 20 to 30 sessions over the course of the intervention, which goes for approximately 2.5 years.

A study conducted by NFP developer Olds et al. (2002) compared the effectiveness of NFP delivered by paraprofessionals compared to the nurse-delivered method and a control group. Findings that were made up to two years after the completion of intervention suggest that the families in the nurse-delivered group had significantly better outcomes than those in the other two groups. These results indicate that delivery of NFP by a nurse is preferable to paraprofessional delivery.

Stated Requirements

According to CEBC:

- 'Nurse home visitors must be registered nurses with a Bachelor's degree in nursing as a minimum qualification
- Nurse supervisors must be registered nurses with a Bachelor's degree in nursing as a minimum qualification, and a Master's degree in nursing is preferred.'

4.1.1.2. Supported interventions

One intervention involving low income/SES parents was rated Supported: ParentCORPS.

Table 2: Interventions involving low income/SES parents

Rating	Intervention	Target population	Outcomes Targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Well Supported	Nurse Family Partnership (NFP)	First-time, low-income or adolescent mothers — commences prenatally and continues until the child is two years old.	✓	✓	✓	✓	✓	✓	✓
Supported	ParentCORPS	Children aged 3 – 6 years in families living in low-income communities.	✓	✓			✓		
Emerging	AVANCE Parent-Child Education Program (PCEP)	Parents with children aged 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education.	✓						
	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents.	✓	✓					
	Parent training prevention model (not the name of an intervention, description only)	Parents of children aged 18 months to 4 years who are at risk of maltreatment and have parents who have a low SES status or who are disadvantaged.	✓	✓	✓	✓	✓		

ParentCORPS

ParentCORPS is targeted at children aged from 3 – 6 years in families living in low-income communities. The intervention aims to promote healthy development and school achievement for this population by improving children's social, emotional, and self-regulatory development. Early childhood educators collaborate to promote children's functioning in behavioural, academic, mental health and physical domains. ParentCORPS targets child development, child behaviour and family functioning.

The intervention consists of both parent and child groups, and is delivered in schools and other community settings (i.e. early childhood education or child care centres). Mental health professionals facilitate parent groups, and trained classroom teachers facilitate child groups. The intervention consists of 14 weekly group sessions lasting two hours each (approximately 15 participants in a group). The contents of parent groups include: creating a structure and routine for children; generating opportunities for positive parent-child interactions; adopting strategies that are meaningful and relevant to the families' culture; and using positive reinforcement for good behaviours and ignoring mild misbehaviours. Parents are introduced to these strategies through group discussions, role-plays, video series and a photography-based book of family stories and homework. Contents of the child groups include: interactive lessons, experiential activities, and play to promote social, emotional and self-regulatory skills.

4.1.1.3. Promising interventions

No interventions involving low income/SES parents were rated Promising in this review.

4.1.1.4. Emerging interventions

Three interventions involving low income/SES parents was rated Emerging: AVANCE Parent-Child Education Program (PCEP); Home Instruction for Parents of Preschool Youngsters (HIPPY); and Parent training prevention model (not the name of an intervention, description only).

AVANCE Parent-Child Education Program (PCEP)

AVANCE Parent-Child Education Program (PCEP) is an intervention for vulnerable pregnant women or women with children aged up to three years. Vulnerabilities include teenage parenting or low education levels. Delivery is based in the home and in community settings. The intervention targets child development.

Parenting education covers topics such as child physical, social, emotional and cognitive development. Parents learn how to make toys and how to support child learning through play. Parent personal growth and education are also supported. Education enrichment is also offered to the child participants in order to prepare them for school.

Staff are trained; the parent educator requires a degree in education, psychology or a similar field. Parents participate in three-hour group sessions once a week. The child education program is run at the same time as these sessions. Home visits with parents and children occur monthly for 30 – 45 minutes. The total intervention duration is nine months.

Stated Requirements

According to CEBC:

- ‘Educational requirements for primary PCEP positions:
  - Parent Educator – BA degree in education, psychology or related human services field
  - Toy-making Instructor – high school diploma or equivalent
  - Home Educator – high school diploma or equivalent
  - Early Childhood Educator – high school diploma or equivalent with a Child Development Associate credential
  - Early Childhood Educator Aide – high school diploma or equivalent
- All positions are required to complete initial AVANCE training and obtain biannual refresher training.’

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Home Instruction for Parents of Preschool Youngsters (HIPPY) is a home-based intervention for parents with children aged up to five years in families with little resources or education or for teenage parents. The target outcomes are child development and child behaviour. The intervention is delivered by staff with training but no particular qualifications. The minimum duration of the home visits is 30 weeks for up to three years, with each session lasting about one hour. The primary purpose is to ensure school readiness. Resources are provided to assist with the child’s education needs, but also their socio-emotional and physical needs. HIPPY uses a curriculum to engage parents and encourage parent and child interaction on educational activities.

Stated Requirements

According to CEBC:

- ‘Educational requirements are usually a high school diploma or GED
- The coordinator is required to have the minimum of a Bachelor's degree.’

Parent training prevention model (this is not the name of intervention, no name provided)

This parent training intervention is for parents of children aged from 18 months – 4 years who are at risk of maltreatment. Parental risk factors include low SES and disadvantage. The intervention targets child development, child behaviour, safety and physical wellbeing, child maltreatment prevention, and family functioning. It is delivered in the home and in group settings by professionals. Families receive 15 sessions over 15 weeks.

The sessions involved discussion between parents and facilitators, as well as written information, role-play, modelling and homework. Intervention content includes positive parenting skills, managing difficult behaviours, problem solving, child health and safety, and anger management.

4.1.1.5. Features of interventions involving families identified as low income/SES

All families targeted in these interventions had children aged from 0 – 6 years. The interventions were delivered to groups of families and to families individually, and were more often delivered to parents but not children. The interventions were most

often home-based, but could also be delivered in community settings where there was delivery to groups of families. Most of the interventions were multicomponent.

Most interventions required staff to be trained clinicians or educators with Bachelor's degrees at minimum, and most interventions required additional staff training. Many interventions indicated that staff supervision was provided.

4.1.1.6. Common components of interventions involving families identified as low income/SES

Eleven components were identified as common across the interventions involving low income or low SES families (see Box 4).

Box 4. Common components of interventions involving low income/SES families

Intervention delivery

- Goal-setting for individuals or families
- Sessions were structured
- Discussion, rather than didactic or lecture-style delivery
- Referral to services
- Role-play.

Intervention content

- Parenting education or training or parenting skills
- Child emotional skills, development or regulation
- Child social skills
- Child development
- How to play and how to use play to promote child development and learning
- Parental life course; e.g. parent employment, education, personal development.

4.2. Interventions associated with family factors

4.2.1. Interventions involving families with children at risk of or exposed to maltreatment

This review identified 16 interventions for families (i.e. parents, children or young people) at risk of maltreatment or maltreating behaviours or families who have already experienced maltreatment. In most cases these were a mixture of neglect and any form of abuse. While all of these interventions involved families where there was a risk of maltreatment or a history of maltreatment, the main aim of the intervention may not have been to prevent or reduce maltreatment. Seven of these interventions were rated Supported, two were rated Promising, and eight were rated Emerging. Ratings and outcomes targeted by the interventions for families of children at risk of or exposed to maltreatment are indicated in Table 3.

4.2.1.1. Well Supported interventions

No interventions targeting maltreatment populations were rated Well Supported.

4.2.1.2. Supported interventions

Six interventions for families of children at risk of or exposed to maltreatment were rated Supported: Attachment and Biobehavioral Catch-up (ABC); Healthy Families America (Home Visiting for Child Well-Being); Parent-Child Interaction Therapy (PCIT); Prolonged Exposure Therapy for Adolescents (PE-A); SafeCare; and Triple P Positive Parenting Programs — Standard and Enhanced Group Behavioural Family Interventions.

Table 3: Interventions involving families of children at risk of or exposed to maltreatment

Rating	Intervention	Target population	Outcomes Targeted						
			Child development	Child behaviour	Safety & physical	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Attachment and Biobehavioral Catch-up (ABC)	Caregivers of infants aged 6 months – 2 years who have experienced early adversity, such as maltreatment or disruptions in care.		✓		✓	✓		
	Healthy Families America (Home Visiting for Child Well-Being)	Families of children aged 0 – 5 years which are at-risk for child maltreatment. Families may be at-risk due to mental illness, substance abuse, or parental history of abuse in childhood.	✓	✓	✓	✓	✓	✓	✓
	Parent-Child Interaction Therapy (PCIT)	Children aged 2 – 7 years with behaviour and parent-child relationship problems. May be conducted with parents or other carers.	✓	✓			✓		
	Prolonged Exposure Therapy for Adolescents (PE-A)	Adolescents who have experienced a trauma of any kind. Has also been used with children aged 6 –12 years.	✓	✓				✓	
	SafeCare	Parents of children aged 0 – 5 years at risk for child neglect and/or abuse and/or parents with a history of child maltreatment.	✓	✓	✓	✓	✓		
	Triple P –Standard and Enhanced	Parenting intervention for children with behavioural problems, adapted for use with maltreatment populations and parents with mental illness.	✓	✓		✓	✓		

Rating	Intervention	Target population	Outcomes Targeted						
			Child development	Child behaviour	Safety & physical	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Promising	Child-Parent Psychotherapy (CPP)	Children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse.	✓	✓	✓		✓	✓	
	Safe Environment for Every Kid Model (SEEK)	Families with children aged 0 – 5 years who are at risk of maltreating behaviours due to parental substance abuse or depression.	✓		✓	✓		✓	
Emerging	Child FIRST	Children aged 6 months – 3 years with emotional and behaviour problems where the parents are at psychosocial risk due to maltreatment or parental mental illness.	✓	✓	✓	✓	✓		✓
	Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP)	Children aged 3 – 6 years with a history of maltreatment.	✓	✓	✓	✓	✓		
	Early Start	Families with children aged up to 3 months who are at risk of maltreatment due to family circumstances including domestic, family or intimate partner violence and parental substance abuse.	✓	✓	✓	✓	✓	✓	✓
	Family Connections	Children aged 5 – 11 years exposed to maltreatment, domestic violence, parental mental illness or parental substance misuse.		✓		✓	✓	✓	✓
	Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Children aged 6 – 17 years who have been maltreated or who are at risk of maltreatment.	✓	✓	✓	✓	✓		✓

Rating	Intervention	Target population	Outcomes Targeted						
			Child development	Child behaviour	Safety & physical	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Emerging	Parent training prevention model (this is not the name of intervention, no name provided)	Parents of children aged 18 months to 4 years who are at risk of maltreatment and have parents who have a low SES status or are disadvantaged.	✓	✓	✓	✓	✓		
	Parents Under Pressure (PUP)	Families of children aged 2 – 8 years who are at risk of child maltreatment due to problems such as parental substance misuse, mental illness, severe financial stress and family conflict.		✓	✓	✓	✓	✓	
	Project Support	Children aged 3 – 8 years who have been exposed or who are at risk of neglect, abuse or domestic violence.		✓		✓	✓		✓

Attachment and Biobehavioral Catch-up (ABC)

Attachment and Biobehavioral Catch-up (ABC) is an attachment-based intervention for carers of children aged from 6 months to 2 years who have experienced adversity due to maltreatment or disruptions in care. The intervention targets child behaviour, child maltreatment prevention and family functioning.

ABC is a manualised intervention, with 10 weekly sessions of one hour delivered by coaches in the home. Coaches are screened, trained over 2 – 3 days, and supervised for a year. The following are involved in ABC: 1) caregiver is coached to provide a nurturing response to child behaviours which push them away, overriding tendencies to respond in kind; 2) caregiver is coached to provide an environment which assists the child's self-regulatory capacity, including by following the child's lead; and 3) caregiver is assisted to decrease their own behaviours which may frighten or overwhelm the child.

Stated Requirements

According to CEBC:

- 'Must be conducted at caregivers' homes – this can include shelters or other temporary living situations.'

Healthy Families America (Home Visiting for Child Well-Being)

Healthy Families America (Home Visiting for Child Well-Being) is a home-visiting intervention for families with children aged from 0 – 5 years who are at-risk for child abuse and neglect. Families may be high-risk due to substance abuse, mental illness, or parental history of abuse in childhood. The intervention targets all outcomes in the outcomes framework.

Families receive one-hour sessions every week for the first six months after their child is born. Frequency then reduces to fortnightly, monthly, then quarterly, and keeps reducing until visits cease about the time of the child's third birthday. Prenatal sessions are also offered. Decreases in service intensity are determined on an individual basis.

Screening and assessment are the first steps in intervention delivery. Individual plans are developed with families. Services are culturally sensitive and all family characteristics are taken into account during interactions with the family. The intervention supports parents, parent-child interactions, health and safety, and child development. Staff members support families to link with services and supports as needed, such as medical, financial and substance abuse services.

Staff are trained but no specific qualifications are required. However, experience working with families is needed, and supervisors and managers require qualifications in a human services field.

Stated Requirements

According to CEBC:

- 'Program staff must identify positive ways to establish a relationship with a family
- Ethnic, racial, language, demographic, and other cultural characteristics identified by the program must be taken into account

- All staff must receive training, professional skill development and receive weekly supervision
- Supervisors should have a Bachelor's degree in human services or related fields (Master's degree preferred).
- Program managers should have a bachelor's degree in human services administration or related fields (Master's degree preferred).'

Note that a variation of this intervention, Healthy Families America (Home Visiting for Prevention of Child Abuse and Neglect), which aims to *prevent* abuse and neglect, has been rated Failed to Demonstrate Effect by CEBC.

Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT) is an intervention for children aged from 2 – 7 years in situations where there are parent-child relationship problems (including maltreating behaviours or risk of maltreating behaviours) and child behaviour problems. The target outcomes of this intervention are child behaviour and development, and family functioning.

PCIT teaches parents skills which they can use as social reinforcers of positive child behaviour, and behaviour management skills to decrease negative behaviour. Parents work with therapist coaches to master the two aspects of PCIT: 1) child directed interaction, where the parent learns to give positive attention to the child following positive/non-negative behaviour while ignoring negative behaviour; 2) parent-directed interaction, where the parent learns to lead the child's behaviour effectively.

Parents are observed via one-way mirror and coached via wireless communications by a therapist at each treatment session, which is typically held in a community agency or outpatient clinic. Parents have one-hour sessions with the therapist once or twice each week for a total of 10 – 20 sessions (sessions continue until each element is mastered and the child's behaviour has improved to criteria). Parents complete homework between sessions to consolidate skills learnt at sessions. Therapists are required to have completed graduate clinical training to Master's level, and be licensed as a mental-health care provider.

Stated Requirements

According to CEBC:

- 'The equivalent of a Master's degree and a licence as a mental health provider is required
- A firm understanding of behavioral principles and adequate prior training in cognitive-behavior therapy, child behavior therapy, and therapy process skills (e.g., facilitative listening) is required.'

Prolonged Exposure Therapy for Adolescents (PE-A)

Prolonged Exposure Therapy for Adolescents (PE-A) is an intervention for adolescents (12 – 18 years) who have experienced maltreatment or trauma (e.g. sexual assault, violent crime, car accident, etc.). In this intervention, adolescents are supported as they approach situations and activities which remind them of their trauma and which they therefore have avoided. Adolescents are supported as they

approach these situations and activities and revisit the traumatic memory by retelling it. According to the definition provided in this report, PE-A is *trauma-informed*.

The aim of PE-A is to teach adolescents that they can safely experience reminders of trauma, that they can tolerate the distress arising from reminders, and that the distress decreases over time. PE-A target outcomes are child development and behaviour, and support networks. The aims of the intervention are: 1) explaining exposure techniques and how they will help; 2) creating an exposure hierarchy and helping the client implement it; 3) supporting the client to re-experience the traumatic memory; and 4) explaining common reactions to trauma and how to deal with those reactions.

PE-A makes use of graded exposure, psychoeducation and relaxation techniques, which are delivered in community agencies and outpatient clinics. Licensed mental health professionals (or staff working under their supervision) deliver sessions of 60 – 90 minutes, once or twice a week, for 2 – 4 months (8 – 15 sessions).

Stated Requirements

According to CEBC:

- ‘Licensed mental health professionals or those working under their supervision can implement PE-A. Psychology, social work and nursing staff can implement PE-A in their respective roles.’

SafeCare

SafeCare is an intervention which targets parents of children aged from 0 – 5 years who are at-risk of, or have a history of, child abuse or neglect. The outcomes targeted by this intervention are: family functioning, child behaviour and development, child safety and physical wellbeing, and maltreatment prevention.

SafeCare is a home-visit intervention, with weekly sessions of 1.5 hours that run for 18 – 20 weeks. Sessions are conducted by trained staff (preferably with college education as minimum) and teach parents to interact positively with their children (planning activities and responding appropriately to challenging behaviours), to recognise and prevent hazards in the home, and to recognise and respond appropriately to symptoms of illness or injuring in the child.

SafeCare involves: 1) planned activities, assessment and training (covering time management, explaining rules to children, rewarding behaviour, incidental teaching, discussing outcomes and expectations with child); 2) home safety assessment and training (identifying and removing hazards); and 3) infant and child healthcare assessment and training (including problem-solving training where needed). Training uses modelling, role rehearsal and set performance criteria, with booster training if performance falls below criteria. Staff are monitored for fidelity to the intervention model.

Stated Requirements

According to CEBC:

- ‘The most important issue regarding staff qualifications is that staff be trained to performance criteria.’

Triple P Positive Parenting Programs — Standard and Enhanced Group Behavioural Family Interventions

Triple P Positive Parenting Program is a widely researched intervention that has various levels and versions. It has typically been delivered to parents of children aged up to 12 years who have behavioural problems. One of the past REAs identified studies in which two versions of Triple P had been tested with populations relevant to the current review. Evidence for these is presented here.

The Triple P Positive Parenting Programs — Standard and Enhanced Group Behavioural Family Interventions (Triple P) target children in families where there is a history of maltreatment. Two interventions are reported here, targeting two populations: 1) children with a mean age of four years; 2) children with a mean age of three years whose parents have mental illness and concerns about child behaviour. There are standard and enhanced interventions for both of these populations. Triple P target outcomes for these populations are: prevention of maltreatment (future maltreatment if this has already occurred); family functioning; child development and behaviour.

Components for and session details for the target population (1) are:

Standard: Strategies for promoting the child's competence and for managing misbehaviour; planning for situations at high-risk for difficult child behaviour; planned activities training. Four weekly *group* sessions in the community and four individual telephone calls.

Enhanced: As above, plus cognitive reframing for parents' negative attributions about child behaviour and anger management strategies. Sessions as above, plus four additional group sessions.

Components and session details for target population (2) are:

Standard: Strategies for promoting the child's competence and for managing misbehaviour; planning for situations at high-risk for difficult child behaviour; planned activities training. Ten weekly *individual* sessions, half at home and half in a clinic.

Enhanced: As above, plus partner support for couples, coping skills for couples, and social support for single parents. Twelve *individual* sessions, half at home and half in a clinic.

The intervention is delivered in the community (for population (1)) and divided between clinic and home (for population (2)). The intervention may be delivered by any relevant qualified professional.

4.2.1.3. Promising interventions

The review identified two interventions for families of children at risk of or exposed to maltreatment that were rated Promising: Child-Parent Psychotherapy (CPP) and Safe Environment for Every Kid Model (SEEK).

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention for children aged from 0 – 5 years who have been exposed to abuse, neglect, sexual abuse, parental substance abuse or domestic or family violence, and their primary caregiver. CPP aims to prevent child maltreatment and support the caregiver-child relationship. The target outcomes of CPP are: child development and behaviour, family functioning, safety

and physical wellbeing, and support networks. This intervention meets the criteria for being *trauma-informed*.

CPP treats the parent-child relationship as the primary target of the intervention. The intervention covers:

- Safety (in the environment, in behaviour, via appropriate limit setting and parent-child roles)
- Affect regulation (guidance on how children regulate affect and develop strategies for doing this appropriately, foster parent's ability to respond in helpful ways to child upset, foster the children's ability to use parent as a secure base)
- Reciprocity in relationship (support expressions of negative and positive feelings for important people and understanding of other's perspective, support parent and child autonomy, change maladaptive patterns of interactions)
- Focusing on the traumatic event (help parent acknowledge child's experience and see links between experience and current behaviour for themselves and the child, support parents and child in creating a joint narrative and master the trauma)
- Continuity of daily living (foster prosocial behaviour, development of routines that are predicable, efforts for engagement in appropriate activities).

CPP can be delivered in the home, or in agencies, schools or outpatient clinics. Sessions of 1 – 1.5 hours are run every week for 52 weeks. Therapists and supervisors must be trained to Master's level, and supervisors have at least one year's training in CPP.

Stated Requirements

According to CEBC:

- 'Minimum qualification for practitioners is a master's degree
- Minimum qualification for supervisors is a 'master's degree plus minimum of 1 year training in the model.'

Safe Environment for Every Kid Model (SEEK)

Safe Environment for Every Kid Model (SEEK) is an intervention to prevent child maltreatment in at-risk families. It targets children aged from 0 – 5 years in families with risk factors for maltreatment such as parental mental illness or substance abuse. The target outcomes for SEEK are: child free of maltreatment, support networks, safety and physical wellbeing, and child development.

SEEK involves: 1) health professional training; 2) motivational interviewing; 3) standardised assessment using a tailored questionnaire; 4) plain-language parent resources; and 5) collaboration between medical and mental health professionals.

SEEK is delivered in paediatric primary settings by licensed medical professionals (paediatricians, family medicine physicians, nurse practitioners, and physician assistants) and licensed, Master's-level mental health professionals. Screening questionnaire should be administered at regular check-ups in the child's first five years; intervention intensity depends on specific situation and continues until the child is five years of age.

Stated Requirements

According to CEBC:

- ‘Mental health professionals need at least a Master’s degree in a relevant field and must be licensed to provide clinical services
- Medical professionals should be licensed to practise as a paediatrician, a family medicine physician, a nurse practitioner or a physician assistant.’

4.2.1.4. Emerging interventions

Eight interventions for families of children exposed to or at risk of maltreatment were rated Emerging: Child FIRST; Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP); Early Start; Family Connections; Multisystemic Therapy for Child Abuse and Neglect (MST-CAN); Parent training prevention model (this is not the name of intervention, no name provided); PUP; and Project Support.

Child FIRST

The Child FIRST intervention targets children aged from 6 months – 3 years with emotional and behavioural problems, where parent psychosocial factors/mental illness put the child at risk of maltreatment. The outcomes targeted by Child FIRST are: child development and behaviour; safety and physical wellbeing; prevention of maltreatment; family functioning; and systems outcomes. The intervention is delivered in the home in 24 weekly sessions.

Child FIRST intervention components are: assessment of child and family; individualised plan; linkage to other services; consideration of family priorities, culture, strengths and needs; collaboration with family; home visits as guided by parental needs; observation of child’s cognitive, emotional and physical development and of parent-child interactions; psychoeducation; reflective process to understand child’s feelings and meaning of the child’s challenging behaviours; psychodynamic understanding of maternal history, feelings and experience of child; alternative perspectives on child behaviour; development of new parental responses; positive reinforcement of parent and child strengths.

Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP)

Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP) is for children with a history of maltreatment who are aged from 3 to 6 years. It is delivered in a clinical setting and targets child development, child behaviour, safety and physical well-being, maltreatment prevention and family functioning. The intervention can be delivered by qualified professionals to parents and children in 90-minute sessions once a week for 12 weeks.

CBT-SAP provides parent education, problem-solving psychoeducation and support. CBT is used to assist with reframing, thought-stopping, positive imagery and contingency reinforcement. The objective is to assist parents and children with their beliefs about sexual abuse, feelings of damage, appropriate emotional support, anxiety and fear, inappropriate behaviours, and safety and assertiveness.

Stated Requirements

According to CEBC:

- ‘Minimum provider qualification is a ‘master’s degree and training in the treatment model’ and relevant ‘experience working with children and families.’

Early Start

Early Start is for families with children aged up to three months who are vulnerable and at risk of exposure to maltreatment. Risk factors within the family may include parental substance misuse and domestic, family or intimate partner violence. Dose is variable, ranging from weekly to monthly, and may extend for up to three years. The intervention is delivered in the home by a professional and it targets all outcome domains in the outcomes framework.

Early Start commences with individual needs and strengths assessments and plan development. Families receive education and supported centred on topics such as: child health and safety; positive and non-punitive parenting; parental mental and physical health; treatment of substance abuse and depression and anxiety; finances; maternal employment; family relationships and crisis management.

Family Connections

Family Connections targets children aged from 5 – 11 years who have been exposed to parental substance misuse, parental mental illness, domestic or family violence or child neglect. The intervention is delivered in the home by social workers to both parents and children. Families receive up to 40 sessions of 90 minutes each.

This intervention targets child behaviour, maltreatment prevention, family functioning, support networks and systems outcomes. Families receive support, community outcomes and tailored interventions. Family Connections is strengths-based and outcomes-driven, with a focus on cultural competence.

Stated Requirements

According to CEBC:

- ‘Minimum provider qualifications are a ‘Master's level worker or Bachelor's level worker supervised by a staff member with a Master's degree or higher.’

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) targets children aged from 6 to 17 years who have been exposed to or who are at risk of maltreatment. It is delivered to all family members in the home and community and targets child development, safety and physical wellbeing, child behaviour, maltreatment prevention, family functioning and systems outcomes. MST-CAN meets the *trauma-informed* practice criteria.

MST-CAN is delivered by teams including counsellors or social workers, a psychiatrist, a crisis caseworker, and a supervisor who is qualified in counselling or social work. The objective is to prevent re-abuse and out-of-home placement. Problem-solving, family communication, anger management, PTSD and issues surrounding abuse and neglect are the focus of therapy. Intensive services are provided at least three times a week, but possibly on a daily basis. Services are available around the clock. Sessions may last from 50 minutes to two hours, with a total service duration of 6 – 9 months.

Stated Requirements

According to CEBC:

- ‘The MST-CAN team must include one full-time crisis caseworker. This staff member should be at least a Bachelor’s-prepared professional.

- In relation to program monitoring and use of data, ‘there must be a formal Memorandum of Agreement (MOA) in place regarding access to abuse and placement data prior to implementation.’

MST-CAN Supervisor minimum provider qualifications:

- ‘Must be assigned to MST-CAN 100%
- Must have a PhD or Master's degree in counselling, social work or a related field, be independently licensed and have an understanding of the child welfare system
- Must have experience in managing severe family crises that involve safety risk to the children and/or entire family
- Must have a thorough understanding of state and national mandated abuse reporting laws.’

MST-CAN Therapist minimum qualifications:

- ‘Must be assigned to a single MST-CAN team 100%
- Must have a Master's degree in counselling, social work, or a related field.’

MST-CAN Psychiatrist minimum qualifications:

- ‘Must be available to team at least 8 hours per week
- Must be trained in the MST treatment model and the MST-CAN adaptations by MST, Inc.
- Must be integrated into the clinical team and should be able to serve adults and children
- Must have a thorough understanding of state and national mandated abuse reporting laws.’

Parents Under Pressure (PuP)

Parents Under Pressure (PuP) is for families of children aged from 2 to 8 years in which there is a parent with substance misuse problems. It targets child behaviours, safety and physical wellbeing, maltreatment prevention, family functioning and support networks. PuP is delivered in the home by a trained PuP therapist in 10 weekly sessions.

PuP commences with an assessment and plan development. Content focuses on strengthening parenting skills that are positive and non-punitive, life skills including budgeting, health care and exercise, and family relationships. Management of substance abuse relapse is also covered in the intervention.

Project Support

Project Support targets children aged from 3 to 8 years who have been exposed to or who are at risk of maltreatment or domestic violence. The intervention is delivered in the home in sessions of 60 to 90 minutes over a period of eight months. The aim of the interventions is to assist families that are leaving domestic violence shelters and to reduce child behaviour problems. The intervention targets child behaviour, maltreatment prevention, family functioning and systems outcomes.

Mothers receive parenting education on child management, non-coercive discipline and positive parenting. Emotional support is also provided to mothers.

4.2.1.5. Features of interventions involving families with children at risk of or exposed to maltreatment

Children in these interventions were typically aged from 0 to 6 years. Interventions tended to be delivered to families individually rather than in groups, and involved components for parents and children. They were typically delivered in the family's home and ran for less than six months. Half of the interventions were multicomponent.

Half of the interventions identified for this population required staff to be trained clinicians or educators with, at minimum, a Bachelor's degree.

4.2.1.6. Common components of interventions involving families with children at risk of or exposed to maltreatment

The analysis of components involved in interventions for families exposed to or at risk of maltreatment identified six common components. Components common across 50% or more interventions appear in Box 5.

Box 5. Common components of interventions involving families with children exposed to or at risk of maltreatment

Intervention delivery

- Intake assessment of some form; e.g. assessment of family needs, strengths and concerns or a clinical assessment
- Sessions were structured.

Intervention content

- Parenting education or training or parenting skills
- Child or home safety or safety checks
- Child/youth behaviour, behaviour change and behaviour management techniques
- Parent-child communication, relationships or interactions.

4.2.2. Interventions involving families exposed to domestic violence

Five interventions that have been evaluated with families exposed to domestic violence or family violence were identified in this review. Although these interventions have been evaluated with populations experiencing domestic violence, they may not have prevention or reduction of domestic violence as their central objective. Table 4 provides an indication of these intervention ratings and outcomes targeted.

Table 4: Interventions involving families exposed to domestic violence

Rating	Intervention	Target population	Outcomes Targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Promising	Child-Parent Psychotherapy (CPP)	Children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse.	✓	✓	✓		✓	✓	
Emerging	Community Advocacy Project (CAP)	Survivors of domestic violence and their children.					✓	✓	✓
	Early Start	Families with children aged up to three months who are at risk of maltreatment due to family circumstances including domestic, family or intimate partner violence and parental substance abuse.	✓	✓	✓	✓	✓	✓	✓
	Family Connections	Children aged 5 – 11 years exposed to maltreatment, domestic violence, parental mental illness or parental substance misuse.		✓		✓	✓	✓	✓
	Project Support	Children aged 3 – 8 years who have been exposed or who are at risk of neglect, abuse or domestic violence.		✓		✓	✓		✓

4.2.2.1. Well Supported interventions

No interventions relevant to a population at risk of domestic violence were rated Well Supported.

4.2.2.2. Supported interventions

No interventions relevant to a population at risk of domestic violence were rated Supported.

4.2.2.3. Promising interventions

One intervention for populations exposed to or at risk of domestic violence was rated Promising in this review: CPP.

4.2.2.4. Emerging interventions

Four interventions for families exposed to domestic violence were rated Emerging in this review: Community Advocacy Project (CAP); Early Start; Family Connections; and Project Support. Early Start, Family Connections and Project Support involved families experiencing various factors that place children at risk, and domestic violence was identified as one of these factors.

Community Advocacy Project (CAP)

The Community Advocacy Project (CAP) is an intervention for survivors of domestic abuse and their children. It was designed for survivors who have used shelters, but it may be suitable for survivors who have not used shelters.

CAP's target outcomes are: increasing children's self-confidence; decreasing women's depression; increasing women's access to resources, social support and quality of life; and increasing women's and children's safety. It therefore targets family functioning, support networks and systems outcomes.

In CAP, activities are driven by clients not advocates; advocates are knowledgeable about community resources and are proactive and effective in linking clients with them; advocates are highly trained in empathy and active listening, and focus on enhancing clients' social support.

CAP is delivered in the home, for 4 – 6 hours per week over 10 weeks. Advocates are trained in domestic abuse dynamics, safety planning, strengths-based philosophy and community resources. Ongoing training and supervision is essential to model fidelity. Supervisors should have at least two years experience in providing domestic abuse services in community settings, and be trained in empathy, active listening, safety planning and strengths-based services.

Stated Requirements

According to CEBC:

- 'Advocates must be highly trained in strengths-based philosophy, domestic abuse dynamics, safety planning, and obtaining community resources.
- Supervisors should have at least two years experience providing domestic abuse services, ideally in community settings.'

4.2.2.5. Features of interventions involving families exposed to domestic violence

Most of the children in these interventions were aged from 0 – 12 years. All interventions were delivered to individual families, not to groups, and they usually

included components for parents and children. Interventions were consistently delivered in the home and typically ran for 6 to 12 months.

4.2.2.6. Common components of interventions involving families exposed to domestic violence

The common components analysis identified seven components that were common across at least 50% of the interventions involving families exposed to or at risk of domestic violence (see Box 6).

Box 6. Common components of interventions involving families exposed to domestic violence

Intervention delivery

- Intake assessment of some form; e.g. assessment of family needs, strengths and concerns
- Individualised family plan
- Discussion, rather than didactic, lecture-style delivery.

Intervention content

- Parenting education or training or parenting skills
- Child or home safety or safety checks
- Child/youth behaviour, behaviour change and behaviour management techniques
- Parent-child interactions, communication or relationships.

4.2.3. Interventions involving families with children or young people at imminent risk of out-of-home placement

Four interventions were identified in this review for families in which the children and young people were at imminent risk of being removed from their family homes and placed in some form of out-of-home arrangement. This may have been foster care, hospitalisation or incarceration. See Table 5 for interventions that target out-of-home placement prevention.

4.2.3.1. Well Supported interventions

No Well Supported interventions for families of children and young people at risk of out-of-home placement were identified in this review.

Table 5: Interventions for families with children or young people at risk of out-of-home placement

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Multisystemic Therapy (MST)	Youth aged 12 – 17 years who are serious juvenile offenders with possible substance abuse issues; who are at risk of out-of-home placement due to antisocial or delinquent behaviours; who might be involved with the juvenile justice system.		✓			✓	✓	✓
	Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB)	Youth aged 13 – 17 years who have committed sexual offences and demonstrated other problem behaviors.		✓			✓	✓	✓
Emerging	Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Children aged 6 – 17 years who have been maltreated or are at risk of maltreatment.	✓	✓	✓	✓	✓		✓
	Homebuilders	Families with children aged up to 18 years at imminent risk of placement into, or needing intensive services to return from, residential or group treatment, foster care, juvenile justice facilities or psychiatric hospitals.	✓	✓		✓	✓	✓	✓

4.2.3.2. Supported interventions

Two of the interventions involving families for children and young people at risk of out-of-home placement were rated Supported: Multisystemic Therapy (MST); and Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB).

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is for delinquent and antisocial youth aged from 12 to 17 years who are at imminent risk of out-of-home placement due to serious offences; who are physically and verbally aggressive; and, who might have substance misuse issues. The intervention is delivered in community and home-based settings with the aim of reducing youth criminal behaviour and out-of-home placements. MST targets child behaviour, family functioning, support networks and systems outcomes.

MST sessions are delivered by therapists with a Master's degree and typically occur from three times a week to daily, with intensity of services depending on the needs of the family. The recommended duration of the intervention is 3 – 5 months, with sessions varying in length from 50 minutes to two hours. Contents of the intervention include: incorporation of treatment approaches to address a range of peer, family, school and community risk factors; empowering caregivers and promoting youth behaviour change; and quality assurance protocols to ensure treatment fidelity and positive intervention outcomes.

Stated Requirements

According to CEBC:

- 'The supervisor must have an understanding of the Juvenile Justice system, and experience with family therapy and cognitive-behavioral therapy
- The supervisor must have experience in managing severe family crises that involve safety risk to the family
- Supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy)
- MST clinical supervisors must be at least 50% part-time and may supervise 1-2 teams only
- At least 66% of the therapists must have a Master's degree in counseling or social work
- The agency must have community support for sustainability.'

Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB)

Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB) is an intervention for adolescents aged from 13 – 17 years who have committed sexual offences and demonstrated other problem behaviours. The aim of the intervention is to reduce problem sexual behaviours and other antisocial behaviours, and decrease the risk of out-of-home placements. MST-PSB is delivered by Master's-level therapists who have been trained in the human services field. The intervention targets child behaviour, family functioning, support networks and systems outcomes, and uses an ecological model of care by incorporating resources based in the community such as case workers, school professionals and probation/parole officers.

The intervention is delivered in home, school and community settings over five to seven months. Families typically require 2 to 4 sessions per week during the most intensive parts of treatment, with high-need families requiring more sessions. Contents of the intervention depend on the individual characteristics and needs of the family but typically focus on deficits in family relations, peer relations, school performance and the youth's cognitive processes. In addition to this, parents attend family therapy sessions and increase their skills in the provision of guidance to youth and development of social support networks.

Stated Requirements

According to CEBC:

- 'MST-PSB clinical supervisors must be allocate at least 50% of their time to each MST-PSB team and may supervise 1-2 teams only
- The agency must have community support for sustainability
- The supervisor must have an understanding of the juvenile justice system, experience with family therapy and cognitive-behavioral therapy, and experience in managing severe family crises that involve safety risk to the family.
- Supervisors are, at a minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy).
- Therapists must have a Master's degree in a mental health-related field.'

4.2.3.3. Promising interventions

No Promising interventions for families for children and young people at risk of out-of-home placement were identified.

4.2.3.4. Emerging interventions

MST-CAN and Homebuilders, both rated Emerging, targeted families with children and young people at imminent risk of removal from their homes.

Homebuilders

Homebuilders is an intensive family preservation service that is delivered in the natural environment, such as the home and community, to children at risk of out-of-home placement into foster care, juvenile justice facilities, group care or psychiatric hospitals. The service is for children and young people aged from birth to 18 years and it targets child behaviour, child development, family functioning, child maltreatment prevention, support networks and systems outcomes.

This service is delivered by qualified, experienced and trained psychologists, social workers or counsellors. The recommended dose is three to five face-to face-sessions of two hours each week plus telephone contact. This intervention lasts for four to six weeks, with booster session available in the following six months. The Homebuilders service works to engage and motivate families, and it uses assessment and goal-setting and cognitive and behavioural practices designed to change behaviour. Parents and children are provided with skill development opportunities, as well as concrete services as required. Homebuilders provides 24/7 crisis assistance and is flexible and individually tailored.

Stated Requirements

According to CEBC:

- ‘Therapists must have a Master's degree in psychology, social work, counselling, or a related field, or a Bachelor's degree in same fields plus two years of experience in working with families.
- Supervisors must have a Master's degree in psychology, social work, counselling or a related field, or a Bachelor's degree in same fields plus two years of experience in providing the program, plus one year of supervisory/management experience.’

4.2.3.5. Features of interventions involving families with children or young people at imminent risk of out-of-home placement

All of these interventions involved adolescents, with half also involving children aged from 6 to 12 years. These interventions were for young people who were involved with multiple child-serving systems and experiencing multiple risks. All interventions included components for parents and children, and all were delivered individually. The interventions were home-based, but they could also be delivered in environments such as schools or community settings. Half the interventions lasted less than six months, and the other half ran from six months to one a year. All interventions were intensive, crisis-response, and available 24 hours and 7 days per week. All the interventions were multicomponent.

These interventions required clinicians and supervisors with a Master’s qualification at minimum. Most required specialised training for staff, and all indicated that staff received supervision. Half of the interventions indicated that staff carried a case-load of four clients at most.

4.2.3.6. Common components of interventions involving families with children or young people at imminent risk of out-of-home placement

A considerable number of components common to at least 50% of interventions were identified for interventions supporting families with young people at imminent risk of removal from the family home (*n* = 31, see Box 7). These commonalities are most likely due to the fact that three of the four interventions reported here are versions of the one intervention, MST.

Box 7. Common components of interventions involving families with children or young people at imminent risk of out-of-home placement

Intervention delivery

- Case management
- Intake assessment of some form; e.g. assessment of family needs, strengths and concerns or a clinical assessment
- Individualised plan for families
- Clinical therapy
- Cognitive-behavioural therapy
- Strength-based
- Worked in collaboration with families
- Worked collaboratively and closely with other relevant child-serving agencies in the community
- Ongoing monitoring of youth and family progress

Intervention content

- Parenting education or training or parenting skills
- Child or home safety or safety checks
- Parent problem-solving
- Parent social support networks
- Parent problem-solving skills were imparted in half of the interventions
- Child/youth behaviour, behaviour change and behaviour management techniques
- Parent-child communication, relationships or interactions
- Family relationships
- Positive/healthy peer relationships
- Youth academic or education skills
- Child or youth mental health
- Parent anger management
- Management of parental substance misuse
- Management of youth substance abuse and abstinence
- Youth offending, violent or criminal behaviour
- Youth delinquent behaviour
- Youth job skills
- Planning and management for future stressors, crises or emergencies
- Negotiation skills

- Family protective factors
- Positive social activities for youth
- Child self-control

4.3. Interventions associated with parent factors

4.3.1. Interventions involving families with parental substance misuse concerns

Six interventions (see Table 6) were identified that involved children of parents with substance misuse concerns, or the interventions directly targeted substance-abusing parents. These interventions have been evaluated with populations where parental substance misuse is of concern, but the primary objective may not be to prevent or reduce substance misuse. In this review, we expressly sought interventions involving children, parents or families, and as such interventions for adult substance misuse in general (e.g. Alcoholics Anonymous) were not included.

Table 6: Interventions involving families with parental substance misuse concerns

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Healthy Families America (Home Visiting for Child Well-Being)	Families of children aged 0 – 5 years who are at-risk for child maltreatment. Families may be at risk due to mental illness, substance abuse or parental history of abuse in childhood.	✓	✓	✓	✓	✓	✓	✓
Promising	Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	Adults with drug abuse and dependence, and other problems including family dysfunction, depression, child maltreatment and trauma.		✓	✓	✓	✓	✓	
Emerging	Early Start	Infants who are at risk of maltreatment due to domestic violence and parental substance misuse.	✓	✓	✓	✓	✓	✓	✓
	Families Facing the Future	Parents who are receiving methadone treatment and their children aged 5 – 14 years.	✓	✓	✓		✓	✓	
	Family Connections	Children aged 5 – 11 years who are exposed to maltreatment, domestic violence, parental mental illness or parental substance misuse.		✓		✓	✓	✓	✓

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Emerging	Parents Under Pressure (PuP)	Families of children aged 2 – 8 years who are at risk of child maltreatment due to problems such as parental substance misuse, mental illness, severe financial stress and family conflict.		✓	✓	✓	✓	✓	

4.3.1.1. Well Supported interventions

No interventions involving families where the parents have substance misuse problems were rated Well Supported in this review.

4.3.1.2. Supported interventions

This review identified one Supported intervention for families where the parent had a substance misuse problem: Healthy Families America (Home Visiting for Child Well-Being).

4.3.1.3. Promising interventions

One intervention for parents with substance misuse problems was rated Promising in this review: Adult-Focused FBT.

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)

Adult-Focused Family Behavior Therapy (Adult-Focused FBT) is a suite of interventions that targets adults with substance misuse and co-existing issues such as mental illness, trauma and family dysfunction, and it addresses child maltreatment. Adult-Focused FBT covers substance misuse management, family and child wellbeing, and instrumental interventions such as providing basic necessities and practical assistance.

The target outcomes of Adult-Focused FBT are: safety and physical wellbeing; family functioning; support networks; child behaviour; and child maltreatment prevention.

Treatment for the parents involves: program orientation; behavioural goal-setting and reward-setting; treatment-planning; communication skills training; job-getting skills training; child management skills training; management of finances; self-control; assurance of basic necessities; home safety; and environmental control.

Adult-focused FBT is delivered by licensed mental health professionals in the home, outpatient clinic, community agency or residential care facility. Sessions of 1 – 2 hours are conducted once or twice in the first week, decreasing in frequency and continuing for six months to one year depending on client and family need. Training for therapists and supervisors takes place in an initial three-day workshop, a 2.5-day top-up workshop four months later, and ongoing telephone training meetings.

Stated Requirements

According to CEBC:

- ‘Therapists should be state-licensed mental health professionals.
- Supervisors must be state-licensed mental health professionals.’

4.3.1.4. Emerging interventions

Four interventions for families where a parent had a substance misuse concern were rated Emerging: Early Start; Families Facing the Future; Family Connections; and Parents Under Pressure (PuP).

Families Facing the Future

Families Facing the Future is an intervention for parents receiving methadone treatment and their children aged from 5 – 15 years. The intervention provides skills training, peer support and practice opportunities to parents.

The target outcomes of Families Facing the Future are: child behaviour and development; safety and physical wellbeing; family functioning; and support networks.

Families Facing the Future intervention sessions cover: family goal-setting; family communication skills; creating family expectations about drugs and alcohol; relapse prevention; family management skills; helping children succeed in school; and teaching children skills.

The intervention also has a case management aspect which helps families to identify and work towards their goals, stabilise their household and reduce relapse, and continue learning and practising parenting skills.

Sessions are attended by 6 – 8 families. The intervention consists of a five-hour family retreat, and 32 training sessions of 1.5 hours in duration, held over 16 weeks (children attend one session a week over 12 weeks). Home visits may be made as part of case management.

The intervention is delivered in outpatient clinics, by Master's-level staff trained in chemical dependency and parenting.

Stated Requirements

According to CEBC:

- 'Minimum provider qualifications are training in chemical dependency and parenting and Master's- level education.'

4.3.1.5. Features of interventions involving families with parent substance misuse concerns

Most of the children in these interventions were aged from 0 and 12 years, and some were teenagers. Interventions were typically delivered to individual families, not to groups, and involved components for parents and children. Delivery was consistently home-based. Most of the interventions were multicomponent.

Half of the interventions required staff with Bachelor's-degree qualifications at minimum. Most interventions required staff training and most provided supervision for staff.

4.3.1.6. Common components for interventions involving families with parent substance misuse concerns

Twelve components were identified as common across at least 50% of interventions for families with parental substance abuse issues (see Box 8).

Box 8. Common components of interventions involving families with parent substance misuse concerns

Intervention delivery

- Intake assessment of some form, e.g. assessment of family needs, strengths and concerns
- Individualised plan for family
- Strength-based
- Conducted in collaboration with families.

Intervention content

- Parenting education or training or parenting skill development
- Child or home safety or safety checks
- Child/youth behaviour, behaviour change and behaviour management techniques
- Parent-child communication, interactions and relationships
- Child development
- Family relationship improvement
- Planning for future stressors, crises and emergencies
- Techniques for improving family relationships was included in many interventions.

4.3.2. Interventions involving families where a parent has a mental illness

As with parental substance misuse, the interventions that targeted parents with mental illness, or children of parents with mental illness, were restricted to interventions involving *parents, children or families*. Interventions for adults with mental illness, in general, were not included. While all of the interventions here have been tested with families where the parent has a mental illness, the objective of the intervention may not have been to improve parent mental health. The review identified five interventions in which the target population included parents with mental illness (see Table 7).

4.3.2.1. Well Supported interventions

No interventions for families where a parent has a mental illness were rated Well Supported in this review.

4.3.2.2. Supported interventions

Two interventions for families where the parent has a mental illness were rated Supported in this review: Healthy Families America (Home Visiting for Child Well-Being); and Triple P.

4.3.2.3. Promising interventions

No Promising interventions targeting families where a parent has a mental illness were identified in this review.

4.3.2.4. Emerging interventions

Three interventions that targeted families where a parent had a mental illness were rated Emerging: Child FIRST; Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk); and Family Connections.

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk) is an intervention for families where a parent has a significant mood disorder and children 6 – 17 years. The outcomes targeted in Family Talk are: child behaviour, support networks and family functioning.

Family Talk involves: 1) family member assessments; 2) education about risks and resilience in children and affective disorders; 3) linking information to the family experience; 4) reducing children's feelings of blame and guilt; and 5) helping children develop relationships within the family and outside the family.

The intervention takes place in the home, and in outpatient and community settings. Sessions for 6 – 11 modules are held with parents alone, and with the whole family. Refresher meetings and telephone contacts continue at six-month to nine-month intervals.

Family Talk is delivered by trained psychologists, social workers and nurses, following an implementation manual.

Table 7: Interventions involving families where the parent has a mental illness

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Healthy Families America (Home Visiting for Child Well-Being)	Families of children aged 0 – 5 years who are at-risk for child maltreatment. Families may be at risk due to mental illness, substance abuse or parental history of abuse in childhood.	✓	✓	✓	✓	✓	✓	✓
	Triple P Positive Parenting Programs — Standard and Enhanced Group Behavioural Family Interventions	Parenting intervention for children with behavioural problems, adapted for use with maltreatment populations and parents with mental illness.	✓	✓		✓	✓		
Emerging	Child FIRST	Children aged 6 months to 3 years with emotional and behavioural problems where the parents are at psychosocial risk due to maltreatment or parental mental illness.	✓	✓	✓	✓	✓		✓
	Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	Parents with significant mood disorders, with children aged 6 years and older.		✓			✓	✓	
	Family Connections	Children aged 5 – 11 years exposed to maltreatment, domestic violence,		✓		✓	✓	✓	✓

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
		parental mental illness or parental substance misuse.							

4.3.2.5. Features of interventions for families where a parent has a mental illness

Most of the children in these interventions were aged from 0 – 6 years. Interventions were usually delivered to individual families rather than to groups, and involved components for parents and children. Delivery was in the home, and interventions typically lasted less than six months. Most interventions were multicomponent.

Most interventions required staff to be trained clinicians or educators with Bachelor's degrees at minimum.

4.3.2.6. Common components of interventions for families where a parent has a mental illness

Analyses identified nine components that were common across at least 50% of interventions for families where the parent has a mental illness (see Box 9).

Box 9. Common components of interventions involving families where the parent has a mental illness

Intervention delivery

- Intake assessment of some form; e.g. assessment of family needs, strengths and concerns
- Individualised plans for families
- Sessions were structured
- Homework for the clients; something to take home and work on or practise in between sessions
- Discussion, as opposed to didactic, lecture-style delivery

Intervention content

- Child or home safety or safety checks
- Child/youth behaviour, behaviour change and behaviour management
- Parent-child communication, relationships and interactions
- Child development.

4.3.3. Interventions involving teenage parents

Three interventions targeting teenage parents were identified in this review. These are listed below (see Table 8).

4.3.3.1. Well Supported interventions

One Well Supported intervention involving young parents was identified in the review: NFP.

4.3.3.2. Supported interventions

No interventions for teenage parents were rated Supported.

Table 8: Interventions involving teenage parents

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Well Supported	Nurse Family Partnership (NFP)	First-time, low-income or adolescent mothers — commences prenatally and continues until the child is two years old.	✓	✓	✓	✓	✓	✓	✓
Emerging	AVANCE Parent-Child Education Program (PCEP)	Parents with children aged 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education levels.	✓						
	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents.	✓	✓					

4.3.3.3. Promising interventions

No interventions for teenage parents were rated Promising.

4.3.3.4. Emerging interventions

Two interventions involving young parents were rated Emerging: PCEP and HIPPY.

4.3.3.5. Features of interventions involving teenage parents

All children targeted in these interventions were aged from 0 and 6 years, with some interventions commencing in the antenatal period. The interventions were delivered to groups of families and individual families, but more often to parents and never to children. All interventions were delivered in the home, but several interventions that were delivered to groups also had community-based components. Interventions were typically of longer duration, lasting from 6 – 12 months. Most interventions were multicomponent.

Most interventions required staff to be trained clinicians or educators with Bachelor's degrees at minimum. All interventions required staff to undertake additional training, and many indicated that staff supervision was provided.

4.3.3.6. Common components of interventions involving teenage parents

Eleven components were identified as common across the interventions involving teenage parents (see Box 10), and these are quite similar to those identified for the interventions involving low income/SES parent due to intervention overlap.

Box 10. Common components of interventions involving teenage parents

Intervention delivery

- Sessions were structured
- Goal-setting for individuals or families
- Referral to services in the community

Intervention content

- Parenting education or training or parenting skills
- Child social skills
- Child development
- Child academic and education skills
- How to play with children and how to use play to aid child development and learning
- Parental life course; e.g. parent employment, education, personal development
- Interventions typically included child social skills content
- Child readiness for school, kindergarten and learning.

4.3.4. Interventions involving parents with an intellectual disability

Clearinghouses identified no interventions *rated Emerging or higher* that specifically targeted — or indicated that the population included — parents with an intellectual disability or learning difficulty. As indicated in the methods section and detailed in Appendix 1, additional measures were taken to address this population gap in the findings.

After consultation with colleagues who are leaders in the field of parenting with intellectual disabilities, seven documents were identified for consideration. Two of the RCTs pre-dated the 2000 onwards date range requested by FACs, however it is worth commenting on all.

Feldman et al. (1992) report on the finding of the evaluation of an unnamed parent-training program. The results indicate significant improvements at the conclusion of the intervention compared to the randomised wait-list group. Follow-up assessments were undertaken at variable time points and so it was not possible to make a judgment about the maintenance of effect or suitability for rating this intervention Emerging. This intervention has been rated Pending. This same intervention has since been labelled Step-by-Step Parenting Program and is reviewed on CEBC with additional, non-randomised studies.

Keltner et al. (1995) tested the effectiveness of Supports to Access Rural Services (STARS). This, too, observed significant improvements for the intervention but not the control group immediately after the interventions. There was no reported follow-up assessment. This intervention is rated Pending.

Llewellyn et al. (2003) reported an RCT of the Home Learning Program (HLP, identified as Healthy and Safe on CEBC) in which significant effects were observed at the end of the intervention. As the follow-up period extended only to three months and not six months post-intervention, HLP cannot be rated Emerging. HLP is rated Pending.

The search of academic databases identified no new RCTs testing the effectiveness of interventions for parents with intellectual disabilities.

4.4. Interventions associated with child factors

4.4.1. Interventions involving families where children or young people have substance misuse concerns or risks

This review identified nine interventions involving families where children and young people have substance misuse problems or who are at risk of these problems (see Table 9). Prevention interventions were in scope in this review, as were some treatment interventions. We did not include treatments for young people unless they were identified as having other problems or risk factors in addition to substance misuse. Although young people with substance misuse problems for risk factors were involved in these interventions, prevention of misuse may not have been the main objective.

4.4.1.1. Well Supported interventions

No interventions for families where a child and young person has substance misuse concerns were rated Well Supported in this review.

Table 9: Interventions involving families in which the child and young person has substance misuse concerns or is at risk of substance misuse

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Coping Power	Children aged 5 – 11 years at risk of substance misuse.	✓	✓			✓	✓	
	DARE to be You	Children aged 2 — 5 years at risk of future substance misuse.	✓	✓			✓	✓	
	Early Risers “Skills for Success”	Children aged 6 — 12 years who are at high risk of conduct problems, including substance misuse.		✓			✓	✓	✓
	Multidimensional Family Therapy (MDFT)	Adolescents aged 11 — 18 years with substance use, delinquency, and related behavioural and emotional problems.	✓	✓			✓	✓	✓
	Project Success	Students aged 12 — 18 years who are at high risk for substance abuse due to discipline problems, truancy, poor academic performance, parental substance abuse and negative attitudes towards school.		✓				✓	✓
	Project Towards no Drug Abuse	Youth aged 15 – 18 years who are at -risk for drug use and violent behaviour.		✓					
Promising	Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	Youth aged 11 – 17 years with drug abuse, and co-existing problems such as conduct problems and depression.	✓	✓	✓		✓	✓	

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Promising	Brief Strategic Family Therapy (BSFT)	Youth aged 12 – 18 years with substance abuse problems and co-occurring behaviour problems such as conduct problems, risky sexual behaviour and aggressive and violent behaviour.		✓			✓	✓	
	Functional Family Therapy (FFT)	Youth aged 11 — 18 years with problems such as violent acting-out, conduct disorder and substance abuse.		✓			✓	✓	✓
	Parenting With Love and Limits (PLL)	Youth aged 10 – 18 years with severe emotional and behavioural problems and co-occurring problems including domestic violence, alcohol or drug use, depression, suicidal ideation, destruction of property, or chronic truancy.		✓	✓		✓		

4.4.1.2. Supported interventions

This review identified six Supported interventions that involved families where the child and young person have substance misuse concerns or is at risk: Coping Power; DARE To Be You (DARE); Early Risers “Skills for Success”; Multidimensional Family Therapy (MDFT); Project Success; and Project Towards no Drug Abuse.

Coping Power

Coping Power is an intervention for children aged from 5 —11 years who are at risk of substance abuse, as well as their parents. Its target outcomes are child development and behaviour, family functioning and support networks.

The intervention has a version for parents and at-risk children, a universal version for parents and children aimed at middle-school transitions, and a stand-alone universal version for children only. The version for at-risk families covers: 1) for children, problem-solving and conflict-management techniques, coping mechanisms, social skill development and positive social supports; and 2) for parents, stress management, disruptive behaviour identification, effective discipline and communication structures, and management of child behaviour outside the home. The universal version covers home-school involvement, concerns about transition to middle school, and predictors of substance use. It is adapted for parents and children as appropriate.

Coping Power is a 16-month intervention delivered in schools. Children attend 22 group sessions in fifth grade and 12 group sessions in sixth grade. Groups consist of 5 – 8 children who meet for 40 – 50 minutes. Children receive a half-hour individual session once every two months. Groups of 12 parents attend 16 sessions in their child’s fifth grade year and five sessions during sixth grade.

Coping Power is delivered by a school-family program specialist and a guidance counsellor. It uses workbooks and other materials.

DARE to be You (DTBY)

DARE to be You (DTBY) is an intervention which targets families where children aged from 2 – 5 years are at high risk of future substance abuse (due to, for example, parent substance abuse or parent mental illness). DTBY is designed to improve the aspects of parenting associated with children’s resilience, and lower children’s risk of potential future substance abuse and other high-risk activities.

The target outcomes of DTBY are: child development and behaviour; family functioning; and support networks. DTBY workshops focus on: developing parental sense of competence and satisfaction with their role as parents; increasing parents’ internal locus of control; enhancing decision-making skills; mastering effective child-rearing strategies; learning stress management and developmental norms (to reduce frustrations with child behaviour and increase empathy); and strengthening of peer support.

Workshop sessions of 2.5 hours run over 10 – 12 weeks. Each includes a 10 – 30 minute joint practice session for parents and children. Annual reinforcement workshops (four two-hour sessions) are available to consolidate skills and foster supportive networks.

DTBY workshops are delivered by multiagency community teams.

Early Risers "Skills for Success"

Early Risers "Skills for Success" is for children aged from 6 to 12 years who are at risk of conduct problems, such as substance misuse. The intervention targets child behaviour, family functioning, support networks and systems outcomes. It is delivered to children in the school setting and in camps, and to parents in the school or at a community location. Information about dose is not indicated.

Early Risers is delivered by personnel with qualifications and experience in child or family education. Children are provided with training in social-emotional skills development, reading, motivation, problem-solving and peer relationships. Academic skills are also supported and home-school communication is facilitated. Parents receive parenting education and support to address their individual concerns. Individual plans are development-set and goals-set. Referral to services is provided as needed.

Stated Requirements

According to SAMHSA:

- 'The family advocate must have a bachelor's degree in child or family education and experience in working with parents or children.'

Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT) targets adolescents aged from 11 – 18 years with substance use, delinquency, and related behavioural and emotional problems. MDFT consists of four domains: the adolescent domain, the parent domain, the family domain and the community domain. The intervention aims to improve parenting practices, family problem-solving skills, parent teamwork, parent and adolescent functioning, as well as adolescent communication, emotional regulation and coping skills. MDFT targets child development, child behaviour, family functioning, support networks and systems outcomes.

MDFT is delivered by therapists with a Master's-level degree in counselling, family therapy, mental health, social work or a related field. It is delivered in home and community settings over 3 – 4 months for at-risk and early-intervention families and 5 – 6 months for youth with more serious problems. With regards to the intensity of the intervention, at-risk youth and early-intervention youth typically have 1 – 2 sessions a week while youth with more severe problems have 1 – 3 sessions a week. Sessions last from 45 – 90 minutes for all cases, and frequency of sessions slowly declines during the last 4 – 6 weeks of treatment. Contents of MDFT include: a mix of youth, family and parent sessions, face-to-face sessions, telephone calls and community sessions with the school or child welfare.

Stated Requirements

According to CEBC:

- 'Therapists must have Master's Degree in counseling, mental health, family therapy, social work, or a related discipline
- Therapist assistants can have a Bachelor's Degree or relevant experience.'

Project SUCCESS

Project SUCCESS is an intervention to prevent and reduce substance use in students aged from 12 – 18 years. It targets students at high risk for substance use

and abuse due to poor academic performance, discipline problems, truancy, negative attitudes towards school, and parent substance abuse.

The target outcomes of Project SUCCESS are: child behaviour, support networks, and systems outcomes.

Project SUCCESS covers topics such as: education on alcohol, tobacco and other drugs; activities and promotional materials to increase understanding of harm; a parent program (information, education, advisory committee); and individual and group counselling.

Project SUCCESS is delivered in schools by counsellors who are trained by the intervention developers. The education element is eight sessions; counselling within the intervention is short-term, with referral to community practitioners if longer/more intensive counselling is needed.

Project Towards no Drug Abuse

Project Towards no Drug Abuse is a prevention intervention targeting youth aged from 15 – 18 years who are at risk for substance misuse, offending/delinquency and violent related behaviour. The intervention targets child behaviour and is delivered by trained health educators in the classroom over a three-week period. The program consists of 12 sessions of 40 minutes which address different issues related to substance abuse and violence. The sessions are: decision-making and commitment; communication and activity-listening; myths and denial; chemical dependency; stereotyping; talk show; self-control; perspectives; stress, health and goals; marijuana panel; positive and negative thought loops and subsequent behaviour; and smoking cessation. Further, the Socratic method is used throughout the intervention; emphasis is placed on the interactions between students and teachers in this method.

4.4.1.3. Promising interventions

Four Promising interventions involving families where a child and young person has substance misuse issues were included: Adolescent-Focused Family Behavior Therapy (Adolescent FBT); Brief Strategic Family Therapy (BSFT); Functional Family Therapy (FFT); and Parenting with Love and Limits (PLL).

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)

Adolescent-Focused Family Behavior Therapy (Adolescent FBT) targets youth aged from 11 – 17 years with substance misuse, mental illness and offending or delinquent behaviours. The aim of Adolescent FBT is to improve outcomes in several areas including substance use, mental health problems, conduct problems, family issues and school/work attendance. The intervention targets child development, child behaviour, safety and physical wellbeing, family functioning and support networks.

The intervention is delivered in an outpatient clinic by state-licensed mental health professionals who have experience in working with the population and an interest in the therapy. The duration and intensity of Adolescent FBT varies depending on multiple factors that are unique to the client, the client's family and the treatment provider. Typically the intervention lasts from six months to one year. Content of the intervention includes: treatment planning, setting behavioural goals, contingency management skills training, emergency management, communication skills, self-control, home safety tours, tele-therapy, job-setting skills training and stimulus control.

Stated Requirements

According to CEBC:

- ‘Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They must have professional therapeutic experience serving the population that is being targeted for treatment.
- Providers should be state-licensed mental health professionals, or supervised by state-licensed mental health professionals (if permitted by law to do so).’

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) targets young people aged from 12 – 18 years with substance abuse problems and other concerns such as conduct disorder, violent behaviour, delinquency, and risky sexual behaviour. Target outcomes include: child behaviour, family functioning and support networks.

BSFT takes a family systems approach to intervention, examining the interactions within the family and how these impact family members’ behaviours. Patterns of interaction that are associated with the negative adolescent behaviour are identified and plans developed to change those patterns. The intervention aims to improve patterns in family relationships, family conflict and problem-solving, family cohesiveness, and methods for managing child behaviour.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) targets youth aged from 11 – 18 years with serious problem behaviours including conduct disorder, violent acting-out, youth offending and delinquency as well as substance misuse. Delivered by therapists in a range of settings (i.e. birth family home, adoptive home, community agency, foster/kinship care and school), the intervention targets child behaviour, family functioning, support networks and systems outcomes.

FFT consists of four phases each targeting unique goals, assessment focus and therapists’ skills and risk and protective factors. The four phases are 1) Engagement, which aims to increase the families’ initial expectation of position change; 2) Motivation, which aims to produce a motivational context for long-term care; 3) Behaviour Change, which has the goal of facilitating individual and interactive/relational change; and 4) Generalisation, which aims to maintain change at individual and family levels as well as facilitate change in multiple systems. FFT is delivered over 8 – 12 one-hour sessions for mild cases and up to 30 sessions for more severe cases. Sessions typically are run every week over 3 – 4 months, but frequency can be increased if needed.

Stated Requirements

According to CEBC:

- ‘Qualifications can vary for therapists, but to become an onsite Program Supervisor a minimum of Master’s level education is required.’

Parenting with Love and Limits (PLL)

Parenting with Love and Limits (PLL) is for youth aged from 10 – 18 years with severe emotional and behavioural problems and co-occurring problems such as depression, substance misuse, truancy, domestic violence, or suicidal ideation. It targets child behaviour, safety and physical wellbeing, and family functioning.

The intervention is delivered to parents and children by trained Master's-level counselling clinicians in two-hour group sessions every week for six weeks. Family sessions are also conducted weekly for 1 – 2 hours over 4 – 20 sessions. Delivery can occur in the home and clinical settings.

Stated Requirements

According to CEBC:

- 'PLL must consist of both of the following:
  - Six multifamily sessions, conducted by one clinician and one co-facilitator.
  - Six to eight individual family intensive 1- to 2-hour therapy sessions in an outpatient or home-based setting to practice the skills learned in the group setting. The number of sessions can be increased up to 20 for youth with more severe problems.
- Minimum clinician qualifications are a Master's level degree in counseling related field
- Minimum co-facilitator or case manager qualifications are a Bachelor's degree.'

4.4.1.4. Emerging interventions

No Emerging interventions involving families with a child or young person with substance misuse problems were identified.

4.4.1.5. Features of interventions involving families where children or young people have substance misuse concerns or risks

The majority of interventions involved adolescents, and several also involved children aged from 6 – 12 years. Interventions usually involved components for parents and children, and typically lasted less than six months.

Most interventions were multicomponent and most required staff training.

4.4.1.6. Common components of interventions involving families where children or young people have substance misuse concerns or risks

Analyses identified seven components that were common across a minimum of 50% of interventions involving families of children with substance abuse issues (see Box 11).

Box 11. Common components of interventions involving families where children or young people have substance misuse problems or risks

Intervention delivery

- Sessions were structured

Intervention content

- Parenting education or training or development of parenting skills
- Child/youth behaviour, behaviour change and behaviour management
- Parent-child interactions, communication and relationship
- Developing family relationships
- Positive/healthy peer relationships
- Management of youth substance abuse and abstinence.

4.4.2. Interventions involving families with child or youth offending behaviours or delinquency

This review identified nine interventions for families in which children or youth are at risk of offending, have committed offences or exhibit delinquent behaviours. These are summarised in Table 10 and below.

4.4.2.1. Well Supported interventions

No interventions for families with children or youth with offending behaviours or delinquency were rated Well Supported in this review.

Table 10: Interventions involving families with child and youth offending behaviour or delinquency concerns

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Early Risers "Skills for Success"	Children aged 6 – 12 years who are at high risk of conduct problems, including substance use.		✓			✓	✓	✓
	Multidimensional Family Therapy (MDFT)	Adolescents aged 11 – 18 years with substance use, delinquency, and related behavioural and emotional problems.	✓	✓			✓	✓	✓
	Multisystemic Therapy (MST)	Youth aged 12 – 17 years old who are serious juvenile offenders with possible substance abuse issues, and who are at risk of out-of-home placement due to antisocial or delinquent behaviours, and/or youth involved with the juvenile justice system.		✓			✓	✓	✓
	Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)	Youths aged 13 – 17 years who have committed sexual offences and demonstrated other problem behaviours.		✓			✓	✓	✓
	Oregon Model Parent Management Training (PMTO)	Parents of children aged 2 – 18 years with disruptive behaviours. Versions adapted for children with substance abuse, delinquency, conduct disorder, and child neglect and abuse.		✓		✓	✓	✓	✓
	Project Towards no Drug Abuse	Youth aged 15 – 18 years who are at-risk for drug use and violent behaviour.		✓					

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	The Incredible Years	Families with children aged 4 – 8 years with behavioural or conduct problems. Also used with children at high-risk.	✓	✓			✓	✓	
Promising	Functional Family Therapy (FFT)	Youth aged 11 – 18 years with problems such as violent acting-out, conduct disorder and substance abuse.		✓			✓	✓	✓
	Parenting With Love and Limits (PLL)	Youth aged 10 – 18 years with severe emotional and behavioural problems and co-occurring problems including domestic violence, alcohol or drug use, depression, suicidal ideation, destruction of property, or chronic truancy.		✓	✓		✓		

4.4.2.2. Supported interventions

Seven interventions involving families with children or youth offending behaviour or delinquency concerns were rated Supported: Early Risers “Skills for Success”; MDFT; MST; MST-PSB; Oregon Model Parent Management Training (PMTO); Project Towards no Drug Abuse; and The Incredible Years.

Oregon Model Parent Management Training (PMTO)

Oregon Model Parent Management Training (PMTO) is for parents of children aged from 2 –18 years with disruptive behaviours. Versions of this intervention have also been adapted for children with conduct disorder, substance abuse and delinquency, and for child neglect and abuse. The intervention targets child behaviour, maltreatment prevention, family functioning, support networks and systems outcomes.

Oregon Model can be delivered in the home or in the community by personnel with Master’s qualifications in a relevant field plus five years of clinical experience. Parents participate in 14 weekly group sessions of 1.5 – 2 hours and 20 –25 one-hour individual family sessions. The total duration of the intervention is 5 – 6 months.

The content of the intervention focuses on behaviour management, such as fostering positive behaviour and preventing and dealing appropriately with undesirable behaviour. Parenting skills, problem-solving abilities and communication skills are also focused on. Goals are developed with the parents, and delivery is experiential and includes role-play and modelling.

Stated Requirements

According to CEBC:

- ‘Providers must have a Bachelor’s degree with 5 years appropriate clinical experience or Master’s Degree in relevant field’.

The Incredible Years

Incredible Years is designed to prevent, reduce and treat emotional and behavioural problems in children aged 4 - 8 years. The intervention targets youth offending and delinquency and is delivered by Master’s-level (or equivalent) clinicians in a variety of different settings, including birth family home, community daily living settings, community agency, foster/kinship care, outpatient clinic, hospital, paediatric primary care setting, religious organisation, school or the workplace. The intervention targets child development, child behaviour, family functioning and support networks. The intervention includes parent, teacher and child programs which can be used separately or together. The parent and child programs consist of one two-hour session per week; the classroom program consists of 60 sessions 2 – 3 times a week, and the teacher program is offered in 5 – 6 full-day workshops or 18 – 21 two-hour sessions.

Incredible Years includes three programs, namely the BASIC Parent Training Program, the ADVANCE Parent Training Program and the Child Training Program. The BASIC program is for parents of high-risk children and parents of children with behaviour problems. The program targets the following skills: building strong relationships with children; providing praise and incentives; building social and academic competency; setting limits and establishing household rules; and handling misbehaviour. The ADVANCE program targets interpersonal skills such as

communicating effectively with children and others, handling stress, anger and depression, problem-solving between adults, helping children to problem-solve and providing and receiving support. The child-training program aims to improve social competency and decrease conduct-related problems. For this program, training occurs in emotion management, social skills, problem-solving and classroom behaviour.

Stated Requirements

According to CEBC:

- 'Minimum provider qualifications are Master's-level clinicians.'

4.4.2.3. Promising interventions

This review identified two Promising interventions that involved families with issues of child or youth offending/delinquency: FFT and PLL.

4.4.2.4. Emerging interventions

No interventions involving families with concerns of offending child and youth behaviour and delinquency were rated Emerging.

4.4.2.5. Features of interventions involving families with child or youth offending behaviour or delinquency

Most interventions involved adolescents, and several involved children aged from 6 – 12 years. Several interventions involved young people experiencing multiple risk factors. Interventions usually included components for parents and children. Interventions were most often delivered in the home, but could also have been delivered in the community. Many utilised the preferred or natural environment for the young people and their families, so clinics and schools could be used for delivery. Interventions typically lasted less than six months. Most of the interventions were multicomponent.

Many interventions required Master's-level qualifications for staff, and Master's-level or higher qualifications for supervisors. Many interventions required staff training and staff supervision.

4.4.2.6. Common components of interventions involving families with child or youth offending behaviour or delinquency

The components of the interventions for families with children or young people demonstrating or at risk of offending or delinquent behaviours were similar to those for youth substance abuse. Ten components were found to be common across at least 50% of these interventions (see Box 12).

Box 12. Common components of interventions involving families with child or youth offending behaviour or delinquency concerns

Intervention delivery

- Individual or family goals
- Sessions were structure
- Interventions were strength-based

Intervention content

- Parenting education or training or strategies for improving parenting skills
- Information and strategies about child/youth behaviour, behaviour change and behaviour management
- Parent-child interactions, communication relationship
- Improving family relationships
- Positive/healthy peer relationship
- Management of youth substance abuse and abstinence
- Information and support related to delinquency.

4.4.3. Interventions involving families where the child or young person has a mental illness

Five interventions families with identified mental health concerns for children or young people were identified in the review (see Table 11). Although these concerns were present in the young people included in evaluations, the main objective may not have been to address mental health.

4.4.3.1. Well Supported interventions

One Well Supported intervention involving families with children and young people with mental illness was identified:

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an intervention for children aged from 3 – 18 years and their parents in situations where the child has been exposed to some form of trauma, including maltreatment or domestic violence. Children participating in TF-CBT have been identified as experiencing significant Post-Traumatic Stress Disorder (PTSD) or symptoms of PTSD arising from the trauma. They may also be experiencing depression, anxiety and shame as a result of the trauma. TF-CBT targets child behaviour; family functioning; child development; safety and physical wellbeing; and support networks. This intervention is *trauma-informed* according to the definition provided earlier in this report.

The intervention is typically delivered by trained psychologists or social workers in the clinical setting, although other settings including the home have been utilised. The intervention is delivered in 8 – 16 sessions lasting 30 – 45 minutes each. Content of the intervention includes: psychoeducation and parenting skills;

relaxation; affective expression; coping; trauma narrative and processing; in vivo exposure; and personal safety and future growth.

Stated Requirements

According to CEBC:

- ‘Minimum provider qualification is a ‘Master’s degree and training in the treatment model’ and ‘experience working with children and families.’

4.4.3.2. Supported interventions

No interventions involving families with child and youth mental illness concerns were rated Supported.

4.4.3.3. Promising interventions

The review identified three Promising interventions involving families with child and youth mental illness concerns: Adolescent FBT; Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric); and Teaching Kids to Cope (TKC).

Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)

Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric) is an intervention for youth (aged 6 – 17 years) at risk of out-of-home placement due to serious behavioural problems and psychiatric problems.

The intervention targets child behaviour, family functioning, support networks and systems outcomes. MST-Psychiatric aims to improve mental-health symptoms, suicidal behaviours, and family relations while allowing youth to spend more time at home and school. The intervention helps parents and caregivers to engage their children with prosocial activities and disengage them from peers engaging in antisocial, inappropriate or illegal behaviours. It addresses individual and systemic barriers to effective parenting and helps parents with monitoring and disciplining their child as well as parent-child communication.

MST-Psychiatric involves the following for practitioners: 1) safety risks due to psychotic, suicidal or homicidal behaviours in youth; 2) the integration of psychiatric interventions that are evidence-based; 3) management of youth and parent/carer substance misuse; 4) evidence-based assessment and treatment of youth and parent/carer mental illness.

MST-Psychiatric is delivered in the child’s home, in school, or in other community settings. It is delivered on a daily basis when needed for about six months. An MST-Psychiatric team consists of a doctoral-level supervisor, Master’s-degree therapists, a part-time psychiatrist and a full-time Bachelor’s-level caseworker. Teams maintain an ongoing relationship with MST consultants and psychiatrists.

Table 11: Interventions involving families with child and youth mental illness concerns

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Well Supported	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Children, and their parents, who are experiencing significant emotional and behavioural problems related to trauma, including maltreatment or vulnerable family circumstances.	✓	✓	✓		✓	✓	
Promising	Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	Youth aged 11 – 17 years with drug abuse, and co-existing problems such as conduct problems and depression.	✓	✓	✓		✓	✓	
	Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)	Children aged 6 – 17 years who are at risk of placement in out-of-home due to serious behavioural problems and co-occurring mental health symptoms.		✓			✓	✓	✓
	Teaching Kids to Cope (TKC)	Youth aged 12 – 18 years with depressive symptomatology and/or suicidal ideation.		✓	✓				
Emerging	Coping and Support Training (CAST)	Youth aged 14 – 19 years who have been identified as being at significant risk for suicide.		✓	✓				

Teaching Kids to Cope (TKC)

Teaching Kids to Cope (TKC) is for young people aged from 12 – 18 years with symptoms of depression and/or suicidal ideation, and it targets child behaviour and safety and physical wellbeing. It is delivered by professionals with degrees in education, social work child development, psychology or nursing or similar fields, and can be delivered in community-based setting such as schools, hospitals and clinics.

Youth participate in 10 weekly, one-hour sessions in a group format. Content covers coping with stressful events, thinking patterns, different ways of viewing and reaction to situations, communication and family relationships. The sessions are experiential and involve role-play, discussions, group work and material delivered through a range of mediums.

4.4.3.4. Emerging interventions

One intervention involving families with child and youth mental illness issues, Coping and Support Training (CAST), was rated Emerging.

Coping and Support Training (CAST)

Coping and Support Training (CAST) is a school-based suicide prevention intervention for at-risk youth aged from 14 – 19 years. The intervention is delivered in a group format (6 – 8 students) and provides valuable life skills training and social support to youth with mental illness who are at significant risk of suicide. Delivered by high school teachers, counsellors and nurses with school experience, CAST targets the outcomes of child behaviour and safety and physical wellbeing.

The intervention is delivered over six weeks in 12 group sessions, each lasting 55 minutes. The sessions aim to increase mood management (depression and anger), improve school performance and decrease drug involvement. In addition, the intervention focuses on group support, self-esteem, goal-setting and monitoring, decision-making skills, improved management of depression and anger, drug-use control and prevention of relapse and self-recognition of progress. Sessions end with “Lifework” assignments that encourage at-risk youth to practise the target skills being taught.

4.4.3.5. Features of interventions involving families where the child or young person has a mental illness

All these interventions involved adolescents, and several also included children from 6 – 12 years. Half of the interventions were delivered to individual families, and interventions usually involved components for parents and children. Interventions were delivered in locations suited to the clients such as their homes, clinics or other community settings. Interventions typically lasted less than six months. Most of the interventions were multicomponent.

Most interventions required staff to be trained clinicians or educators with Bachelor’s degrees at minimum. All interventions required staff to be trained and most provided staff supervision.

4.4.3.6. Common components of interventions involving families where the child or young person has a mental illness

Analyses identified 19 components that were common across at least 50% of the interventions for families of children with a mental illness (see Box 13).

Box 13. Common components of interventions involving families with child or youth with a mental illness

Intervention delivery

- Intake assessment of some form; for example, assessment of family needs, strengths and concerns or a clinical assessment
- Individual or family goal-setting
- Sessions were structured
- Homework for the clients; something to take home and work on or practise in between sessions
- Clinical therapy
- Discussion, as opposed to didactic or lecture-style
- Opportunities for rehearsal; practising the skills learnt in sessions

Intervention content

- Parenting education or training or parenting skills development
- Child emotions, emotional skill developments, or emotional regulation
- Child or home safety information or safety checks
- Child/youth behaviour, behaviour change and behaviour management
- Parent-child interactions, communication and relationships
- Improving family relationships
- Child decision-making skills
- Child academic or educational skills
- Child communication skills
- Child or youth mental health problems and management
- Child anger management
- Management of youth substance abuse and abstinence.

4.4.4. Interventions involving families where the child or young person has been identified as at risk of suicide

Two interventions involving families where the child or young person was identified as at risk of suicide were identified in this review (see Table 12).

4.4.4.1. Well Supported interventions

No interventions involving families where the child or young person was identified as at risk of suicide were rated Well Supported.

4.4.4.2. Supported interventions

No interventions involving families where the child or young person was identified as at risk of suicide were rated Supported.

4.4.4.3. Promising interventions

One intervention involving families where the child or young person was identified as at risk of suicide was rated Promising in the review: TKC.

Table 12: Interventions involving families where the child or young person is at risk of suicide

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Promising	Parenting With Love and Limits (PLL)	Youth aged 10 – 18 years with severe emotional and behavioural problems and co-occurring problems including domestic violence, alcohol or drug use, depression, suicidal ideation, destruction of property, or chronic truancy.		✓	✓		✓		
	Teaching Kids to Cope (TKC)	Youth aged 12 – 18 years with depressive symptomatology and/or suicidal ideation.		✓	✓				
Emerging	Coping and Support Training (CAST)	Youth aged 14 – 19 years who have been identified as being at significant risk for suicide.		✓	✓				

4.4.4.4. Emerging interventions

One intervention for families with children or youth at risk of suicide was rated Emerging: CAST.

4.4.4.5. Features of interventions involving families where the child or young person was identified as at risk of suicide

These interventions involved adolescents and were delivered to children (not parents) in group format. The interventions lasted less than six months. The interventions required staff to be trained clinicians or educators with Bachelor's degrees at minimum, and they required staff to be trained in the intervention.

4.4.4.6. Common components of interventions involving families where the child or young person was identified as at risk of suicide

Eleven components were found to be common these three interventions (see Box 14).

Box 14. Common components of interventions involving families with children or young persons at risk of suicide

Intervention delivery

- Sessions were structured
- Homework was given to the clients; something to take home and work on or practise in between sessions
- Videos were used as a means of delivering information
- Role-play
- Opportunities for rehearsal; practising the skills acquired in sessions

Intervention content

- Parent-child interactions, communication and relationships
- Improving family relationships
- Child decision-making skills
- Child or youth mental health and management of mental health problems
- Child or youth anger management.

4.4.5. Interventions involving families of children and youth identified as at risk for problematic sexual behaviours or practices

This review identified three interventions addressing child and youth sexual behaviour/practices, one for sexual offenders and one to encourage safe sex (see Table 13).

Table 13: Interventions involving families of children and youth identified as at risk of problematic sexual behaviours or practices

Rating	Intervention	Target population	Outcomes targeted						
			Child development	Child behaviour	Safety & physical wellbeing	Maltreatment prevention	Family functioning	Support networks	Systems outcomes
Supported	Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB)	Youth aged 13 – 17 years who have committed sexual offences and demonstrated other problem behaviours.		✓			✓	✓	✓
	Be Proud! Be Responsible!	At risk, “minority” youth aged 11 – 19 years. Delivered primarily to African-American and Latino adolescents.		✓	✓				
Emerging	Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Program	Children aged 6 – 12 years with problem sexual behaviours, and their parents.		✓			✓		

4.4.5.1. Well Supported interventions

No interventions on child and youth sexual behaviour or practice were rated Well Supported.

4.4.5.2. Supported interventions

Two interventions addressing child and youth sexual behaviour were rated Supported: MST-PSB; and Be Proud! Be Responsible!

Be Proud! Be Responsible!

Be Proud! Be Responsible! is a school-based intervention targeting minority (African-American, Latino) adolescents aged from 11 – 19 years living in low SES environments. The intervention is designed to reduce the incidence of risky sexual behaviours and related HIV/STD infection among this population by improving adolescent knowledge about HIV/STDs and improving self-efficacy and skills that might help to avoid risky sexual behaviours. Delivered by teachers and school nurses, the intervention is based on cognitive-behaviour theory and targets child behaviour and safety and physical wellbeing.

Be Proud! Be Responsible! is delivered over six sessions lasting 60 minutes each; it can be implemented in a six-day, two-day or one-day format. Contents of the intervention include: group discussions, videos, games, brain-storming, experiential exercises and skills-building activities.

4.4.5.3. Promising interventions

No child and youth sexual behaviour interventions were rated Promising.

4.4.5.4. Emerging interventions

One child and youth sexual behaviour intervention was rated Emerging: Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Program.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group

Children with Problematic Sexual Behaviour Cognitive-Behavioral Treatment Program: School-age Group is an intervention designed to reduce or eliminate incidents of sexual behaviour problems. The intervention is for children aged from 6 – 12 years with problem sexual behaviours, and their parents.

The intervention's target outcomes are: child behaviour and family functioning. Its aims are to: 1) eliminate or reduce problematic sexual behaviour; 2) improve child behaviour by improving parental monitoring, supervision and behaviour management skills; and 3) improve parent-child communication and interaction.

This intervention involves: 1) observing, modelling and receiving feedback on skills; 2) providers giving structure and direction; 3) helping children with rules about sexual behaviour; setting boundaries; teaching abuse prevention skills; teaching emotional regulation, coping, impulse control and problem-solving skills; providing sex education; addressing social skills and peer relationships; acknowledging and apologising and making amends for past behaviour. An additional aspect for caregivers covers: 4) parent training in prevention; education in child sexual and moral development; dispelling misconceptions; and support.

The intervention is delivered in outpatient clinics for groups of children aged from 6 – 9 years and 10 –12 years (5 – 8 children per group). Caregivers meet in a separate group. Sessions of 60 – 90 minutes are delivered weekly for 4 – 5 months (ceasing on meeting graduation criteria). Supervisors and lead therapists are licensed mental health professionals with previous experience in the field.

4.4.5.5. Features of interventions involving families of children and youth identified as at risk of problematic sexual behaviours or practices

Most of these interventions were multicomponent and targeted adolescents, and most were delivered in a group setting. Interventions typically involved components for parents and children, and many were delivered in schools. Most interventions lasted less than six months, and most were multicomponent.

Most interventions required staff to be trained clinicians or educators with Bachelor's degrees at minimum. Many interventions required staff to be trained and all provided staff supervision.

4.4.5.6. Common components of interventions involving families of children and youth identified as at risk of problematic sexual behaviours or practices

Twenty-four components were found to be common across at least 50% of interventions involving child or young people at risk of problematic sexual behaviours (see Box 15).

Box 15. Common components of interventions involving children and youth identified as at risk of problematic sexual behaviours or practices

Intervention delivery

- Intake assessment of some form; for example, assessment of family needs, strengths and concerns or a clinical assessment
- Sessions were structured
- Clinical therapy
- Cognitive-behavioural therapy
- Discussion, as opposed to didactic, lecture-style delivery
- Strength-based
- Culturally sensitive
- Opportunities for rehearsal; practising the skills acquired in sessions

Intervention content

- Parenting education or training or parenting skills
- Child or home safety information or safety checks
- Child health
- Child problem-solving
- Child social skills
- Child/youth behaviour, behaviour change and behaviour management techniques
- Parent-child interactions, communications or relationships
- Family relationships
- Establishment of positive/healthy peer relationships
- Predictable environment for the young person – set limits, routines, rules and expectations
- Child mental health and mental health management
- Management of youth substance abuse and abstinence
- Youth offending, violent or criminal behaviour
- Appropriate sexual behaviour or safe sex practices
- Negotiation skills
- Child self-control.

4.5. Interventions meeting the criteria for trauma-informed care

Trauma can arise from a range of circumstances and may be associated with one event or multiple, ongoing traumatic circumstances. This complexity is further

complicated in research and practice because of poorly defined and interchanged terminology (trauma-informed, trauma-focused, trauma-specific). Several interventions included in this review state that they, to some degree, consider or address trauma or involve populations exposed to trauma: Adult-Focused FBT; CPP; Family Connections; Healthy Families; MST-CAN; NFP; PE-A; Project Support; PUP; and TF-CBT. These interventions were for populations exposed to trauma related to child maltreatment and at-risk family circumstances such as domestic violence, parent substance misuse and parental mental illness, however some involved other forms of trauma exposure such as war trauma and natural disasters. They did not all, however, meet the criteria for being trauma-informed practice.

The (National Child Traumatic Stress Network, 2008, 2012) stated that child and family services adopting a trauma-informed care framework should understand and respond to the needs of individuals who have been victimised. This network outlined seven criteria (below) for trauma-informed care. Interventions included in this review needed to meet at least one of these criteria to be considered trauma-informed:

- screen for trauma exposure and related symptoms
- assess and treat traumatic stress and related symptoms
- make resources about trauma exposure, impact, and treatment to clients and providers
- strengthen the resilience of children and families vulnerable to and affected by trauma
- assess parent or caregiver trauma, and its impact on the family
- strive for continuity of care across child service systems
- minimise and treat secondary trauma in its staff, and foster staff resilience.

Of the 10 interventions that have some degree of focus on trauma or trauma-exposed populations, only four interventions were identified that met the criteria for trauma informed care: TF-CBT, PE-A, CPP, and MST-CAN.

4.5.1.1. Features of interventions using trauma-informed approaches

Most of these interventions involved adolescents, and half also involved children aged from 6 – 12 years. All were delivered to individual families, and most included components for parents and children. Delivery settings were variable depending on family circumstances; most offered delivery in the home, in clinics, or in community settings. Half of the interventions lasted less than six months; the other half lasted six months to one year. All the interventions were multicomponent.

Most interventions required clinicians and supervisors with a Master's-level qualification at minimum. All required training and supervision for staff.

4.5.1.2. Common components of interventions using trauma-informed approaches

While all interventions identified here as trauma-informed have already been described in relation to child maltreatment and/or parent vulnerabilities, they are now grouped together in order to identify which components the trauma-informed approaches have in common. Seventeen components were found to be common across at least 50% of these approaches (see Box 16).

Box 16. Common components of trauma-informed approaches

Intervention delivery

- Psycho-education
- Case management
- Intake assessment of some form; for example, assessment of family needs, strengths and concerns or a clinical assessment
- Sessions were structured
- Clinical therapy
- Cognitive-behavioural therapy
- Discussion, rather than didactic, lecture-style learning
- Trauma narrative
- Trauma processing
- In vivo exposure

Intervention content

- Child emotional skills and regulation
- Child coping skills
- Child or home safety or safety checks
- Parent-child interactions, relationships or communication
- Child or youth mental health
- Child breathing exercises
- Planning and management for future stressors, crises or emergencies.

5. Discussion

The purpose of this review was to identify interventions involving families with a range of vulnerabilities that may be applicable to the reform of FACS services. The information regarding what these interventions consist of and how effective they are was sourced from international clearinghouses and previous REAs conducted by PRC. A rigorous rating scheme was applied across interventions to identify which are better-evidenced. Details of intervention components were extracted and drawn together in groups according to the types of families that are targeted by the interventions. Common components across these interventions were identified. The following section provides a narrative analysis of the findings and gaps in the findings, a discussion of implementation considerations in the NSW context, limitations of this review, and suggestions for future directions.

5.1. Analysis of findings

This review identified 136 interventions that have been evaluated in RCTs with parents and/or children or young people with a range of identified vulnerabilities. Two of these interventions received the highest rating of Well Supported. A further 18 interventions were rated Supported. Nine interventions were rated Promising, 16 were Emerging, and 91 were rated Pending. This review has focused on the interventions that can be more confidently considered effective based on the rigour of evaluations and demonstration of effect for six months beyond the intervention period. A discussion of the interventions rated Emerging and higher follows, giving consideration to differences and similarities across rating groups based on intervention factors, populations and outcomes.

5.1.1. Target populations

Much of the evidence for interventions centres on families where the child has been maltreated or is at risk of maltreatment. This is not surprising, as child maltreatment risk is often what brings families to the attention of child and family serving agencies, and although it may not have been stated in intervention descriptions, many will have prevention of maltreatment as an objective.

Typically, the interventions in this review cover more than one type of family vulnerability, and may encompass several child, parent and/or family factors that influence risk of maltreatment or harm. Again, this was not unexpected given that families typically present with more than one issue and the multicomponent interventions targeting these families tend to work across the various issues families present with.

There were some notable differences across identified vulnerability groups regarding child age. The interventions involving families exposed to domestic violence, interventions where there was risk of maltreatment, and interventions for low income and teenage parents were more often delivered in the early childhood years. Interventions for young people at imminent risk of removal from the family home and interventions more associated with risky youth behaviour were unsurprisingly more often targeted at adolescents.

5.1.2. Targeted outcomes

As well as considering the types of populations included in these interventions, we considered the outcomes that were targeted. Interestingly, prevention of child maltreatment was not identified as a main outcome for a large proportion of interventions, but the ultimate objective of targeting other outcomes (such as behaviour and functioning) may have been to reduce the risk of future maltreatment.

We found that the highest proportion of interventions targeted child behaviour, with all Well Supported and Supported and most Promising and Emerging interventions (88%) targeting this outcome. This is unsurprising given that difficult child behaviour can be a key factor that places them at risk of maltreatment; and so addressing child behaviour and parent strategies for dealing with behaviour is a frequent target of both parent-oriented and child-oriented interventions.

Family functioning was targeted by the next highest proportion of interventions (80%), with no difference in percentage observed when the Well Supported and Supported interventions were compared with the lower-rated interventions. As with child behaviour, this was expected, because improving relationships within families, interactions between parents and children, and parent wellbeing was a part of most interventions.

Slightly more Well Supported and Supported interventions targeted child development (60%) than did the Promising and Emerging interventions (48%). More Promising and Emerging interventions (56%) than Well Supported and Supported interventions (25%) targeted the safety and physical wellbeing of children. More Promising and Emerging interventions (44%) than Well Supported and Supported interventions (30%) targeted maltreatment prevention.

There was a comparable percentage of interventions targeting family support networks across the higher-rated and lower-rated interventions (55% and 56%) and a similar percentage also was found for interventions targeting systems outcomes (40% for the Well Supported and Supported, 36% for the Promising and Emerging).

5.1.3. Aspects of interventions relevant to delivery

5.1.3.1. Delivery mode and duration

Many of the interventions included in this review were multicomponent. This was a feature across all but one identified vulnerability group (young people at risk of suicide). Interestingly, a higher proportion of the Well Supported and Supported interventions, compared to the Promising and Emerging interventions, were considered multicomponent.

Most interventions included in this review were delivered on an individual basis and involved intervention for parents and children. The exception was the interventions for youth at risk of suicide, which were delivered on a group basis to children only. There was a greater proportion of Well Supported and Supported interventions that provided interventions solely for parents, with a greater proportion of Promising and Emerging interventions delivering to both parents and children.

Interventions were typically delivered in the home over a period of no more than six months, although in interventions for families experiencing domestic violence, for teenage parents, for families with a child at risk of removal, and for trauma-informed interventions, interventions lasting up to a year were also frequently used. Further, a higher proportion of the Well Supported and Supported interventions compared to

the Promising and Emerging interventions were conducted in less than six months, and a higher proportion of the Promising and Emerging interventions were home-based. The Well Supported and Supported interventions were also frequently based in the home, but many also had an option for community-based delivery.

5.1.3.2. Training and supervision of staff

Staff delivering these interventions were often trained and supervised. Interventions for young people at risk of out-of-home care and trauma-informed interventions had greater staffing requirements, typically clinical Master's degree qualifications. It should be pointed out that three of the four interventions for young people at risk of removal from their family homes were variations of MST; so similarity of minimum staffing requirement is not surprising.

5.1.3.3. Intensity of intervention

When looking at intensity of services, a factor that may be particularly relevant to FACS services given the crisis situations many families present with, this review identified that the interventions for families with children or youth at imminent risk of removal from the family home were the most intensive. They were identified as responding to crisis situations and were intensive due to the high frequency of weekly contact and staff availability, not necessarily in terms of duration.

5.2. Intervention delivery and content components

This review identified 49 distinct intervention delivery components and 118 content components. Components common across the various family, parent and child vulnerabilities were identified and reported in the main findings of this review. Only four delivery and content components were found to be *common* across at least 50% of all 45 interventions: interventions were delivered in structured sessions; and content included parenting skills education or training; child/youth behaviour and behaviour management; and parent-child interactions, communication and relationships. The great variation between the 45 intervention types is likely to be the reason for the low number of common components across these interventions.

While not reflecting the *common* components analysis, some differences can be noted between delivery and content components when comparisons are made between interventions rated Well Supported and Supported, and those rated Promising and Emerging.

For instance, a higher proportion of Well Supported and Supported interventions compared to Promising and Emerging involved the use of modelling as a delivery technique, and content related to parent stress management, positive peer relationships, using praise with children, and having quality time with and giving positive attention to children.

When compared to the components of Well Supported and Supported interventions, Promising and Emerging involved a higher proportion of intake and family assessments, individualised family plans, working in collaboration with families, and content related to child and home safety, parent conflict management, child development, parent life course, and meeting the families' basic needs.

5.3. Gaps in the evidence

Many interventions were identified on the clearinghouses searched for this review. Although they had been evaluated, these evaluations generally were not of rigorous

design, and did not assess maintenance and replication of effect. While we do not suggest these interventions are not effective, there is not enough information available yet to make a determination either way. These interventions could be revisited in the future to see if more and better quality assessments have been conducted.

Of those interventions we were able to rate, there was on the whole not a great deal of strong evidence — only two interventions rated Well Supported. The evidence for interventions rated Emerging and Pending (see Appendix 1 for a list of Pending interventions) is limited and we would hesitate to make recommendations about general applicability outside their specific implementation context.

We have identified several populations for which very little information on interventions was available. Based on our searches of the clearinghouses, no interventions for parents with intellectual disabilities were rated Emerging or higher. Given this obvious gap and given that this is a population of key interest to FACS, we consulted colleagues who are experts in this field, and conducted a search to identify new studies. Unfortunately this process yielded no interventions rated Emerging or higher. Interventions rated Pending were identified, however further research is needed to establish their effectiveness. Further information about parenting with an intellectual disability and support for parents is available through Healthy Start. Healthy Start is Australia's only national strategy for parents with learning difficulties (http://www.healthystart.net.au/).

Generally, there was limited higher-rated evidence for interventions involving families with youth mental health and suicide issues and youth at risk of out-of-home placement. Also, while the review was able to identify several interventions involving parents with particular identified vulnerabilities, the evidence for these was not at the higher end of the rating scale. Notably, there were few interventions that specifically target families exposed to domestic violence, however there were several in which domestic violence was an additional family concern; i.e. domestic violence was just one of several family factors that may have been present. There were also a limited range of interventions specifically targeted at parents with substance misuse problems, parental mental illness, low income/SES families, teenage parents and parents in the antenatal period.

It is reasonable to suggest that other interventions exist that specifically target these populations or are suitable for these populations. These interventions may not have been rigorously evaluated or they may not have been identified in this review. Although they do not specifically target these populations, it is also probable that interventions included in this review have included some participants with these vulnerabilities since multicomponent interventions such as these typically target multi-problem families.

5.4. Factors to consider when implementing and selecting interventions

Identifying effective interventions is a vital first step when making policy and practice decisions; however, it is only the first step. Despite strong evidence that quality of implementation has an important influence on outcomes, typically there is insufficient emphasis placed on the systematic assessment of the extent to which interventions are implemented effectively and on the evaluation of intervention impact on outcomes (Aarons, Sommerfield, & Walrath-Greene, 2009).

Implementation is a process rather than an event, and refers to a set of planned and intentional activities or strategies in order to introduce or change interventions of empirically supported practices (ESPs) in real-world settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Mitchell, 2011). Implementation is different to “adoption”, which is the decision to use an intervention or set of ESPs (Mitchell, 2011). Implementing a ‘one size fits all’ intervention in a way that suits the individual organisation can be a watershed moment for that organisation.

While effective implementation has traditionally been thought of as full implementation of all intervention or practice components as planned, implementation researchers have recently started to investigate the extent to which components of intervention can be used to allow for local adaptation of intervention. Adaptions of interventions are sometimes required at a system, policy or organisation level in order to aid effective implementation or sustainment (Aarons et al., 2012).

Implementation of effective interventions is a complex and challenging process. Many efforts to implement interventions have previously not been fully successful due to problems in the implementation process and in family support services (Aarons, Hurlburt, & Horwitz, 2011; Mildon & Shlonsky, 2011). In order to achieve desired outcomes for families, organisational challenges need to be addressed as in a set of planned, purposeful and integrated implementation activities. Focus needs to therefore be on *how* to implement an intervention, as well as *what* is being implemented. Not only do governments need to attend to the evidence regarding effective interventions, they also need to attend to the way interventions can be implemented to achieve good results for parents and children.

In recent years there has been increased attention by researchers on describing the implementation process, such as by outlining the main steps in implementation or developing more detailed theoretical frameworks and conceptual models based on the literature (Meyers, Durlak, & Wandersman, 2012). Implementation frameworks provide structures for describing the implementation process and challenges, facilitators and attributes of implementation (Flaspohler, Anderson-Butcher, & Wandersman, 2008). In some cases, implementation frameworks can provide guidance for practitioners, researchers and policy-makers regarding steps to take when planning and commencing the implementation process, as well as mistakes to avoid (Meyers et al., 2012).

In a synthesis of 25 implementation frameworks that described the “how to” of implementation across multiple research and practice areas, Meyers et al. (2012) suggested that identifying action-oriented steps can serve as a guide for implantation. It was found that most frameworks separated implementation processes into temporal phases, within which there was generally consensus regarding the elements of activities that form each phase. Fourteen elements were identified, and they were divided into four temporal phases (Meyers et al., 2012).

Phase one is *Initial Considerations Regarding the Host Setting,* and it considers the ecological fit between the intervention and the host-setting. Elements of this phase include assessments of organisational needs, intervention-organisation fit, and organisational readiness and implementation capacity, exploration of the possible need for intervention adaptation and how adaptation could be achieved, seeking interest from stakeholders, developing a supportive organisational culture, building capacity within the organisation, recruiting staff, and conducting training.

Dymnicki, Osher, Grigorescu, and Huang (2014) state that readiness to implement interventions is central to the failure or success of change. Organisational readiness can be defined as "the extent to which organization members are psychologically and behaviourally prepared to implement organizational change" (Weiner, Amick, & Lee, 2008) or the extent to which organisation members are motivated and have the capacity for change (Dymnicki et al., 2014). Scaccia (2014) developed a formula for organisational readiness — Readiness = Motivation x General Capacity and Intervention-Specific Capacity (R=MC2) — suggesting that organisations need to consider their capacity to implement any intervention or practice in the current context, as well as the specific requirements of a given intervention.

According to Shea, Jacobs, Esserman, Bruce, and Weiner (2014), organisational readiness is a multi-faceted concept, including whether the organisation and its staff are committed to change and also organisational efficacy for change. Efficacy for change is influenced by whether staff feel they know what to do and how to do it and whether they feel they have the resources needed to make the change. Implementation of interventions may be unsuccessful when staff do not understand or accept reasons for change or the possible benefits of change, or it may be due to inadequate resourcing or expertise to implement and sustain the intervention (Simpson, 2009). In order for implementation to work, organisation staff and leaders need to believe the intervention will be effective and feasible in the context of the service, as well as sustainable given the funding and staff skill set (Simpson, 2009).

Related to this, the climate or culture of an organisation is also a critical factor to consider in the host organisation. In this context, organisation climate can be considered as the extent to which the organisation and its leadership demonstrate their support for the adoption, implementation and use of an intervention (Ehrhart, Aarons, & Farahnak, 2014). Consensus across an organisation, particularly from leadership, regarding the value of change or of a particular intervention supports the implementation process. This is especially important where established providers are being asked to alter their preferred practice to incorporate new interventions or components of interventions — practitioners need a reason to change their practice, and organisation climate can influence this.

The second phase identified by Meyers et al. (2012) is *Creating a Structure for Implementation*. This involves two elements: developing an implementation plan; and forming an implementation team. Part of this planning process requires the identification of roles, responsibilities and tasks.

Phase three, *Ongoing Structure Once Implementation Begins*, includes three elements: technical assistance, which includes training, coaching and supervision; monitoring implementation through process evaluation; and developing supportive feedback systems to ensure all parties have an understanding of progress being made in the implementation process.

Phase four is *Improving Future Applications*, and involves learning from experience. Retrospective analysis and self-reflection that includes receiving feedback from the host organisation helps to identify strengths or weaknesses during the implementation process.

Several of the frameworks included in the synthesis by Meyers et al. (2012) were based on learning from experience and via staff feedback. Few modifications of frameworks were based on the findings arising from empirical testing of the

framework. Modifications were more often based on staff feedback regarding ineffective and effective strategies, taking into account what was beginning to be reported in the literature, and/or by self-reflection about implementation.

In a recent systematic review, Novins, Green, Legha, and Aarons (2013) synthesised findings from studies that examined dissemination and implementation of evidenced-based practices in the field of mental health for children and youth. While there were several inner contextual factors (factors within the organisation such as staff attitudes and financial viability) considered in the studies reported in the review, fidelity monitoring and staff supervision were examined most frequently, and according to Novins et al. (2013), they have the best available empirical evidence. These factors increase the chance that described intervention effects will be observed and they result in better staffing outcomes such as retention of personnel. Novins et al. (2013) also suggest that the studies that focused on improvements in the culture and climate of organisations were associated with better outcomes for families. Characteristics of the workplace therefore need to be considered if interventions are to be delivered as intended (Novins et al., 2013).

Novins also found that technologies to support the intervention and staff training are important for the outer context (factors external to the organisation such as policies and funding). Having a connection with intervention developers and networks with other organisations was also found to improve communication and inter-agency interaction.

According to Palinkas et al. (2011), social networking between organisation members and leaders is an important factor in implementation, as it can aid in successful collaborations and help organisations obtain support and information. Networks that go outside an organisation's service system may be of particular importance. Further to this, collaboration is a critical element in the establishment of the networks between organisations (Palinkas et al., 2014). Interagency collaboration facilitates sharing of resources, information and advice, and may support implementation (Palinkas et al., 2014).

Interventions may be implemented in a single organisation, or scaled up to delivery across a whole sector or sectors. Hurlburt et al. (2014) investigated implementation capacity from a whole implementation team and systems perspective. Several factors were found to be important in the implementation of a large-scale intervention: key stakeholder commitment and collaboration; identification and quality of leadership in terms of the lead group, the lead directors, and the leaders at a practice level; communication between all levels; the degree of fit between the new interventions and existing practice and fidelity; establishing the rights, roles and responsibilities of all parties; and experiencing some early success in the process of planning, preparation and implementation of the intervention.

Box 17 summarises several aspects of implementation identified within implementation science literature that should be taken into account when selecting an intervention to deliver to families and when planning intervention implementation.

Box 17. Factors to consider when selecting and implementing interventions (adapted from Wade et al., 2012)

Appropriateness of intervention aims and outcomes

- Is the intervention based on a clearly defined theory of change?
- Are there clear intervention aims?
- Are there clear intended outcomes of the intervention that match our desired outcomes?

Targeted participants

- Is the target population of the intervention identified and does it match our intended target population?
- What are the participant (child, parent or family) eligibility requirements (ages of caregivers or children, type of person, presenting problem, gender)?

Delivery setting

- What are the intervention delivery options (e.g. group, individual, self-administered, home-based, centre-based)?
- Is there flexibility in delivery modes that suit our service context?

Host setting

- Is the organisational climate and culture of the host organisation conducive of the implementation of the intervention?
- Do values implicit to the intervention fit with organisational values and strategies?
- Does the current organisational infrastructure match the needs of the intervention or will changes need to be made?
- What defines 'organisational readiness' for the implementation of the intervention — and can the organisation consider itself to be 'ready'?

Implementation infrastructure

- Who among internal and external stakeholders needs to be involved in implementation efforts and therefore included in decision-making and planning processes?
- If the implementation depends on inter-agency collaboration, what are the resources, structures, roles, processes and procedures needed to enable that multi-agency collaboration?
- What type of administrative and system supports needs to be provided by the hosting organisation (e.g. administrative support and data systems)?

Implementation capacity

- Implementation will always create an additional layer of work, which typically cannot be done by practitioners who are supposed to deliver the intervention. This work involves the building of structures, systems and capacity to enable

program intervention. Therefore it is relevant to ask: Who is supposed to do the implementation work?

- Which additional capacities — internally and for the collaboration with others — are needed to plan and enable an implementation?
- What are the competencies and responsibilities the implementation staff should have?

Costs

- What are the costs to purchase the intervention?
- What are the costs to train staff in the intervention?
- What are the ongoing costs associated with purchasing manuals and technical assistance (e.g. coaching and supervision of staff)?
- What are the costs to implement the intervention with families (in terms of staff time, resources to deliver, travel cost to agency, travel cost to families, costs to families in terms of time off work and childcare)?
- Are cost-effectiveness studies available?

Accessibility

- Are the materials, trainers and experts available to provide technical assistance (i.e. training, coaching and supervision) to staff who will deliver the intervention?
- Is the intervention developer accessible for support during implementation of the intervention?
- Does the intervention come with adequate supporting documentation? For instance, are the content and methods of the intervention well documented (e.g. in provider training courses and user manuals); are the content and methods standardised to control quality of service delivery?
- Are the intervention content and materials suited for the professionals and parents we work with, in terms of comprehension of content (e.g. reading level of materials, amount of text to read or write, use of complex terminology)?
- Does the intervention suit our service's access policies (e.g. 'no wrong door' principles; 'soft' entry or access points; community-based access; access in remote communities)?

Technical assistance required

- What are staff training needs (frequency, duration, location, cost)?
- What amount of ongoing technical assistance is required (including top-up training, coaching or supervision)?

Fidelity

- What are the requirements around the fidelity or quality assurance of delivery of the intervention components to families? That is, how well do practitioners need to demonstrate use of the intervention either during training or while they are working with families (e.g. are there tests, checklists or observations that they need to perform during training; are there certain things they need to do to

prove/show to the trainers that they are using the intervention correctly, such as video-taped sessions, diaries, checklists about their skills or use of the intervention with families)?

- Are there certain intervention components that MUST be delivered to families? That is, if they don't do X, they are not actually using the intervention as intended.
- What are the intervention dosage or quantity requirements for effective results (i.e. how often and for how long do families need to receive the intervention)? Can our service meet those requirements?

Data and measurement of effectiveness

- How is progress towards goals, milestones and outcomes tracked?
- What are the requirements for data collection (i.e. what measures are recommended, how often are they to be administered, who can administer them)?
- How accessible and relevant are the developer-recommended evaluation tools (ease of access, cost, ease of administration and scoring, relevance to NSW context)?

Languages

- What languages is the intervention available in and does that match our client population?
- Is the intervention relevant and accessible to particular cultural and language groups (e.g. Indigenous families)?

Policy-makers and organisations face various challenges when selecting and implementing interventions. One significant challenge is that an effective intervention may not exist for an organisation's identified needs, the target population, desired outcomes, and service and cultural context. An additional difficultly frequently faced by community-based organisations is that the monetary cost of an intervention may be too high. While the cost of not implementing an intervention should be considered in these circumstances, cost is often a barrier to the quality implementation.

Organisations also face the challenge of deciding if interventions should be adapted to fit the context, and if so, how the intervention should be adapted while retaining the necessary elements and ensuring that it is implemented to effect. Generally it is best to adhere as closely as possible to the intervention as designed by the developer in order to ensure the interventions if implemented with fidelity, and to avoid losing any benefits of the intervention. For example, in the case of NFP, it has been found that substituting nurses for paraprofessionals did not result in desired outcomes. While it is unknown if other professionals could deliver NFP with success, it is possible that adaptation of this intervention to include delivery by other professionals may not result in desired outcomes.

Adaptation of interventions is, however, sometimes necessary to suit particular context and population needs. In these circumstances, evaluation of adaptations or innovations is necessary in order to determine if desired outcomes for children and parents are being achieved, and to ensure that no harm is caused. Where an

evaluation finds an indication that an intervention appears to be effective, evaluation should be conducted on an ongoing basis in order to establish higher levels of evidence.

5.5. Implementing interventions in the NSW context

This review has summarised a range of interventions that can be considered effective and relevant to the NSW intensive family services system for a population identified as high risk of recurring maltreatment. Common components of these interventions have also been identified. Considerations when implementing interventions in the NSW context are now described.

5.5.1. Consider the target population of the intervention

One of the first considerations when selecting interventions and planning implementation is to determine if the intervention/s is/are suitable for the population of interest to FACS. Broadly, this population either meets or is at risk of meeting the criteria for "Risk of Significant Harm" or ROSH. This population is at risk for ongoing maltreatment and requires some level of intervention from child protection services.

Matching interventions to populations requires further understanding and analysis of this broad population into more discrete target groups; for example: programs reducing maltreatment for 0 – 5 year-olds, interventions that prevent out-of-home care for 12 – 17 year-olds with challenging behaviours, etc. This analysis seeks to understand what interventions work for whom and when. Further examination of each of the population descriptions would assist in the selection of interventions, including the age of the children/youth, whether the effect was seen across differing parent and child vulnerabilities common in the child welfare population, etc. In keeping with the social ecology theory of families, maltreatment and related services as interrelated systems, consideration should be given to the flow-on effects of addressing a given vulnerability. Problems are not discrete. Treating one problem such as improving parenting skills may have positive impacts on outcomes such as maternal depression or even some harmful substance use.

5.5.1.1. Service provision for Indigenous clients

Of particular relevance to FACS services is the suitability and accessibility of interventions to Indigenous families. A recent scoping review of parenting interventions for Indigenous families (Macvean, Shlonsky, Mildon, & Devine, 2015) found that there have been few rigorous evaluations of interventions targeting parents of Indigenous children, and that a full systematic review is needed. This is also true for interventions for Indigenous families that are not related solely to parenting. Few of the interventions included in the current review will have been evaluated specifically with Indigenous families, although SafeCare is an example of one intervention that has demonstrated effect with Indigenous populations and this has recently been introduced in NSW.

As with the implementation of all interventions, any interventions with Indigenous populations will need to be evaluated to determine their suitability and effectiveness with this particular group. Adaptations may be required in order to suit the language and culture of the families being supported. Macvean et al., (2015) found that one of the notable differences between interventions for Indigenous parents and general parenting interventions is the consideration of cultural factors extending beyond just translation and interpretation. This suggests that when adapting services to

Indigenous families, Indigenous culture should be central to development and embedded in content and delivery.

Relevant to working with local Indigenous communities and organisations, Martiniuk, Ivers, Senserrick, Boufous, and Clapham (2010) provide some guidance on how best to conduct intervention research with Aboriginal populations in NSW. Their key recommendations are to:

1. Align with key documents providing guidance on the best ways of working with Aboriginal communities
    a. The National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003)
    b. The NSW 'Two Ways Together' plan for working well with Indigenous communities (2003-2013)
2. Put more effort into scaling up programs and policies that are already known to work, and increase efforts on understanding how best to implement such programs (effect of local settings and contextual influences)
3. Support programs, which are initiated by communities, addressing high priority community concerns. In the context of this review, that might mean identifying small local programs and supporting their implementation and evaluation.
4. Consider systemic and institutional barriers. In this context, that means increasing time available to establish and increase engagement with communities and develop and deliver programs, and investing resources in local capacity development.

5.5.2. Consider gaps in the evidence and where interventions can be used in other populations

The gaps identified in this study need closer consideration. There were several gaps identified in some of the child vulnerability groups (such as youth suicide and youth with diagnosed mental illness), and across all family/parent vulnerabilities (such as parents with an intellectual disability, domestic violence, parents with substance misuse problems, parental mental illness, low income/SES families, and teenage parents). It would be a mistake to conclude that the target population of effective interventions did not include parents and children with these identified vulnerabilities or combination of vulnerabilities.

A helpful line of questioning would be whether these interventions specifically excluded groups of parents or children based on vulnerability; what types of families benefited; is there information regarding differing effect size, etc. Many of the interventions identified could very well be suited to these vulnerable groups, even if they have not specifically targeted or evaluated that subgroup/vulnerability.

Additionally, multicomponent interventions, by design, tailor and combine intervention strategies based on the assessed factors contributing to maltreatment for each family. Matching the outcome of interest in these circumstances is critical. The overall outcome of these multicomponent interventions is a reduction in maltreatment, whereby individual strategies may have included contingency management for substance use, CBT for depression, parenting skill development, for example.

Therefore when assessing apparent service gaps, consideration should be given to the relevance of the intervention content and the suitability of delivery method for the population at hand. For instance, consider questions such as: is material relevant to young, first-time mothers; does it support the needs of parents with a mental illness, does it cater to the issues associated with parenting with an intellectual disability? A further consideration regarding parents with intellectual disabilities is that the absence of well-evidenced interventions may not be the true gap; the gap may be in our knowledge about the interventions' capacity to cater for the individual learning needs of participating parents. Parents with intellectual disabilities need not become involved with child protection services simply because they have a disability (although this has historically been the case). When selecting relevant interventions, consideration needs instead to be given to the other child, parent and family factors that have brought families to these services, and to an assessment of the match between desired outcomes for the family and outcomes targeted by the intervention.

With regards to interventions for parents with a mental illness and parents with substance misuse concerns, this review only sought interventions specifically associated with parents dealing with these problems, rather than the treatment literature for adults in general. There are several additional effective interventions available for adults with these vulnerabilities. Services could look beyond the specific parent-focused interventions especially, as referrals are often made for such services for child-welfare involved families. There are also shared objectives to implement effective interventions in adult substance abuse and mental health service systems. However, consideration would need to be given to whether these types of interventions take into account the role of parenting/child caregiving or the broader family context. Delivering these interventions to adults without children or to parents without maltreating behaviours may be different to delivering them to effect with families seen by FACS services. In this case, the gap lies in our knowledge of whether general adult interventions can work in the context of families and maltreatment.

5.5.3. Consider the outcomes and objectives of the intervention

An analysis of the outcomes and objectives of the interventions is also a key consideration for effective implementation. What does the intervention target; what might change for parents, children and families as a result of the intervention? When selecting interventions, consider if the interventions' target outcomes and objectives match the objectives and targeted outcomes of the service, or whether the outcomes and objectives of the service need modification or increased specificity. It should not be assumed that if intervention populations match those of the service, then the outcomes targeted will also match. There may be an intervention involving mothers experiencing or separating from domestic violence, but it could seek to improve parent education and employment opportunities, whereas FACS's interest may be reduction in maltreatment and improving parent and child safety.

5.5.4. Consider the setting, context, and other variables of the intervention

Other factors to consider when selecting interventions are those related to setting/context and implementation variables/supports. Most of the interventions presented in this review were based in the home and some in the community, and this may suit the current structure of FACS's system. Some, however, included school-based components or medical or out-patient clinics. Consider if these are

suitable or if the setting can be adjusted. It is important to note that the majority of interventions included in the review were brief to short-term; but some were moderate and longer-term interventions. It is important to select interventions based on outcome focus rather than a duration focus. Many brief/short-term interventions are delivered at a high intensity. If a brief to short-term intervention has effect it should not be dismissed simply on the basis of short duration. These interventions may be able to be offered more widely than longer-term interventions.

5.5.5. Consider whether interventions are designed for crisis response

As this is a review of intensive family services and many of the families seen by FACS services are facing significant crises, one of the factors to consider when selecting interventions will be whether the interventions are designed to respond to crises and deliver intensive services. This review identified four interventions that are designed to meet this purpose. Three of these interventions were variations of MST. When deciding if these interventions are suitable, not only do population factors such as child age and presenting problems need to be considered, but also the capacity of the services and staff. These interventions, particularly MST, list extensive requirements that must be met in order to achieve effective implementation. These include an array of highly qualified clinical staff; a requirement that may not be achievable with current staffing arrangements. Homebuilder has fewer stated requirements, however the evidence supporting this intervention is not as strong as for MST. Several other interventions reported here also have particular staffing qualification requirements, and consideration would need to be given to whether these are good organisational fit.

5.5.6. Consider the cost-benefit of interventions

Limited cost benefit information was available for the included interventions. Appendix 2 details costing information where available (in US dollars). Cost of the intervention including staff salaries, training and coaching, cost to purchase manuals and any other materials and costs of running the intervention need to be considered, along with any available cost-benefit analyses.

5.5.7. Consider applicability for the Australian context

Several of the interventions included in this review have not been evaluated in Australia and therefore their applicability to the Australian context is not known. However, it is no longer the case that effective implementation of these interventions is limited to the country originally developed. Much can be learnt from implementation studies in various countries and across different jurisdictions, and systems. In this instance, Australian jurisdictions can benefit and leverage this knowledge in their ongoing reform efforts. Further to this, some of the interventions may not be readily available in Australia or training and technical assistance may require additional planning.

5.6. Limitations of this review

The scope of interventions and populations included in this review was broad. Generally, questions addressed by systematic reviews are narrowed to particular populations and interventions. Time limitations did not allow for a full systematic review, and the breadth of the topic of interest was not conducive to the systematic

search for and selection of original studies that would typically be undertaken in a rapid evidence assessment.

It was not possible within time constraints to seek original studies for further information or contact authors or intervention developers for additional information, or to actively seek unpublished studies that were not already summarised in the sources searched in the review process. In addition, information considered for the review was limited to the English language, although the sources were international.

To overcome these limitations, this review involved a detailed and systematic search, collection and synthesis of interventions using previous REAs and authoritative clearinghouses that conduct systematic searches. In addition, top-up searches were conducted for further evidence, and rigorous rating scheme was consistently applied across assessed interventions. We are confident that this approach has identified the majority of effective interventions that are relevant to intensive family services.

An additional limitation is in the reporting of intervention details. In this review we extracted and collated numerous details regarding the interventions reported on clearinghouses and drew this together with information previously gathered in the past REAs. In addition, intervention delivery and content components were sourced from developer websites and on other clearinghouses. Unfortunately not all details were available, including components. While we have endeavoured to extract and analyse all components available, there are no doubt more components involved in most of the interventions included in this review.

5.7. Suggestions to consider when using this review

Identifying effective interventions and the common components of these interventions is only a starting point for FACS services. The final section of this report provides some suggestions for using the information reported here and some potential next steps to consider.

1. Assess the fit between the interventions reported here and the FACS service context

   Taking into account the information presented above regarding key implementation factors, such as capacity and infrastructure, important decisions need to be made about how FACS can actively implement these interventions given the current service context and how the service context needs to change in order to implement interventions effectively. A detailed examination of the outlined implementation factors in relation to the service context is warranted.

   Consider also if the interventions address populations and outcomes of relevance to the services. This requires clarity regarding the families being supported and the outcomes services want to achieve for the families. Interventions may target a main client group, but be relevant for others. The clients in any service context may fit several of the descriptors presented in this report. Similarly, an intervention may have several outcomes of interest.

2. Assess if further investigation into interventions is required

   There may be gaps in the review findings that FACS wishes to pursue, such as populations with limited evidence or interventions that were out of the scope of this review. For example, it may be useful to assess the effectiveness of

interventions for adults with mental illness or substance abuse concerns, which are not parent-oriented or family-oriented interventions.

3. Give further consideration to the delivery and content components identified

   This review provides an indication of components that were common across groups of interventions. Further investigation may identify additional components, and increasing the “common” cut-off to a higher percentage than 50% may assist to fine-tune what components interventions have in common.

   While it has been suggested that identifying common components can help to shape adaptations of interventions, caution should be exercised. It cannot be assumed that discrete components are effective simply because they are found to be common across effective interventions. It is possible that combined sets of components within particular interventions result in benefits and that these components cannot produce good results in isolation.

   At this stage much of what is found in the literature regarding common components comes from the adolescent mental health field. While this is a factor that may place youth at risk of maltreatment, the application of the common components approach in the child welfare context is comparatively new. This approach has the potential to assist intervention design or adaptation, however the selection of components should not be undertaken without a clear understanding of the interventions from which they are drawn and with consideration of the interplay between other components in this intervention. Ideally, assistance should be sought before combining components when forming a new or adapted intervention.

4. Make plans for implementation and evaluation of all interventions and adaptations

   Plans for how implementation will be carried out and monitored, and how interventions will be evaluated, need to be established well before implementation commences. This applies to all service delivery, including where adaptations are made to interventions. If interventions are adapted for the local context, this needs to be done in a planned, structured way with quality improvement data. These adaptations would first require testing for feasibility, acceptability and effectiveness, since the evidence rating of the original intervention would no longer apply. Ensure an understanding of any necessary minimum requirements as well as the delivery and content components when making plans for implementing interventions or adaptations.

   Where possible, obtain training and support regarding selection and implementation decisions, and implementation planning and evaluation.

   Implementation plans also need to pay attention to the system level of implementation — in some implementation models also called the ‘outer context’ of implementation (Aarons et al., 2011). The system level includes: a) the socio-political context of an implementation, i.e. federal, state and local policies, different types of legislation, and changing policy agendas; b) the funding structures that support an implementation; c) single organisations and inter-organisational networks that directly or indirectly will be involved in an implementation, e.g. intervention developers, professional organisations, clearinghouses, research centres, client advocacy groups, and intermediary organisations that provide technical assistance and implementation support to

provider agencies – to just name a few. Taken together, these system level factors represent a broad array of stakeholder interests, legislative, administrative and governance requirements that may impact upon an implementation — especially in the case of large-scale implementations that cross the boundaries of sectors and communities (Sotham-Gerow, Rodriguez, & Chorpita, 2012). As a consequence, current agreements between government bodies and service providers regarding service targets may need to be modified, governance structures and collaborative patterns adjusted, funding streams secured, and administrative resources aligned. For many interventions this may also involve an examination of how data streams — necessary to monitor implementation quality, program performance and client outcomes across sectors and organisations — are organised and can be made accessible at the system level.

5. Consider the social ecological context

   For all implementations and adaptations, consider the interrelating child, parent, and family factors, which may influence the appropriateness of any given intervention. Child factors influence parent and family factors, and vice versa. Consider also the range of community and ecological factors, which may affect child and family factors, and the service context for each intervention selected.

6. Consider the availability of new evidence

   There is a vast array of interventions available for vulnerable families and many are subject to ongoing evaluation. As evidence is cumulative, it would be useful to update the searches conducted for this review in five years or specifically seek new evidence for particular interventions. Interventions currently rated as Emerging and Pending may gather increased support as further evaluations are undertaken, and more information may be available on interventions for which there is currently insufficient evidence to determine their effectiveness.

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