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.

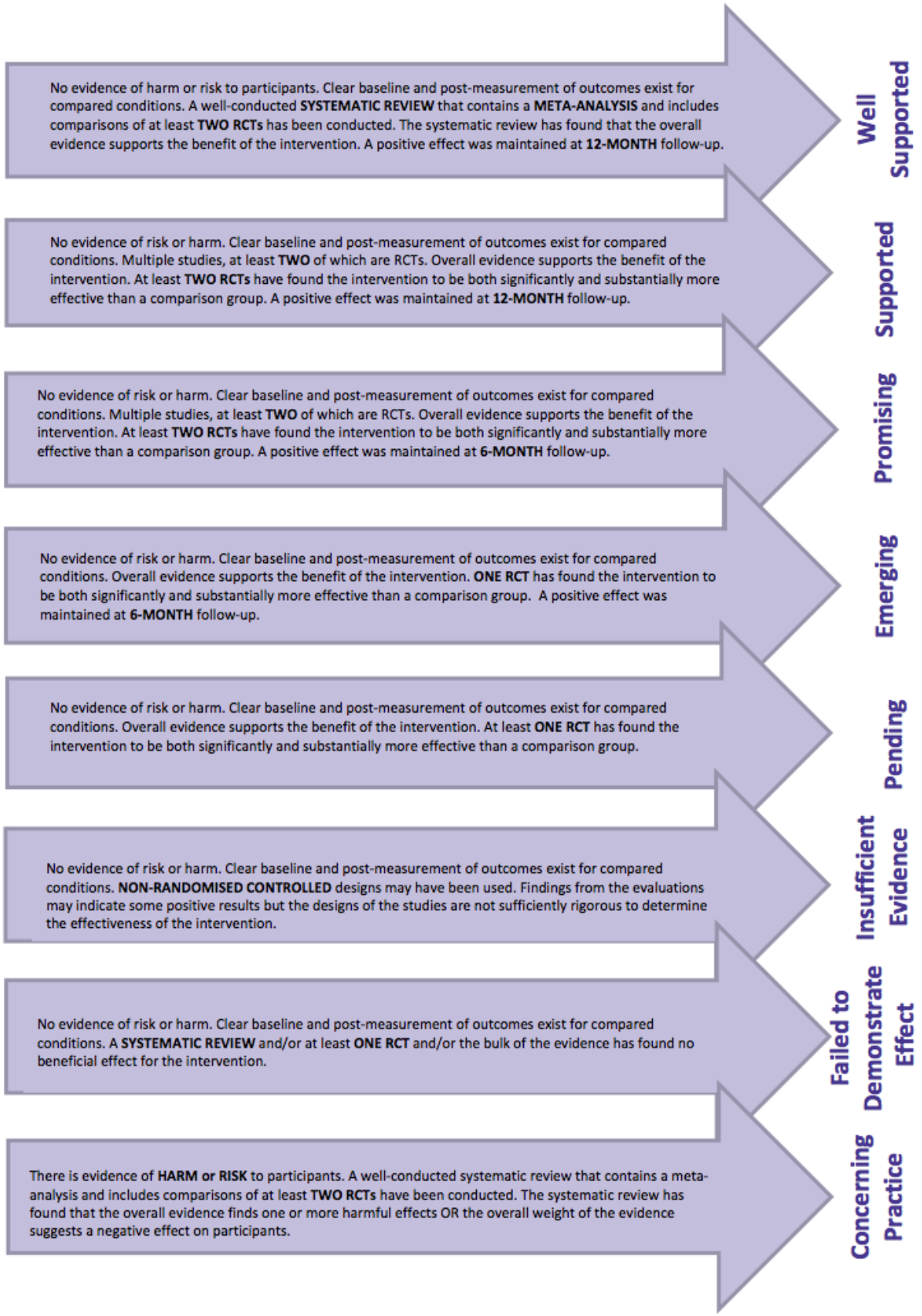
Family functioning: includes parent-child interactions (e.g. positive interactions between parents and children, emotional warmth and responsiveness, absence of hostility); consistency and reliability (e.g. children able to rely on supportive adults, providing guidance, providing adequate boundaries); 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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NSW GOVERNMENT Family & Community Services

Review of the evidence for intensive family service models

Appendix 2: Intervention details

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.

Report commissioned by the NSW Government Department of Family and Community Services

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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.

Suggested citation

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Contents

1. Well Supported

Please note: It is assumed that all dollars are given in US dollars. However, this was not clearly stated by the organisations.

1.1. Nurse-Family Partnership (NFP)

Nurse-Family Partnership (NFP)	
Intervention description	'The *Nurse-Family Partnership (NFP)* program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.'
Population	'First-time, low-income mothers (no previous live births) For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment • Family functioning • Support networks • Systems outcomes
Intervention details	• 'Clients: ▪ Voluntary ▪ First time mothers ▪ Low income ▪ Enrolled early in pregnancy • Intervention context:

Nurse-Family Partnership (NFP)	
	▪ Within a 1:1 therapeutic relationship ▪ Visits are in the clients home ▪ Visit schedule per guidelines and client's needs • Nurses and Supervisors: ▪ Complete all NFP core education • Application of the intervention: ▪ Nurses use their judgment to apply the *NFP* visit guidelines across 6 domains: o Personal Health o Environmental Health o Life Course Development o Maternal Role o Family and Friends o Health and Human Services ▪ Nurses apply the three theories through current strategies: o Self-Efficacy o Human Ecology o Attachment ▪ Nurses carry manageable caseloads, no more than 25 families • Reflection and Clinical Supervision: ▪ 1:1 weekly clinical supervision for each nurse with the nurse supervisor ▪ Case conferences are structure, at least 2 times a month ▪ Nurse supervisors conduct joint home visits with each nurse three times a year • Program Monitoring and Use of Data:

Nurse-Family Partnership (NFP)	
	▪ Nurses collect data as specified by the *Nurse-Family Partnership* National Service Office (NFP NSO), and all data is sent to the *NFP* NSO's national database called Efforts to Outcomes (ETO) ▪ ***NFP*** NSO reports data to agencies to assess and guide program implementation ▪ Agencies use these reports to monitor, identify and improve variances, and assure fidelity to the *NFP* model • Agency: ▪ Is networked with other services in the community ▪ Has community support for sustainability.' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level : individual Delivery: • Service linkage • Individual plan • Family goals • Praise for parents • Structured sessions Content: • Parent mental and physical health • Child care skills/caregiving • Problem-solving skills • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships
Delivery setting	• Birth Family Home

Nurse-Family Partnership (NFP)	
	• Community Agency
Dose	‘*Recommended Intensity:* Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 week’s gestation). Registered nurses visit weekly for the first month after enrolment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. *Recommended Duration:* Clients are able to participate in the program for two-and-a-half years and the program is voluntary.’
Staffing	‘*Nurse home visitors*: Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification *Nurse Supervisor*: Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification, and a Master's Degree in Nursing preferred.’
Resources or supporting tools	‘The typical resources for implementing the program are: • Office space that facilitates confidentiality related to clients and health care records • Computer and telecommunication capabilities • Cell phones • 1 FTE Nurse Supervisor per 4 FTE nurse home visitors • 0.50 FTE clerical/data entry support for each 4-nurse team serving 100 families • Adequate travel expense reimbursement (mileage) for home visitors In addition, a community advisory board and strong, stable, and sustainable funding for agency operations is recommended.’
Cost information	‘Program Benefits (*per individual*): $27,174

Nurse-Family Partnership (NFP)	
	Program Costs (*per individual*): $9,842 Net Present Value (*Benefits minus Costs, per individual*): $17,332 Measured Risk (*odds of a positive Net Present Value*): 71%'
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	June 2013

1.2. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
Intervention description	'*TF-CBT* is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.' It is a hybrid treatment model 'that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.'
Population	'Target Population: Children with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment. For children/adolescents ages: 3 – 18 For parents/caregivers of children ages: 3 – 18'
Target outcomes	• Child behaviour • Family functioning • Child development • Safety and physical wellbeing

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
	• Support networks
Intervention details	'The intervention includes: • P – Psycho-education and parenting skills • R – Relaxation techniques: Focused breathing, progressive muscle relaxation, and teaching the child to control their thoughts (thought stopping). • A – Affective expression and regulation: To help the child and parent learn to control their emotional reaction to reminders by expanding their emotional vocabulary, enhancing their skills in identification and expression of emotions, and encouraging self-soothing activities • C – Cognitive coping: The child learns to understand the relationships between thoughts, feelings and behaviors and think in new and healthier ways. • T – Trauma narrative and processing: Gradual exposure exercises including verbal, written and/or symbolic recounting (i.e., utilizing dolls, art, puppets, etc.) of traumatic event(s) so the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions. Following the completion of the narrative, clients are supported in identifying, challenging and correcting cognitive distortions and dysfunctional beliefs. • I – In vivo exposure: Encourage the gradual exposure to innocuous (harmless) trauma reminders in child's environment (e.g., basement, darkness, school, etc.) so the child learns they can control their emotional reactions to things that remind them of the trauma, starting with non-threatening examples of reminders. • C – Conjoint parent/child sessions: Held typically toward the end of the treatment, but maybe initiated earlier when children have significant behavior problems so parents can be coached in the use of behavior management skills. Sessions generally deal with psycho-education, sharing the trauma narrative, anxiety management, and correction of cognitive distortions. The family works to enhance communication and create opportunities for therapeutic discussion regarding the trauma. • E – Enhancing personal safety and future growth: Provide training and education with respect to personal safety skills and healthy sexuality/ interpersonal relationships; encourage the utilization of skills learned in managing future stressors and/or trauma reminders.'
Delivery setting	'This program is typically conducted in a(n): • Birth Family Home

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
	• Community Agency • Community Daily Living Settings • Outpatient Clinic • Residential Treatment Center’
Dose	‘Recommended Intensity: Sessions are conducted once a week. Recommended Duration: For each session: 30 – 45 minutes for child; 30 – 45 minutes for parent. The program model also includes conjoint child-parent sessions toward the end of treatment that last approximately 30 – 45 minutes. Treatment lasts 12 – 18 sessions.’
Staffing	• ‘Master's degree and training in the treatment model. • Experience working with children and families. Training is obtained: National Conferences; CARES Institute, Allegheny General Hospital and onsite by request. Number of days/hours: Introductory Overview: 1–8 hours; Basic Training: 2–3 days; Ongoing Phone Consultation (twice monthly for 6-12 months): groups of 5-12 clinicians receive ongoing case consultation to implement TF-CBT for patients in their setting; Advanced Training: 1–3 days’
Resources or supporting tools	‘The typical resources for implementing the program are: • Private space to conduct sessions • Waiting area for children when parents are being seen • Therapeutic books and materials’
Cost information	No information available
PRC rating	Supported
Primary source	CEBC
Date last reviewed	March 2014

2. Supported

2.1. Attachment and Biobehavioral Catch-up (ABC)

Attachment and Biobehavioral Catch-up (ABC)	
Intervention description	‘*ABC* targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children’s lead with delight. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child. Program Goals: The program goals of *Attachment and Biobehavioral Catch-up (ABC)* are: • Increase caregiver nurturance, sensitivity, and delight • Decrease caregiver frightening behaviors • Increase child attachment security and decrease disorganized attachment • Increase child behavioral and biological regulation’
Population	‘Caregivers of infants 6 months to 2 years old who have experienced early adversity, such as due to maltreatment or disruptions in care.’
Target outcomes	• Child behaviour • Child maltreatment prevention

Attachment and Biobehavioral Catch-up (ABC)	
	• Family functioning
Intervention details	'Targets three key issues: ▪ Child behaves in ways that push caregiver away: The caregiver is helped to override tendencies to respond "in kind" and to provide nurturance regardless. ▪ Child is dysregulated at behavioral and biological levels: Caregiver is helped to provide environment that helps child develop regulatory capabilities. This includes parent following child's lead and showing delight in child. ▪ Caregiver is helped to decrease behaviors that may be frightening or overwhelming to the child. • While *ABC* is a manualized intervention that also incorporates video-feedback and homework, the most crucial aspect of the intervention is the parent coach's use of "In the Moment"' comments that target the caregiver behaviors of nurturance, following the lead, delight, and non-frightening behaviors. These are used throughout the home visiting session while working with the parent.' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Structured sessions • Written material • Discussions • Feedback Content: • Child behaviour and behaviour management • Nurturance in response to child distress • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits

Attachment and Biobehavioral Catch-up (ABC)	
Delivery setting	Adoptive Home Birth Family Home Foster/Kinship Care
Dose	‘Recommended Intensity: Weekly one-hour sessions Recommended Duration: 10 sessions’
Staffing	‘There is no educational level requirement for parent coaches. Potential parent coaches participate in a screening prior to training. If they pass the short screening, coaches attend a 2-3 day training and a year of supervision.’
Resources or supporting tools	‘A/V: Laptop computer Video camera Webcam for supervision Personnel: Clinician with excellent interpersonal skills Space: Must be conducted at caregivers’ homes; this can include shelters or other temporary living situations.’
Cost information	No information provided
PRC rating	Supported

Attachment and Biobehavioral Catch-up (ABC)	
Primary source	CEBC
Date last reviewed	September 2014

2.2. Be Proud! Be Responsible!

Be Proud! Be Responsible!	
Intervention description	'*Be Proud! Be Responsible!* is designed to decrease the frequency of risky sexual behavior and related HIV/STD infection among minority (African American, Latino) adolescents. Based on cognitive-behavior theory, the program uses group discussions, videos, games, brain-storming, experiential exercises, and skill-building activities to improve teens knowledge about HIV and STDs, and to increase self-efficacy and skills that might help to avoid risky sexual behavior (e.g., abstinence, condom use).'
Population	'Minority (mostly African American and Latinos) adolescents (age 11-19) of both genders. At risk teens living in low SES environments.'
Target outcomes	• Child behaviour • Safety and physical wellbeing
Intervention details	'Based on cognitive-behavior theory, the program uses group discussions, videos, games, brain-storming, experiential exercises, and skill-building activities to improve teens knowledge about HIV and STDs, and to increase self-efficacy and skills that might help to avoid risky sexual behavior (e.g., abstinence, condom use).'
Delivery setting	School
Dose	'The intervention includes six sessions, of 60-minute length. The program can be implemented in a six-day, two-day, or one-day format.'
Staffing	Teachers and school nurses
Resources or supporting tools	'*Be Proud! Be Responsible!* offers a two-day onsite training of educators, from 8:30-4:30, at an estimated $6,000 plus travel. Educators are trained to implement the curriculum with fidelity, model how to answer

Be Proud! Be Responsible!	
	sensitive questions, do some values clarifications, and make fidelity-based adaptations. Training also include practice in conducting the lessons. Training Certification Process: A 5-day train the trainer, offered on-site, for 8 trainees costs an estimated $25,000 plus travel. The five-day training includes fidelity monitoring, evaluation training, and training of facilitators. Participants who complete the training are certified to train others to be facilitators of the program.'
Cost information	Training '…estimated $6,000 plus travel.' 'Training certification process: A 5-day train the trainer, offered on-site, for 8 trainees costs an estimated $25,000 plus travel.'
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Date last reviewed not indicated but last study was dated 2009

2.3. Coping Power

Coping Power	
Intervention description	'*Coping Power* for parents and their at-risk children consists of two components (Parent Focus and Child Focus) designed to impact four variables that have been identified as predicting substance abuse (lack of social competence, poor self-regulation and self-control, poor bonding with school, and poor caregiver involvement with child). The program's Child component emphasizes problem-solving and conflict management techniques, coping mechanisms, positive social supports, and social skill development. The Parent component teaches parents skills to manage stress, identify disruptive child behaviours, effectively discipline and reward their children, establish effective communication structures, and manage child behaviour outside the home. *Coping Power* is a 16-month program delivered during the 5th and 6th grade school years. Children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade. Groups are led by a school-family program specialist and a guidance counsellor. Children also receive half hour individual sessions once every two months. Parents attend 11 group sessions during their children's 5th grade year and 5 sessions during the 6th grade year.'

Coping Power	
	‘There is also a universal intervention, known as Coping with Middle School Transitions. This program consists of Parent Meetings and Teacher In-service Meetings. Three parent meetings are held during 5th grade and one parent meeting is held in 6th grade. Teachers participate in five 2-hour meetings during the 5th grade year. These two components are designed to promote home-school involvement, address parents' upcoming concerns about the transition to middle school, and address the four identified predictors of substance use.’ ‘A stand-alone universal version adapts the program for all elementary-school children. It uses 24 sessions, one each week, based on the child component of the program but with some changes in activities to encourage participation of all children in the classroom. A certified *Coping Power* Program psychologist and teacher deliver the intervention. The program does not include the parent component and makes changes to fit the whole classroom but otherwise is said to be essentially the same as the original.’
Population	For children aged 5 – 11 years at risk of substance abuse and their parents. ‘Parents and their at-risk children)’ Age: Late Childhood (5 – 11) – K/Elementary Gender: Male and Female Race/Ethnicity: All Race/Ethnicity
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks
Intervention details	*Coping Power* for parents and at-risk children: ‘The program's Child component emphasizes problem-solving and conflict management techniques, coping mechanisms, positive social supports, and social skill development. The Parent component teaches parents skills to manage stress, identify disruptive child behaviours, effectively discipline and reward their children, establish effective communication structures, and manage child behaviour outside the home’ Universal intervention: as Coping with Middle School Transitions:

Coping Power	
	'…promote home-school involvement, address parents' upcoming concerns about the transition to middle school, and address the four identified predictors of substance use.' Stand-alone universal intervention: 'The program does not include the parent component and makes changes to fit the whole classroom but otherwise is said to be essentially the same as the original.'
Delivery setting	School
Dose	16-month program delivered during the 5th and 6th grade school years. 'Child - children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade. Groups of 5-8 children meet for 40-50 minutes. Additionally, each student receives a half hour individual session once every two months.' 'Parent - The Parent component is delivered over the same 16-month period as the Child component. Groups of 12 or more parents meet in 16 sessions during their children's 5th grade year and 5 sessions during the 6th grade year.'
Staffing	School-family program specialist and a guidance counsellor. For the stand-alone universal intervention: 'A certified *Coping Power* Program psychologist and teacher deliver the intervention.'
Resources or supporting tools	'Training in the *Coping Power* Program is conducted in a workshop format and is generally completed over a 2 or 3 day period. Training includes hands-on opportunities for participants to learn and practice intervention techniques, as well as presentations, discussions, and videotape modeling on the intervention. The workshops also cover the developmental model upon which *Coping Power* is based and a review of empirical evidence supporting the program. Workshops are offered twice per year on the University of Alabama campus. The program will also arrange on-site trainings for interested agencies and school systems on an individual basis. Ongoing consultation and technical assistance can be arranged as needed.'
Cost information	'Initial Training and Technical Assistance: In-person training is available at the implementation site and at the University of Alabama campus at a cost for a 2-day training for up to 30 participants starting at $1,500. Additional costs may be incurred for more extensive planning and preparation, to be determined based on the individual needs of the group to be trained. Travel for the trainees or trainers would be an extra expense.

Coping Power	
	Additional training days can be added based upon the experience of trainees. Web-based training is also available. Curriculum and Materials: • Child Group Facilitator's Guide: $59.95 • Parent Group Facilitator's Guide: $47.95 • Child Group Workbooks (pack of 8): $67.50 • Parent Group Workbooks (pack of 8): $98.50 Licensing: none. Intervention Implementation costs: Ongoing Curriculum and Materials: Each parent-child pair needs a set of workbooks that cost $20.75 per set. In addition, it is estimated that each student will need materials costing $53. These include things like prizes, puppets, dominoes, etc. Staffing: Two facilitators are required for groups of six parent-child pairs. One should be a master's degree or Ph.D. clinician. A co-facilitator is often at a bachelor's level. Although the developers calculate costs on an hourly basis, typically *Coping Power* would be implemented by staff already employed by the sponsor organization. Since the program has been most often implemented in schools, qualified guidance staff, perhaps paired with teachers as co-leaders, could conduct the groups. *Coping Power* can also be provided in community agencies and outpatient mental health centers, again likely using existing qualified staff. Groups meet for one hour (child) and 90 minutes (parents). In addition, there is preparation and documentation time needed. This requires 1-2 hours for each group session. Other Implementation costs: Some programs include home visits by clinicians to recruit participants. These visits could represent an additional cost. Implementation Support and Fidelity Monitoring Costs: Ongoing Training and Technical Assistance: After the initial training, *Coping Power* training staff provides ongoing consultation, typically through twice-monthly, one-hour conference calls at $100 per hour. The cost of this TA is estimated to be $283 per parent-child pair. Fidelity Monitoring and Evaluation: *Coping Power* staff are available to review for quality audio or video tapes of sessions at $100 per hour. This typically costs $150 per parent-child pair.

Coping Power	
	Ongoing License Fees: none. Other Cost Considerations: Using unlicensed facilitators would require supervision, possibly from an outside consultant charging fees for their time. Year One Cost Example: This cost example will include 15 teams of two facilitators each serving two groups of six parent-child pairs during Year One of implementation. Thus, 180 parent-student pairs will be served. It will be assumed that the facilitators are already employed by the sponsor organization and that no home visits would be made. On-site 2-day training for 30: $1,500 Trainer travel: $2,000 Facilitator Guides-30 sets: $5,400 Workbooks for 180 parent-child pairs: $3,735 Materials for each student: $9,540 Consultation from *Coping Power* @ $283/parent-child pair: $50,940 Quality monitoring of recordings @ $150/parent-child pair: $27,000 Total Year One Cost: $100,115 The cost per parent-child pair in Year One would be $556.’
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Date last reviewed not indicated but last cited paper is dated 2014

2.4. DARE to be You

DARE to be You	
Intervention description	‘*DARE to be You (DTBY)* is a multilevel prevention program aimed at high-risk families with children ages 2–5. The program is designed to lower children’s risk of future substance abuse and other high-risk activities by improving aspects of parenting that contribute to children’s resiliency. *DTBY* combines three supporting aspects—educational activities for children, strategies for the parents or teachers, and environmental structures—to enable program participants to learn and practice the desired skills. Originally, the community-based *DTBY* curriculum concentrated on youths, their parents, and community professionals. The training was aimed toward the multiagency community teams who provided services to youth. The parent training of the current *DTBY* program evolved from the community trainings. The objectives of the parent–child workshops include improving self-efficacy and self-esteem; increasing internal locus of control; enhancing decision-making skills through effective reasoning; mastering effective child-rearing strategies, particularly communication skills; learning effective stress management; learning developmental norms to reduce frustration with children’s behavior and increase empathy; and strengthening peer support. Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, providing knowledge of appropriate child management strategies, improving parents' and children's relationships with their families and peers, and contributing to child developmental advancement. *DTBY* seeks to improve parent and child protective factors by improving parents’ sense of competence and satisfaction with being parents, providing them with knowledge and understanding of a multilevel, primary prevention program that targets Native American, Hispanic, African American, and white parents and their preschool children.’
Population	High-risk families (including substance abuse and mental illness) with children 2 to 5 years old
Target outcomes	• Child development

DARE to be You	
	• Child behaviour • Family functioning • Support networks
Intervention details	‘Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, providing knowledge of appropriate child management strategies, improving parents' and children's relationships with their families and peers, and contributing to child developmental advancement.’ ‘The objectives of the parent–child workshops include: • improving self-efficacy and self-esteem; • increasing internal locus of control; • enhancing decision-making skills through effective reasoning; • mastering effective child-rearing strategies, particularly communication skills; • learning effective stress management; • learning developmental norms to reduce frustration with children’s behavior and increase empathy; • and strengthening peer support.’
Delivery setting	No information provided
Dose	‘Sessions are ideally given in 2½-hour increments over 10–12 weeks and include a 10- to 30-minute joint activity for parents and children to practice skills learned in the session. ‘ ‘After completing the program, parents are welcome to attend annual reinforcement workshops. These boosters are given with a minimum of two series of four 2-hour sessions and are designed to enhance skills learned without duplicating previous activities. The boosters are intended to foster supportive networks and to consolidate the skills gained from DTBY.’
Staffing	Multiagency community teams
Resources or supporting tools	‘The program includes a preschool activity book for children ages 2–5 and developmentally appropriate curricula for children in kindergarten through second grade, in grades 3–5, and in grades 6–8’

DARE to be You	
Cost information	• 'Implementation manuals: Included in cost of training; additional manuals are $65 each. • Activity kit for children's program: $225. • 20 hours of on-site training (includes evaluation manual with process and content instruments): $5,500 for up to 35 participants, plus travel expenses. • 20 hours of off-site training (includes evaluation manual with process and content instruments): $500 for the first participant, $250 for each additional participant from the same agency. • Phone or email consultation (up to three calls or emails): Free. • Additional technical assistance: $50 per hour.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	November 2006

2.5. Early Risers "Skills for Success"

Early Risers "Skills for Success"	
Intervention description	'*Early Risers "Skills for Success*" is a developmentally focused, competency-enhancement program that targets 6- to 12-year-old elementary school students who are at high risk for early development of conduct problems, including substance use (who display early aggressive, disruptive, or nonconformist behaviors). *Early Risers* is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions, coordinated by a family advocate, to move high-risk children onto a more adaptive developmental pathway.'
Population	'6- to 12-year-old elementary school students who are at high risk for early development of conduct problems, including substance use'

Early Risers “Skills for Success”	
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	Child-focused component: ‘The child-focused component has three parts: summer camp, school year friendship groups, and school support. The summer camp consists of 24 hours each of social-emotional skills training, reading enrichment and motivation, and creative activities, all supported by behavioral management protocols to build and support social, emotional, problem-solving, and peer friendship skills. The social-emotional skills training is implemented using a program such as *Promoting Alternative THinking Strategies (PATHS), Second Step*, or *Incredible Years*, each of which was reviewed by NREPP separately. The school year friendship group is offered during or after school and promotes advancement and maintenance of skills learned over the summer. School support, which occurs throughout each school year during the school day, is intended to promote academic skill building, such as task organization and home-school communication, as well as to address children's behavior while in school, through case management, consultation, and mentoring activities.’ Family-focused component: ‘The family-focused component has two parts: family nights with parent education (called *Parents Excited About Kids, or PEAK*) and family support. At family nights, held in a center or school five times per year during the evening, children participate in fun activities while their parents meet in small groups for parenting-focused education and skills training. Family support involves the implementation of an individually designed case plan for each family to address its specific needs, strengths, and maladaptive patterns through goal setting, brief interventions, referrals to community supports, continuous monitoring, and, if indicated, more intensive and tailored parent skills training.’
Delivery setting	Child-focused – school and summer camp

Early Risers "Skills for Success"	
	Family-focused – school or a centre
Dose	Information not provided
Staffing	'The family advocate must have a bachelor's degree in child or family education and experience working with parents or children.'
Resources or supporting tools	Information not provided
Cost information	• '3-day, on-site training (includes implementation manual, curriculum with CD-ROM, fidelity checklists, and consultation and technical assistance on topics such as suggested outcome measures): $7,000 for up to 20 participants (includes travel expenses). • Social-emotional skills training curriculum: Varies, depending on program selected by implementer. • Phone and email consultation and technical assistance: Included in the cost of training for 1 year; fee based after the first year. • Phone and email support: Free. • On-site technical assistance: Varies depending on the assistance needed, plus travel expenses.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	July 2012

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

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
Intervention description	'*HFA* is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby). The goals of *Healthy Families American (HFA)* are to: • Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth. • Cultivate and strengthen nurturing parent-child relationships. • Promote healthy childhood growth and development. • Enhance family functioning by reducing risk and building protective factors.'
Population	'Families with children aged 0 – 5 years who are at-risk for child abuse and neglect. Families may be at risk due to substance abuse, mental illness, or parental history of abuse in childhood.'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'They can be broken into three broad areas: Service initiation, service content, and staff characteristics and supervision. Service Initiation: ▪ Initiate services prenatally or at birth. ▪ The screening and assessment should occur within two weeks after the birth of the baby. ▪ The first home visit should occur within three months after the birth of the baby – preferably prenatally. ▪ Administer a standardized (i.e., in a consistent way for all families) assessment

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ The Parent Survey (formerly the Kempe Family Stress Checklist) is conducted to identify the family strengths as well as family history and/or issues related to higher risk of child maltreatment and/or poor childhood outcomes. ▪ *HFA* staff must be well-trained in how to administer and score the assessment. ▪ Offer services voluntarily and use positive outreach efforts to build family trust. ▪ Services must be voluntary. ▪ Program staff must identify positive ways to establish a relationship with a family and keep families interested and connected over time because many participants are often reluctant to engage in services and may have difficulty building trusting relationships. Service Content: ▪ Offer services intensively with well-defined criteria for increasing or decreasing frequency of service and over the long-term. ▪ Services should be offered AT LEAST WEEKLY during the 1st six months after the birth of the baby. ▪ The family's progress is used for determining service intensity – as the family's confidence and self-sufficiency increases, the frequency of visits decrease. ▪ *HFA* offers services for a minimum of three years and up to five years after the birth of the baby. ▪ Provide services that are culturally sensitive. ▪ Ethnic, racial, language, demographic, and other cultural characteristics identified by the program must be taken into account in overseeing staff-family interactions. ▪ Staff receives training designed to increase understanding and sensitivity of the unique characteristics of the service population. ▪ The program analyzes the extent to which all aspects of its service delivery system (assessment, home visitation, and supervision) are culturally sensitive. ▪ Provide services that focus on supporting the parent as well as supporting parent-child interaction and child development. ▪ Home visiting staff discuss and review, in supervision and with families, issues identified in the initial assessment during the course of home visiting services. ▪ Program services to families are guided by the Individual Family Support Plan (IFSP).

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ The program promotes positive parent-child interaction, child development skills, and health and safety practices with families through the use of curriculum or other educational materials. ▪ The program monitors the development of participating infants and children with a standardized developmental screening, tracks children who are suspected of having a developmental delay, and follows through with appropriate referrals and follow-up. ▪ Link all families to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters. ▪ Participating Target Children are linked to a medical/health care provider ▪ The program ensures immunizations are up-to-date for target children and provides information, referrals, and linkages to available health care resources for all participating family members. ▪ Families are connected to additional services in the community. ▪ Limit staff caseloads ▪ No more than 15 families who are currently being seen weekly ▪ No more than 25 families per caseload Staff Characteristics: ▪ Select service providers based on their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job. Service providers have a framework, based on education or experience, for handling the variety of situations they may encounter when working with at-risk families. ▪ Provide basic training for service providers in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community. ▪ All staff must receive Orientation training prior to working with families. ▪ All staff must receive training in Wraparound topics within 6 months and 12 months of hire (distance learning modules and/or in person). ▪ Provide intensive training to Service providers specific to their role.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ All staff must receive in-person Core Training in either Parent Survey (Assessment) or Integrated Strategies (Home Visitors) within six months of hire. ▪ Supervisors also receive in-person training based on the track (assessment or home visiting) they supervise and administrative, clinical, and reflective practice training within six months of hire. ▪ Provide ongoing, effective, accountable, clinical, and reflective supervision to all service providers. ▪ Direct service providers must receive weekly, individualized supervision. ▪ Full-time supervisors are to have 6 or fewer direct services staff. ▪ Direct service staff must receive skill development and professional support and be held accountable for the quality of their work. ▪ Supervisors and Program Managers are also held accountable for the quality of their work and provided with skill development and professional support. ▪ Additionally, it is very important that materials be presented in a lower grade level of reading, typically 5th grade or lower.'
Delivery setting	Birth Family Home
Dose	'Recommended Intensity: Families are to be offered weekly home visits for a minimum of six months after the birth of the baby. Home visits typically run 50-60 minutes. Upon meeting the defined criteria for family functioning, visit frequency is reduced to biweekly visits, monthly visits, and quarterly visits and services are tapered off over time. Typically, during pregnancy, families receive 2-4 visits per month. During times of crisis, families may be seen 2 or more times in a week. Recommended Duration: Services are offered prenatally or at birth until the child is at least three years of age and can be offered until he/she is five years of age.'
Staffing	'Program staff is selected because of a combination of personal characteristics, experiential, and educational qualifications. Direct Service Staff should have qualifications including, but not limited to: • Experience in working with or providing services to children and families.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	• An ability to establish trusting relationships. • Acceptance of individual differences. • Experience and willingness to work with the culturally diverse populations that are present among the program's target population. • Knowledge of infant and child development. Supervisors should have qualifications including, but not limited to: • A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments. • Knowledge of infant and child development and parent-child attachment. • Experience with family services that embrace the concepts of family-centered and strength-based service provision. • Knowledge of maternal-infant health and dynamics of child abuse and neglect. • Experience in providing services to culturally diverse communities/families. • Experience in home visitation with a strong background in prevention services to the 0-3 age population. • Bachelor's degree in human services or related field required (Master's degree preferred). Program managers should have qualifications including, but not limited to: • A solid understanding of and experience in managing staff. • Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development. • A bachelor's degree in human services administration or related field required (Master's degree preferred).'
Resources or supporting tools	'The typical resources for implementing the program are: • A host agency or a collaboration of host agencies that provide office space with confidentiality related to participant files/records • Computer and email

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	• Data or tracking system • Cell phones • Program Manager • 1 FTE Supervisor per 5-6 FTE home visitors • 1 FTE Supervisor per 5-6 FTE assessment staff • Travel expense reimbursement (mileage) for home visitors • A community advisory board • Diversified, and sustainable funding.'
Cost information	No information provided
PRC rating	Supported
Primary source	CEBC
Date last reviewed	June 2014

2.7. Incredible Years (IY)

Incredible Years (IY)	
Intervention description	'The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.'
Population	Families with children aged 4-8 years with behavior or conduct problems. Also used with children at high risk. 'Parents, teachers, and children

Incredible Years (IY)	
	For children/adolescents ages: 4 – 8 For parents/caregivers of children ages: 4 – 8’
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks
Intervention details	• ‘The Incredible Years BASIC Parent Training Program targets parents of high-risk children and those displaying behavior problems. Highlighted parenting skills include: ▪ How to build strong relationships with children through child-directed play interactions ▪ How to be a social, emotional and academic coach for children ▪ How to provide praise and incentives to build social and academic competency ▪ How to set limits and establish household rules ▪ How to handle misbehavior • The Incredible Years ADVANCE Parent Training Program addresses interpersonal skills such as: ▪ How to effectively communicate with your children and other adults ▪ How to handle stress, anger and depression management issues ▪ How to problem solve between adults ▪ How to help children learn to problem solve ▪ How to provide and receive support • The Incredible Years Child Training Program (Dina Dinosaur Social Skills and Problem-Solving Curriculum) - The Child Training program promotes social competency and reduces conduct problems. Children are trained in four areas: ▪ Emotion Management o How to talk about feelings

Incredible Years (IY)	
	○ How to understand and detect feelings in others ○ How to self-regulate and manage upsetting feelings ▪ Social Skills ○ How to talk to and make friends ○ How to work in teams ○ How to cooperate and help others ○ How to effectively communicate ○ How to follow rules ○ How to play with others and enter into groups ▪ Problem Solving ○ How to deal with anger ○ How to solve problems step-by-step ○ How to be friendly ▪ Classroom Behavior ○ How to listen ○ How to follow school rules ○ How to stop-look-think-check’
Delivery setting	• Birth Family Home • Community Agency • Community Daily Living Settings • Foster/Kinship Care • Hospital • Outpatient Clinic • Religious Organization

Incredible Years (IY)	
	• School • Workplace • Pediatric Primary Care Setting
Dose	'Recommended Intensity: One two-hour session per week. Classroom program offered 2-3 times weekly for 60 lessons. Teacher sessions can be completed in 5-6 full-day workshops or 18-21 two-hour sessions. Recommended Duration: The Basic Parent Training Program is 14 weeks for prevention populations, and 18 - 20 weeks for treatment. The Child Training Program is 18-22 weeks. For treatment version, the Advance Parent Program is recommended as a supplemental program. Basic plus Advance takes 26-30 weeks. The Child Prevention Program is 20 to 30 weeks and may be spaced over two years. The Teachers Program is 5 to 6 full-day workshops spaced over 6 to 8 months.'
Staffing	Master's level (or equivalent) clinicians
Resources or supporting tools	• TV/DVD or Computer with projector • Room for 16 people • Two group leaders for the group, etc.
Cost information	No information available
PRC rating	Supported
Primary source	Primary Source CEBC
Date last reviewed	June2013

2.8. Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT)	
Intervention description	‘MDFT is a family-based treatment system for adolescent substance use, delinquency, and related behavioral and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and community. Once a therapeutic alliance is established and youth and parent motivation is enhanced, the MDFT therapist focuses on facilitating behavioral and interactional change. The final stage of MDFT works to solidify behavioral and relational changes and launch the family successfully so that treatment gains are maintained.’ ‘ The goals of Multidimensional Family Therapy (MDFT) are split into four domains: • Adolescent Domain: ▪ Address identity formation, improve self-awareness, and enhance self-worth and confidence ▪ Develop meaningful short-term and long-term life goals ▪ Improve emotional regulation, coping, and problem solving skills ▪ Improve expressive and communication skills ▪ Promote success in school/work ▪ Promote pro-social peer relations and activities ▪ Reduce drug use and problem behaviors ▪ Improve and stabilize mental health problems • Parent Domain: ▪ Strengthen parental teamwork ▪ Improve parenting skills & practices ▪ Rebuild emotional bonds with teen ▪ Enhance parents individual functioning • Family Domain:

Multidimensional Family Therapy (MDFT)	
	▪ Improve family communication and problem solving skills ▪ Strengthen emotional attachments and feelings of love and connection among family members ▪ Improve everyday functioning of the family unit • Community Domain: ▪ Improve family member's functional relationships with social systems such as school, court, legal system, child welfare workplace, and neighborhood Build family member capacity to actively reach out to access and actualize needed resources necessary for stress reduction or daily life needs'
Population	'Target Population: Adolescents 11 to 18 with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school and other behavioral problems, and both internalizing and externalizing symptoms For children/adolescents ages: 11 – 18 For parents/caregivers of children ages: 11 – 18'
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	• 'Being an integrated family therapy approach that attempts to improve: ▪ Parenting practices ▪ Family problem solving skills ▪ Parental teamwork ▪ Parent functioning by motivating them to obtain substance abuse or mental health treatment for themselves, if needed. ▪ Adolescent communication, emotion regulation and coping skills

Multidimensional Family Therapy (MDFT)	
	▪ Adolescent functioning by reducing substance use and delinquency, and improving school bonding and performance, and family relationships. • Emphasizing parental self-care throughout treatment to ensure that parents are maximally available to and effective with their teens • Following these intervention parameters: ▪ Number of sessions per week: 1-3 with an average of 2 ▪ Length of treatment: 3-6 months ▪ A mix of individual youth, parent, and family sessions of approximately 40% youth, 20% parent, and 40% family ▪ Use of telephone calls with youth and family in between face-to-face sessions ▪ Community sessions with school, juvenile justice, child welfare, etc. ▪ MDFT has specific clinical supervision protocols; each therapist receives: o Weekly case review supervision o Either DVD/video or live supervision each month ▪ Case and supervision information entered into in the web-based MDFT Clinical Portal by MDFT therapists and supervisors which facilitates adherence to the approach ▪ In programs serving youth and families with few resources and high need, a therapist assistant/family advocate an added benefit to the MDFT program; works to reduce barrier to treatment participation and facilitate access to community resources'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Day Treatment Program • Foster/Kinship Care • Hospital • Residential Care Facility

Multidimensional Family Therapy (MDFT)	
	• School • Juvenile detention facility
Dose	‘Recommended Intensity: For at-risk and early intervention, therapists typically provide 1-2 sessions per week, with sessions lasting between 45 and 90 minutes. More severe cases will require sessions 1- 3 times per week (average of 2) with each session lasting 45-90 minutes. For all cases, the dose titrates down as the treatment progresses. The dose is more intense in the first third of treatment and is gradually reduced to 1 session per week during the last 4-6 weeks. Recommended Duration: 3-4 months for at-risk and early intervention youth and families. 5-6 months for youth with a substance abuse and/or conduct disorder diagnosis.’
Staffing	‘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.’
Resources or supporting tools	‘The typical resources for implementing the program are: • Clinic treatment rooms large enough to accommodate a family • Cell phones for therapists, case managers/therapist assistants, and supervisors to call each other and clients. • Equipment to record therapy session for supervision (DVD, videotape), and equipment to play back sessions for supervision. • Capacity to conduct live supervision sessions. • If serving a drug-using or high-risk population, funds to pay for instant urine screen testing that is incorporated into ongoing treatment.’
Cost information	Information not available
PRC rating	Supported

Multidimensional Family Therapy (MDFT)	
Primary source	CEBC
Date last reviewed	May 2014

2.9. Multisystemic Therapy (MST)

Multisystemic Therapy (MST)	
Intervention description	'*Multisystemic Therapy (MST*) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of *MST* are to decrease youth criminal behavior and out-of-home placements. Critical features of *MST* include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.'
Population	'Target Population: Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system. For children/adolescents ages: 12 – 17 For parents/caregivers of children ages: 12 – 17'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	'Delinquent or antisocial youth who are 12 to 17 years old and may also meet the following criteria: • Youth at Imminent risk of out-of-home placement due to criminal offenses

Multisystemic Therapy (MST)	
	• Physical aggression at home, at school, or in the community • Verbal aggression, verbal threats of harm to others • Substance abuse in the context of problems listed above Programs will need to exclude: • Youth living independently or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers • Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors • Youth referred primarily for problem sexual behavior. *MST*–Problem Sexual Behavior (*MST-PSB*), however, is an adaptation of *MST* that is available for youth with externalizing, delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses • Youth with pervasive developmental delays Intervention Context: • Services are provided in the family's home or other places convenient to them and at times convenient to the family. • Services are intensive, with intervention sessions being conducted from once per week to daily. • A 24 hour/7 day/week on-call schedule is utilized to provide round-the-clock availability of clinical services for families. Therapists and Supervisors: • *MST* staff members work on a clinical team of 2-4 therapists and a supervisor. • *MST* therapists are Masters-prepared (clinical-degreed) professionals. • *MST* clinical supervisors must be at least 50% part-time and may supervise 1-2 teams only. • *MST* clinical supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (e.g., Structural Family Therapy and Strategic Family Therapy). Application of the Intervention:

Multisystemic Therapy (MST)	
	• Interventions are developed using an analytical model that guides the therapist to assess factors that are driving the key clinical problems, and then in designing interventions that are applied to these driving factors or "fit factors." • All intervention techniques are evidence-based or evidence-informed. • Each therapist carries a maximum caseload of 6 families and case length ranges from 3 to 5 months. Clinical Supervision: • The *MST* clinical supervisor conducts on-site weekly team clinical supervision, facilitates the weekly *MST* telephone consultation, and is available for individual clinical supervision for crises. Program Monitoring and Use of Data: • Agencies collect data as specified by *MST* Services, and all data are sent to the *MST* Institute (MSTI) which is charged with keeping the national database system. • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the *MST* model. Agency: • The agency must have community support for sustainability. • With the buy-in of other organizations and agencies, *MST* is able to "take the lead" for clinical decision-making on each case. • Stakeholders in the overall *MST* program have responsibility for initiating these collaborative relationships with other organizations and agencies while *MST* staff sustain them through ongoing, case-specific collaboration.'
Delivery setting	• Adoptive Home • Birth Family Home • Foster/Kinship Care • School
Dose	'Recommended Intensity:

Multisystemic Therapy (MST)	
	Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation on a specific number of contact hours as staff contact is based on the clinical needs of the families. Session length also depends on the treatment needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving). Recommended Duration: 3-5 months'
Staffing	• '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). • At least 66% of the therapists must have a Master's degree in counselling or social work.'
Resources or supporting tools	'Office space to house the team and conduct consultation and supervision is required as well as laptops and cell phones for all staff.'
Cost information	Information not available
PRC rating	Supported
Primary source	CEBC
Date last reviewed	June 2013

2.10. Multisystemic Therapy for Youth with Problem Sexual Behaviours (MST-PSB)

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
Intervention description	‘*Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)* is a clinical adaptation of *Multisystemic Therapy (MST)* that is specifically targeted to adolescents who have committed sexual offenses and demonstrated other problem behaviors. *MST-PSB* is suitable for use with male and female youth, although the youth included in the studies reviewed for this summary were primarily male. The primary objectives of *MST-PSB* are to decrease problem sexual and other antisocial behaviors and out-of-home placements. Based in principle on an ecological model, the intervention is directed at youth and their families, with the collaboration of community-based resources such as case workers, probation/parole officers, and school professionals. Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth's behavior but typically address deficits in overall family relations and the youth's cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks. *MST-PSB* is delivered in the youth's natural environment (i.e., home, school, community) by master's-level therapists trained in a clinical area of the human service field. Each therapist provides approximately 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.’ Outcomes addressed: • ‘Problem sexual behaviour • Incarceration and other out-of-home placement • Delinquent activities other than problem sexual behaviors • Mental health symptoms • Family and peer relations • Substance use’

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
Population	'Adolescents aged 13-17 who have committed sexual offenses and demonstrated other problem behaviors'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	'*MST for Problem Sexual Behavior (MST-PSB)* is an adaptation of *MST* that was developed for 10- to 17.5-year-old youth with sexually related externalizing delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses. Youth may also exhibit the following characteristics: • At imminent risk of out-of-home placement due to criminal offenses. • Physical aggression at home or school or in the community. • Verbal aggression and threats of harm to others. • Substance abuse in the context of the problems listed above. Programs will need to exclude: • Youth living independently or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers. • Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors. • Youth with pervasive developmental delays.' 'Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth's behavior but typically address deficits in overall family relations and the youth's cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks.'

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
	'Intervention Context: • Services are provided in the family's home or other convenient places and at times convenient to the family. • Services are intensive, with intervention sessions conducted from once a week to every day. • A 24 hour/7 day per week on-call schedule is utilized to provide round-the-clock availability of clinical services for families. Therapists and Supervisors: • *MST-PSB* staff members work on a clinical team of 2-4 therapists and a supervisor. • *MST-PSB* therapists are Master's-prepared (clinical-degreed) professionals. • *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. • *MST-PSB* clinical 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). Application of the Intervention: • Interventions are developed using an analytical model that guides the therapist to assess factors that are driving the key clinical problems, and then in designing interventions that are applied to these driving factors or "fit factors." • Each therapist carries a maximum caseload of 4 families and case length ranges from 5 to 7 months. Clinical Supervision: • The *MST-PSB* clinical supervisor conducts on-site weekly team clinical supervision, facilitates the weekly *MST-PSB* telephone consultation, and is available for individual clinical supervision for crises. Program Monitoring and Use of Data:

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
	• Agencies collect data as specified by MST Services/MST Associates, and all data are sent to the MST Institute (MSTI), which is charged with keeping the national database system • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the *MST-PSB* model. Agency: • The agency must have community support for sustainability. • With the buy-in of other organizations and agencies, *MST-PSB* staff is able to "take the lead" for clinical decision-making on each case. • Stakeholders in the overall *MST-PSB* program have responsibility for initiating these collaborative relationships with other organizations and agencies while *MST-PSB* staff sustains them through ongoing, case-specific collaboration.' (CEBC)
Delivery setting	'*MST-PSB* is delivered in the youth's natural environment (i.e., home, school, community)'
Dose	'Therapists provide 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.'
Staffing	Delivered 'by master's-level therapists trained in a clinical area of the human service field.'
Resources or supporting tools	'Office space to house the team and conduct consultation and supervision is required. All team members must also have cell phones and access to computers. Each team must have at least one video camera (for training and quality assurance purposes).' (CEBC)
Cost information	• 'Implementation materials and licensing fees: $4,000 per site and $2,500 per team. • Start-up support, site assessment, and all system consultation (includes 2-day, on-site orientation training): $11,000 plus travel expenses. • Ongoing support (includes quarterly on-site booster training): $38,000 per year plus travel expenses. • Quality assurance data collection support: $10,800 per team.'

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	December 2009

2.11. Oregon Model, Parent Management Training (PMTO)

Oregon Model, Parent Management Training (PMTO***)***	
Intervention description	'*PMTO* refers to a set of parent training interventions developed over forty years, originating with the theoretical work, basic research, and intervention development of Gerald Patterson and colleagues at Oregon Social Learning Center. *PMTO* can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent led, and foster families. *PMTO* can be used as a preventative program and a treatment program. It can be delivered in many formats, including parent groups, individual family treatment, books, audiotapes and video recordings. *PMTO* interventions have been tailored for specific clinical problems, such as antisocial behavior, conduct problems, theft, delinquency, substance abuse, and child neglect and abuse. The goals of *PMTO* include: • Improving parenting practices • Reducing family coercion • Reducing and preventing internalizing and externalizing behaviors in youth • Reducing and preventing substance use and abuse in youth • Reducing and preventing delinquency and police arrests in youth • Reducing and preventing out-of-home placements in youth • Reducing and preventing deviant peer association in youth • Increasing academic performance in youth • Increasing social competency in youth

Oregon Model, Parent Management Training (PMTO)	
	• Increasing peer relations in youth'
Population	'Parents of children 2-18 years of age with disruptive behaviors. Versions adapted for children with conduct disorder, delinquency, substance abuse, and child neglect and abuse.'
Target outcomes	• Child behaviour • Maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'Parents being the focus of the *PMTO* intervention because they are the presumed agents of change;, however, parents, focal youth, and the family should all benefit from the intervention Core components of *PMTO*: • Encouragement of positive behavior • Systematic, mild consequences for negative behavior • Monitoring • Problem-solving • Positive involvement Supporting components of *PMTO*: • Giving good directions • Observing and recording behavior • Identifying and regulating emotions • Fostering communication through cooperation • Promoting school success Important therapeutic strategies in *PMTO* focused on:

Oregon Model, Parent Management Training (PMTO)	
	• Supporting and encouraging the development of parenting skills • Helping to prevent and manage resistance to change • Using sophisticated clinical practices to build therapeutic alliance and provide a supportive environment for change • Providing active teaching that includes modelling, role play and other experiential exercises that provide opportunity for practice with coaching • Incorporating a problem solving process that focuses on specifying future-oriented goals • Placing an emphasis on eliciting goal behavior from parents rather than direct teaching • When administered in parent groups, the recommended group size is 12-15 participants'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Community Daily Living Settings • Foster/Kinship Care • Outpatient Clinic
Dose	'Recommended Intensity: 1.5 to 2-hour weekly parent group sessions and 60-minute weekly individual/family sessions Recommended Duration: 14 group sessions and 20-25 individual/family sessions, depending on severity; individual family treatment is not typically provided together with group treatment. The time frame can be 5-6 months or longer, depending on circumstances'
Staffing	'Bachelor's degree with 5 years appropriate clinical experience or Master's Degree in relevant field'
Resources or supporting tools	'All sessions are video recorded and uploaded to HIPAA-compliant website for coaching/supervision and certification. Thus, video recording equipment, computer, and high speed internet access are required.'

Oregon Model, Parent Management Training (PMTO)	
Cost information	Information not provided
PRC rating	Supported
Primary source	CEBC
Date last reviewed	April 2014

2.12. ParentCorps

ParentCorps	
Intervention description	'*ParentCorps* is a culturally informed, family-centered preventive intervention designed to foster healthy development and school success among young children (ages 3-6) in families living in low-income communities. *ParentCorps* helps parents promote their children's social, emotional, and self-regulatory skill development and effectively partner with early childhood educators to advance their children's behavioral and academic functioning, mental health, and physical development. The parent groups are facilitated by trained mental health professionals who present a specific set of parenting strategies: establishing structure and routines for children, providing opportunities for positive parent-child interactions during nondirective play, using positive reinforcement to encourage compliance and social and behavioral competence, selectively ignoring mild misbehaviors, and using effective forms of discipline for misbehavior (e.g., timeouts, loss of privileges). As part of the collaborative group process, facilitators help parents tailor and adopt strategies so they are meaningful and relevant given their family's cultural background, values, and goals. Participants are introduced to the parenting strategies through group discussions, role-plays, an animated video series portraying a day in the life of families from one community, and a photography-based book of *ParentCorps* family stories and homework. In a manner that is sensitive to and respectful of the parents' readiness for change, facilitators' help parents anticipate barriers and generate solutions so that families can successfully implement the strategies. Parents share their progress and experiences as they attempt the new parenting strategies at home, and they engage in open discussions about the difficulties of parenting under stressful conditions. These group experiences create a sense of belonging to a community of parents working together toward shared goals for their children. The child groups are led by trained classroom teachers who promote social, emotional, and self-regulatory skills through interactive lessons, experiential activities, and play. In support of the individualized goals that

ParentCorps	
	parents set for their children, the teachers promote skills and shape behaviors using strategies that complement the parenting strategies being introduced to parents. Additionally, the teachers communicate with parents after each session to provide feedback regarding the child's progress in skill development and goal attainment. ‘
Population	‘Young children (ages 3-6) in families living in low-income communities.’
Target outcomes	• Child development • Child behaviour • Family functioning
Intervention details	Parent groups: • ‘Establishing structure and routines for children, • providing opportunities for positive parent-child interactions during nondirective play, • using positive reinforcement to encourage compliance and social and behavioral competence, • selectively ignoring mild misbehaviors, and using effective forms of discipline for misbehavior (e.g., timeouts, loss of privileges). • … facilitators help parents tailor and adopt strategies so they are meaningful and relevant given their family's cultural background, values, and goals. • Participants are introduced to the parenting strategies through group discussions, role-plays, an animated video series portraying a day in the life of families from one community, and a photography-based book of *ParentCorps* family stories and homework. • …facilitators help parents anticipate barriers and generate solutions so that families can successfully implement the strategies. • Parents share their progress and experiences as they attempt the new parenting strategies at home, and they engage in open discussions about the difficulties of parenting under stressful conditions.’ Child groups:

ParentCorps	
	• Promotion of: 'social, emotional, and self-regulatory skills through interactive lessons, experiential activities, and play. • …teachers promote skills and shape behaviors using strategies that complement the parenting strategies being introduced to parents. • … teachers communicate with parents after each session to provide feedback regarding the child's progress in skill development and goal attainment. '
Delivery setting	School Other community settings - early childhood education or child care settings
Dose	Fourteen weekly 2-hour group sessions, which occur concurrently for parents and children. Groups include approximately 15 participants
Staffing	Trained mental health professionals The child groups are led by trained classroom teachers
Resources or supporting tools	• '*ParentCorps* training and start-up materials (includes leader's manuals and resource guides for use with the child and parent groups; props, puppet, and music CD for use with the child group; and DVD for use with the parent group). • Family group materials (includes parent workbooks, parent toolkit, and wordless picture book).'
Cost information	• '*ParentCorps* training and start-up materials (includes leader's manuals and resource guides for use with the child and parent groups; props, puppet, and music CD for use with the child group; and DVD for use with the parent group): $2,000 (for up to 4 child group leaders and 1 parent group leader). • Family group materials (includes parent workbooks, parent toolkit, and wordless picture book): $30 per family. • *ParentCorps* 101: Web-based training: $50 per user. • 5-day training at New York University: $5,000 per site (for up to 4 participants). • 2-day, on-site consultation: $5,000 plus travel expenses. • Group leader coaching (14 hours during the first cycle of implementation): $2,000.

ParentCorps	
	• Phone and email support: $150 per hour. • Technical support for *ParentCorps* 101: Included in cost of Web-based training. • Quality assurance measures: Included in cost of implementation materials.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	November 2011

2.13. Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT)	
Intervention description	'*Parent-Child Interaction Therapy (PCIT)* is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. *PCIT* is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions.'
Population	'Target Population: Children ages 2.0 - 7.0 years old with behavior and parent-child relationship problems. May be conducted with parents, foster parents, or other caretakers. For children/adolescents ages: 2 – 6 For parents/caregivers of children ages: 2 – 6'

Parent-Child Interaction Therapy (PCIT)	
Target outcomes	• Child behaviour • Family functioning • Child development
Intervention details	‘Child Directed Interaction (CDI): • Parent-child dyads attend treatment sessions together and the parent learns to follow the child's lead in play. • The parent is taught how to decrease the negative aspects of their relationship with their child and to develop positive communication. • The parent is taught and coached to use CDI skills. These skills help the parents give positive attention to the child following positive (e.g. non-negative) behavior and ignore negative behavior. • By learning CDI skills, the parent is taught: ▪ To give labeled praise following positive child behavior. ▪ To reflect or paraphrase the child's appropriate talk. ▪ To use behavioral descriptions to describe the child's positive behavior. ▪ To avoid using commands, questions, or criticism because these verbalizations are intrusive and often give attention to negative behavior. • The parent is observed and coached through a one-way mirror at each treatment session. • After the first session, at least half of each session is spent coaching the parent in CDI skills utilizing a 'bug in the ear’. A wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears. • The parent's CDI skills are observed and recorded during the first five minutes of each session to assess progress and to guide skills learned through coaching during session. • Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in positive interactions and the achievement of skill mastery. • The parent is provided with homework between sessions to enhance skills learned in the session.

Parent-Child Interaction Therapy (PCIT)	
	• Dyads do not proceed to the Parent Directed Interaction (PDI) until the parent demonstrates mastery of the CDI. Parent Directed Interaction (PDI): • Parent-child dyads attend treatment sessions together and the parent learns skills to lead the child's behavior effectively. • The parent is taught how to direct the child's behavior when it is important that the child obey their instruction. • The parent is observed and coached through a one-way mirror at each treatment session. • After the first session, at least half of each session is spent coaching the parent in PDI utilizing a 'bug in the ear,' a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears. • Parent's PDI skills are observed and recorded during the first five minutes of each session to assess progress and guide the coaching of the session. • The parent learns to incorporate the effective instructions and commands (e.g. commands that are direct, specific, positively stated, polite, given one at a time, given only when essential, and accompanied by a reason that either immediately precedes the command or accompanies the praise for compliance) learned during the CDI component. • The parent learns to follow through on direct commands by giving labeled praise after every time the child obeys and beginning a time-out procedure after every time the child disobeys. • The parent learns a time-out procedure to use in the event that the child disobeys a direct command. The parent begins by issuing a warning, which will lead to the time-out chair, and then to the time-out room if the child continues disobeying. • The parent is coached to use the PDI algorithm, which gives the child an opportunity to obey and stop the time-out procedure at each step. • Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in their PDI skills. • Once the parent demonstrates mastery of the procedures, she/he is given homework that gradually increases the intensity of the situations as the child learns to obey.

Parent-Child Interaction Therapy (PCIT)	
	• Treatment does not end until the parent meets pre-set mastery criteria for both phases of treatment and the child's behavior is within normal limits on a parent-report measure of disruptive behavior at home. ***PCIT*** can be delivered in a group format as well. When done so, small groups of 3 or 4 families in 90-minute sessions are recommended. This will allow adequate time for individual coaching of each parent-child dyad while other parents observe, code, and provide feedback in each session. For additional information, please check the ***PCIT*** website homepage at www.pcit.org and select "*PCIT* Integrity Checklists and Materials."' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Praise for parents • Structured sessions • Coaching while parents interact with child/ active skills training • Remediation of inappropriate response to child • Mastery skills attainment Content: • Child behaviour and behaviour management • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Descriptive for child behaviour/descriptive/labelled praise for child • Praise for desired child behaviour • Avoids commands, questions, criticism

Parent-Child Interaction Therapy (PCIT)	
	• Follow through on commands • Time out
Delivery setting	'This program is typically conducted in a(n): • Community Agency • Outpatient Clinic'
Dose	'Recommended Intensity: One or two 1-hour sessions per week with the therapist Recommended Duration: The average number of sessions is 14, but varies from 10 to 20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits'
Staffing	'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. For training in this treatment protocol outside an established graduate clinical training program, the equivalent of a master's degree and licensure as a mental health provider is required. It is recommended that the 40 hours of intensive skills training be followed by completion of two supervised cases prior to independent practice. For within program supervisors, it is recommended that they complete a minimum of 4 prior cases and complete a within program trainer training.' 'Training is obtained: On-site and off-site Number of days/hours: 5 days for a total of 40 hours. Follow-up consultation through the completion of two cases.'
Resources or supporting tools	'The typical resources for implementing the program are: • Two connected rooms with a one-way mirror on the adjoining wall (one room for client, other room for coach) or another method for the therapist to unobtrusively observe the parent. • A wireless communications set consisting of a head set with microphone and an ear receiver (i.e., "bug in the ear") • A VCR and television monitor to tape record sessions for supervision, training, and research purposes'
Cost information	Information not available

Parent-Child Interaction Therapy (PCIT)	
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	June 2013

2.14. Project SUCCESS

Project SUCCESS	
Intervention description	'*Project SUCCESS* (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse. In recent years, *Project SUCCESS* has been used in regular middle and high schools for a broader range of high-risk students. '
Population	'Students 12 to 18 years of age attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.'
Target outcomes	• Child behaviour • Systems outcomes
Intervention details	• 'The Prevention Education Series (PES), an alcohol, tobacco, and other drug program conducted by *Project SUCCESS* counselors (local staff trained by the developers) who help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use. • Schoolwide activities and promotional materials to increase the perception of the harm of substance use, positively change social norms about substance use, and increase enforcement of and compliance with school policies and community laws.

Project SUCCESS	
	• A parent program that includes informational meetings, parent education, and the formation of a parent advisory committee. • Individual and group counseling, in which the *Project SUCCESS* counselors conduct time-limited counseling for youth following their participation in the PES and an individual assessment. Students and parents who require more intensive counseling, treatment, or other services are referred to appropriate agencies or practitioners in the community.'
Delivery setting	School
Dose	The Prevention Education Series (PES) — 8 sessions
Staffing	Counselors — local staff trained by the developers
Resources or supporting tools	Information not provided
Cost information	• 'Implementation manual (includes implementation checklists): $150 each. • Brochure for teachers: $0.50 each. • 3-day training in Tarrytown, NY (includes implementation manual, resource manual, and brochure for teachers): $350 per person. • 3-day, on-site training (includes implementation manual and resource manual): $4,200 for up to 30 participants, plus travel expenses. • Scheduled telephone conference calls: $150 per hour. • On-site consultation: $200 per hour plus travel expenses. • Process evaluation data collection log: $50 each.'
PRC rating	Supported.
Primary source	SAMHSA
Date last reviewed	November 2007

2.15. Project Towards No Drug Abuse

Project Towards No Drug Abuse	
Intervention description	'*Project TND* is a drug prevention program for high school youth who are at-risk for drug use and violence-related behavior. It originally consisted of nine sessions designed to address issues of substance abuse and violence: 1) Communication and Active Listening, 2) Stereotyping, 3) Myths and Denial, 4) Chemical Dependency, 5) Talk Show, 6) Stress, Health and Goals, 7) Self Control, 8) Perspectives, and 9) Decision Making and Commitment. Three new sessions were added from the third trial on; that is, most trials utilized a 12-session program. These three newer sessions are the 1) Marijuana Panel, 2) Positive and Negative Thought Loops and Subsequent Behavior, and 3) Smoking Cessation. Classes are taught by trained health educators, who administer the curriculum over a 3-week period. Each session lasts 40 minutes and is conducted during the class period. The current version of TND contains twelve 40-minute interactive sessions. The sessions should be taught as written. Those students who are absent on days that a lesson is implemented should be provided with single-page summaries of the material from each lesson that they can utilize as a means to "make-up" learning of missed lesson material. The Socratic method is used throughout the curriculum. Thus, the emphasis is on interactions between the students and the teacher and the students with each other. The teacher's use of questioning leads students to generate the answers based on the reasoning that information is internalized more readily when it is not imposed from someone else. Classroom management in *Project TND* involves development of positive norms of classroom behavior. Although interaction among the youth is encouraged, the course is primarily teacher-directed and highly structured. In *Project TND*, the teacher's role is to actively develop and maintain peer group support in the class by modelling support, positively reinforcing it among group members, and negatively reinforcing deviant peer bonds and activities. The teacher creates and structures interactions among youth in prosocial directions.'
Population	'High school youth who are at-risk for drug use and violence-related behaviour' 'AGE - Late Adolescence (15-18) - High School'
Target outcomes	• Child behaviour
Intervention details	'It originally consisted of nine sessions designed to address issues of substance abuse and violence: 1) Communication and Active Listening, 2) Stereotyping, 3) Myths and Denial, 4) Chemical Dependency, 5) Talk Show, 6) Stress, Health and Goals, 7) Self Control, 8) Perspectives, and 9) Decision Making and Commitment. Three new sessions were added from the third trial on; that is, most trials utilized a 12-session

Project Towards No Drug Abuse	
	program. These three newer sessions are the 1) Marijuana Panel, 2) Positive and Negative Thought Loops and Subsequent Behavior, and 3) Smoking Cessation.' The Socratic method is also used to enhance learning.
Delivery setting	Classroom.
Dose	Twelve 40-minute interactive sessions taught over a 3-week period.
Staffing	Teachers or health educators
Resources or supporting tools	Teacher's manual, Student workbooks, Drugs and Life's Dreams video, Game board
Cost information	• 'Program Benefits *(per individual)*: $174 • Program Costs *(per individual)*: $64 • Net Present Value *(Benefits minus Costs, per individual)*: $110 • Measured Risk *(odds of a positive Net Present Value)*: 51%' • 'Teacher's manual: $90 each. • Student workbook: $60 for five. • Drugs and Life's Dreams video: $25 each. • Game board: $15 each. • 1-day, on-site training: $1,200-$1,400 for up to 25 participants, plus travel expenses.' (SAMHSA)
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Not indicated but last cited publication is dated 2012

2.16. Prolonged Exposure Therapy for Adolescents (PE-A)

Prolonged Exposure Therapy for Adolescents (PE-A)	
Intervention description	'*PE-A* is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories through imaginal and in vivo exposure. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they are capable of tolerating this distress'
Population	'Target Population: Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma. For children/adolescents ages: 12 – 18'
Target outcomes	• Child development • Child behavior
Intervention details	• 'Delivering rationales for the treatment program, as well as for the in vivo and imaginal exposure, to the client in order to increase understanding of the treatment', 'and how they will help diminish PTSD symptoms.' • 'Creating an in vivo exposure hierarchy together with the client and guiding the client in implementing in vivo exposures to trauma reminders and situations that feel unsafe as a result of the trauma. • Conducting repeated and prolonged imaginal exposure to the trauma memory with the client, where the client is asked to recall and retell the trauma memory. • Delivering psychoeducation regarding common reactions to trauma. • Teaching breathing retraining exercise that can help patients to feel more calm'
Delivery setting	'This program is typically conducted in a(n): • Community Agency • Outpatient Clinic'

Prolonged Exposure Therapy for Adolescents (PE-A)	
Dose	'Recommended Intensity: Once or twice a week treatment sessions that are 60-90 minutes in length Recommended Duration: Approximately 8-15 sessions, or 2 to 4 months'
Staffing	'Licensed mental health professionals or those working under the supervision of a licensed mental health professional. Psychology, social, work, and nursing staff can implement ***PE-A*** in their respective roles.' 'Training is obtained: Training can be provided onsite. Number of days/hours: 4 full days (32 hours)'
Resources or supporting tools	'The typical resources for implementing the program are: A quiet room with no interruptions or distractions is necessary to implement ***PE-A***. DVD camcorders are necessary for conducting intensive individual and group supervision. Digital voice recorders are required for audio recording the treatment sessions which the client is required to listen as part of his homework. Clients can take the recorders with them or providers can use a CD burner to burn the audio recording onto a compact disc.'
Cost information	No information available
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	April 2014

2.17. SafeCare®

SafeCare®	
Intervention description	'*SafeCare*® is an in-home parenting program in which parents are taught (1) how to interact in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviors; (2) to recognize hazards in the home in order to improve the home environment; and (3) to recognize and respond to symptoms of illness and injury, in addition to keeping good health records.'

SafeCare®	
Population	**‘**Target Population: Parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5**’**
Target outcomes	• Family functioning • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Child development
Intervention details	‘Planned Activities assessment and training: • Teach parent time management • Explain rules to child • Reinforcement/rewards • Incidental teaching • Activity preparation • Outcome discussions with child • Explain expectations to child Home Safety assessment and training: • Assess accessible home hazards with the *Home Accident Prevention Inventory-Revised* to assess accessible home hazards • Provide parents with door and cabinet latches • Use graduated plan to have parents remove identified hazards and to child proof doors and cabinets • Perform healthy home assessment and training

SafeCare®	
	Infant and child health care assessment and training: • Use *HEALTH* checklists to assess parent skills • Teach any skill deficits (i.e., how to take a temperature) • Teach use of health checklists and how to determine when to self-treat illness and when to seek medical care • Include problem solving training as needed Parent and staff training: • Modeling • Role rehearsal • Performance criteria in simulation and actual interactions. • Monitoring of staff for model fidelity. • Booster training if performance falls below criteria' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Assessment • Praise for parents • Structured sessions • Discussion • Feedback • Modelling • Role-play

SafeCare®	
	• Didactic teaching • Coaching while parents interact with child/ active skills training • Mastery skills attainment • Verbal instructions • Homework tasks Content: • Child care skills/care-giving • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Child health and development • Praise for desired child behaviour • Home, environment and child safety • Planned activities and training • Parent time management • Use of reinforcement/rewards for child/ behaviour charts
Delivery setting	'This program is typically conducted in a(n): • Adoptive Home • Birth Family Home • Foster/Kinship Care'
Dose	'Recommended Intensity: Weekly sessions at approximately 1.5 hours each. Recommended Duration: 18-20 weeks.'

SafeCare®	
Staffing	‘Experience suggests at least a college education, but it has not been fully explored. The most important issue is that staff be trained to performance criteria.’ Training is obtained: Provided onsite by certified trainers. Number of days/hours: 1.5 training hours per week.
Resources or supporting tools	‘The typical resources for implementing the program are: • A Home Visitor • A Coach • Space for offices Material resources needed to implement the program include: • Audio recorders (one for each home visitor so that they can audiotape each sessions for the purpose of coaching) • Basic safety latches (cabinet latches, drawer latches, and door knob latches), which are fairly inexpensive (e.g., 10 for $2) • A screwdriver for each home visitor for the installation of safety latches • Dolls (used dolls are fine) to use during role-plays with the parents • Plastic bins to carry materials • Other optional supplies include such things as digital thermometers, stickers for reinforcing children's positive behaviors • Band-Aids • An electric screwdriver for the installation of safety latches, etc.’
Cost information	Information not available
PRC rating	Supported
Primary source	CEBC

SafeCare®	
Date last reviewed	September 2013

2.18. Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
Intervention description	Intervention description ‘Triple P is a well-researched Australian-developed program that was originally designed for parents of children with behavioural problems and has since been adapted for other groups of parents.’
Population	‘Parenting intervention for children with behavioural problems, adapted for use with maltreatment populations and parents with mental illness.’ This program has been evaluated in ‘Mean age of 4 years. History of Maltreatment’ ‘Mean age of 3 years. Parents with a mental illness and concerns about child behavior’
Target outcomes	• Maltreatment prevention • Family functioning • Child development • Child behaviour
Intervention details	Program with Target Population: Mean age 4 years. History of Child Maltreatment ‘Standard - Child behaviour management, 10 strategies for promoting children’s competence (i.e., quality time; talking with children; physical affection; praise; attention; engaging activities; setting a good example; Ask, Say, Do; incidental teaching; and behaviour charts)

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	Seven strategies for managing misbehaviour (i.e., setting rules; directed discussion; planned ignoring; clear, direct instructions; logical consequences; quiet time; and time-out). Planning ahead for high risk situations in relation to difficult child behaviour. Planned activities training Enhanced - As above plus. Cognitive re-framing in relation to negative parental attributions about child behaviour. Anger management using physical, cognitive and planning strategies.' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour Standard- Child behaviour management – 10 strategies for promoting children's competence and seven strategies for managing misbehaviour. Planning ahead for high risk situations in relation to difficult child behaviour. Planned activities training Enhanced- As above plus. Partner support for couples (positive listening and speaking, strategies for building a caring relationship). Coping skills for couples (assist with personal adjustment difficulties such as depression, anger, anxiety, stress). Social support via a significant other for single parents' Components identified by PRC (Macvean et. al., 2013) Delivery level: Individual and group Delivery: Standard • Family goals • Structured Sessions • Written material • Discussion • Feedback

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	• Modelling • Role-play • Homework tasks • Rehearsal Enhanced (in addition to the above) • Cognitive re-framing Content: Standard • Child behaviour and behaviour management • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Praise for desired child behaviour • Time out • Planned activities and training • Use of reinforcement/rewards for child/behaviour charts • Planning ahead for high risk situations/crisis management • Quality time • Talking to children • Physical affection • Attention for child • Setting a good example for children • Incidental teaching

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	• Quiet time • Logical consequences • Directed discussions • Planned ignoring Enhanced (in addition to the above) • Partner support • Coping skills for couples • Social support • Emotional regulation
Delivery setting	Program with Target Population: Mean age 4 years. History of Child Maltreatment '… delivered in the community by a professional.' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour '…half delivered in a clinic and half at home.'
Dose	Program with Target Population: Mean age 4 years. History of Child Maltreatment 'Standard - 4 weekly group sessions in the community and 4 individual telephone calls. All delivered by a professional Enhanced – As above, plus 4 additional group sessions delivered in the community by a professional' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour 'Standard- Average of 10 weekly individual sessions delivered by a professional. Half delivered in a clinic and half at home.

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	Enhanced- Average of 12 weekly individual sessions delivered by a professional. Half delivered in a clinic and half at home'
Staffing	Delivered by a professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Supported
Primary source	Macvean *et. al.* (2013)
Date last reviewed	2013

3. Promising

3.1. Adolescent-Focused Family Behavior Therapy (Adolescent FBT)

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
Intervention description	'*Adolescent FBT* includes more than a dozen treatments including management of emergencies, treatment planning, behavioral goals, contingency management skills training, communication skills training, job-getting skills training, self-control, stimulus control, home safety tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive. *Adolescent FBT*'s goal is to result in positive outcomes in such areas as alcohol and drug use, depression, conduct problems, family dysfunction, and days absent from work/school. *Adolescent FBT* is designed to be used with youth, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. Drafts of standardized client record keeping forms and quality assurance may be customized to fit agency needs.'
Population	Target Population: Youth (11-17) with drug abuse and dependence, as well as other co-existing problems. For children/adolescents ages: 11 – 17. For parents/caregivers of children ages: 11 – 17.' Other co-existing problems can include conduct problems and depression.
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks • Safety and physical wellbeing
Intervention details	▪ A structured Program Orientation that includes prompts to assist in gaining feedback from clients about the obtained assessment results, and providing opportunities to review issues that are common to the target population. ▪ Assurance of Basic Necessities in which potential or impending emergencies are endorsed by clients from a list, and a self-control procedure is taught to keep the family safe.

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	▪ A list of commonly experienced triggers to problem behaviors that when endorsed by clients may be quickly switched into pre-established Behavioral Goals that are anchored to rewards that are provided by family members. ▪ Treatment Planning options that are anchored to specific *Adolescent FBT* components and prioritized by the client and family. ▪ Communication Skills Training exercises in which clients and their families share what they love, admire, and respect about one another, learn to make positive requests, and develop conflict resolutions skills. ▪ Job-getting Skills Training to teach clients and family how to solicit and do well in job interviews. ▪ A Self-Control intervention in which clients and their family learn to identify and manage triggers to problem behaviors, such as child neglect, HIV risk, drug abuse, and anger in imaginary trials. ▪ A Stimulus Control intervention in which clients and their family learn to restructure their environment to eliminate or manage negative emotions and things in the environment that cause them to engage in troublesome behaviors, such as substance abuse, child maltreatment, arguments, etc. ▪ Tele-therapy with clients and their significant others to assure therapy assignments and treatments are being reviewed as prescribed, and increase therapy session attendance. • Contextual Programming ▪ Structured Pre-Training Questionnaires to be completed by therapists and administrators of the treatment agency to customize the *Adolescent FBT* training experience to fit the unique needs of the agency's culture. ▪ Published and Non-Published Training Manuals include brief overviews and rationales of each of the intervention approaches, client worksheets and homework assignment forms, and methods of implementing the therapy components. ▪ Protocol Checklists depict how to implement the *Adolescent FBT* treatment components, and include step-by-step instructions for therapists to utilize during their intervention sessions. ▪ Training/Supervision Protocol Checklist depicts steps involved in maintaining on-going training and supervision protocol that are consistent with *Adolescent FBT*. ▪ Forms Relevant to Client Record Keeping include standardized progress notes, treatment plans, log of contacts, monthly client progress reports to outside parties (i.e., caseworker, judges), termination reports, etc. that correspond to *Adolescent FBT* components.

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	▪ Quality Assurance Monitoring forms to assure adequacy of client charting and clinic procedures. ▪ Data Management System that may be used to organize program related outcome data that is relevant to *Adolescent FBT*. • *Adolescent FBT* has a family component where siblings/children are treated at the same time as the substance abuser.'
Delivery setting	Outpatient Clinic
Dose	'Recommended Intensity: Starts with 1- to 2-hour initial outpatient or home-based sessions once or twice in the first week then it varies depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort). Recommended Duration: Typically 6 months to 1 year. It varies depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort).' 'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and 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). They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.'
Staffing	'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and 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). They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.'
Resources or supporting tools	• 'Protocol checklists to guide therapy implementation

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	• A private place in which to conduct therapy • Donohue, B., & Azrin, N. H. (2011). Family Behavior Therapy: A step-by-step approach to adolescent substance abuse. Hoboken, NJ: John Wiley & Sons, Inc.'
Cost information	• 'Family Behavior Therapy: A Step-by-Step Approach to Adolescent Substance Abuse (manual that includes CD-ROM with protocol checklists and program forms): About $48 each. • Initial 2-day, on-site training workshop: Contact the developer. • 1-day, on-site booster workshop: Contact the developer. • Annual case reviews: Contact the developer. • Annual audiotape integrity checks: Contact the developer. • Half-day, on-site consultation to review FBT clinic integration: Contact the developer.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	March 2014

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

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
Intervention description	Intervention description '*Adult-Focused FBT* includes more than a dozen treatments including management of emergencies, treatment planning, home safety tours, behavioral goals and rewards, contingency management skills training, communication skills training, child management skills training, job-getting skills training, financial management, self-control, environmental control, home safety and aesthetics tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive. *Adult-Focused FBT* is designed to be used with adults, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. Drafts of standardized client record keeping forms and quality assurance may be customized to fit agency needs.'

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
Population	‘Target Population: Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, noncompliance, employment, HIV/STIs risk behavior, and poor communication skills’
Target outcomes	• Safety and physical wellbeing • Family functioning • Child behaviour • Child maltreatment prevention • Support networks
Intervention details	• ‘A structured Program Orientation that includes prompts to assist in gaining feedback from clients about the obtained assessment results, and provides opportunities to review issues that are common to the target population. • A list of commonly experienced triggers to substance abuse and other problem behaviors that, when endorsed by clients, may be quickly switched into pre-established Behavioral Goals and Rewards through the establishment of family support systems. • Treatment Planning options that are anchored to specific *Adult-Focused FBT* components and prioritized by both the client and client's family. • Communication Skills Training exercises in which clients and their families share what they love, admire, and respect about one another, learn to make positive requests, and develop conflict resolutions skills. • Child Management Skills Training in which parents learn to discipline their children by catching them being good, positive practice learning exercises, and, when necessary, provision of firm directives and undesired consequences. • Job-getting Skills Training to teach clients and family how to solicit and do well in job interviews. • A Financial Management intervention in which clients and their family learn to use a standardized worksheet with common methods of earning and saving extra income and reducing expenses. • A Self-Control intervention in which clients and their family learn to identify and manage triggers to problem behaviors, such as child neglect, HIV risk, drug abuse, and anger in imaginary trials.

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	• Assurance of Basic Necessities in which potential or impending emergencies are endorsed by clients from a list, and the self-control procedure is taught to keep the family safe. • Home Safety and Aesthetics Tours when intervention is implemented within the home to assist in preventing home accidents, which are the leading cause of death and serious injury in small children. • Environmental Control in which clients and their family learn to restructure their environment to eliminate or manage negative emotions and things in the environment that cause them to engage in troublesome behaviors, such as substance abuse, child maltreatment, arguments, etc. • Tele-therapy with clients and their significant others to assure therapy assignments and treatments are being reviewed as prescribed, and increase therapy session attendance.' Contextual Programming: • 'Structured Pre-Training Questionnaires to be completed by therapists and administrators of the treatment agency to customize the *Adult-Focused FBT* training experience to fit the unique needs of the agency's culture. • Published and Non-Published Training Manuals include brief overviews and rationales of each of the intervention approaches, client worksheets and homework assignment forms, and methods of implementing the therapy' • Protocol Checklists depict how to implement the *Adult-Focused FBT* and 'include step-by-step instructions for therapists to utilize during their intervention sessions.' • Training/Supervision Protocol Checklist depicts steps involved in maintaining on-going training and supervision protocol that are consistent with *Adult-Focused FBT*. • Forms Relevant to Client Record Keeping include standardized progress notes, treatment plans, log of contacts, monthly client progress reports to outside parties (e.g., caseworker, judges), termination reports, etc. that correspond to *Adult-Focused FBT* components. • Quality Assurance Monitoring forms to assure adequacy of client charting and clinic procedures. • Data Management System that may be used to organize program related outcome data that is relevant to *Adult-Focused FBT*.'
Delivery setting	'This program is typically conducted in a(n):

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	• Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • Residential Care Facility'
Dose	'Recommended Intensity: Starts with 1- to 2-hour initial outpatient or home-based sessions once or twice in the first week then fades in frequency depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort). Recommended Duration: Typically 6 months to 1 year. It varies depending on multiple factors (e.g., population, setting, intensity of treatment plan, effort) that are determined by the client, client's family, and treatment provider'
Staffing	'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and should have professional therapeutic experience serving the population that is being targeted for treatment. Therapists should be state-licensed mental health professionals. They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.' 'Training is obtained: Training may occur at the treatment agency. Other training sites are currently available in Pennsylvania, Nevada, California, Florida, Tennessee, and Kentucky. Number of days/hours: The process begins with conference calls and questionnaires to learn the unique needs of the agency wishing to be trained. Several training options are available. The full FBT training package includes 4 modules: • Substance Abuse/Problem Behavior interventions • Family Relationship Building interventions • Job-Getting and Financial Management • Child management Skills Training (when clients are parents)

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	The full package is conducted across a 2.5- to 3-day workshop, a 2- to 2.5-day booster workshop 4 months after the initial workshop, a 2- to 2.5-day workshop 8 months after the initial workshop, and approximately 33 on-going telephone training meetings. When less intensive training is desired, the modules can be separated. The Substance Abuse/Problem Behavior module and Child Management Skills Training Module each requires a 2-day workshop w/ 19 on-going telephone training sessions; the Family Relationship Building module, as well as the Job-Getting and Financial Management modules each require a 1-day workshop with 7 on-going telephone training sessions'
Resources or supporting tools	'The typical resources for implementing the program are: • Protocol checklists to guide therapy implementation • A private place in which to conduct therapy • Donohue, B., & Allen, D. A. (2011). Family Behavior Therapy: A step-by-step approach to adult substance abuse. Hoboken, NJ: John Wiley & Sons, Inc.'
Cost information	• 'Family Behavior Therapy: A Step-by-Step Approach to Adult Substance Abuse (manual that includes CD-ROM with protocol checklists and program forms): About $48 each. • Initial 2-day, on-site training workshop: Contact the developer. • 1-day, on-site booster workshop: Contact the developer. • Annual case reviews: Contact the developer. • Annual audiotape integrity checks: Contact the developer. • Half-day, on-site consultation to review FBT clinic integration: Contact the developer.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	April 2014

3.3. Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT)	
Intervention description	‘*BSFT* is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. *BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counsellor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors. The goals of Brief Strategic Family Therapy (*BSFT*) are: For the child/youth: • Reduce behavior problems, while improving self-control • Reduce associations with antisocial peers • Reduce drug use • Develop prosocial behaviors For the family: • Improvements in maladaptive patterns of family interactions (family functioning) • Improvements in family communication, conflict-resolution, and problem-solving skills • Improvements in family cohesiveness, collaboration, and child/family bonding • Effective parenting, including successful management of children's behavior and positive affect in the parent-child interaction’
Population	‘Youth aged 12 – 18 years with substance abuse problems and co-occurring behaviour problems such as conduct problems, aggressive and violent behavior, and risky sexual behavior.’

Brief Strategic Family Therapy (BSFT)	
Target outcomes	• Child behaviour • Family functioning • Support networks
Intervention details	‘*BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counsellor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors.’ ‘*BSFT*'s therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interactions. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction.’ (SAMHSA)
Delivery setting	‘Sessions are conducted at locations that are convenient to the family, including the family's home in some cases.’ (SAMHSA)
Dose	‘*BSFT* is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family.’ (SAMHSA)
Staffing	No information provided
Resources or supporting tools	Implementation, training and quality assurance materials and resources.
Cost information	‘Implementation, training, and quality assurance materials and resources are disseminated through two different entities that offer different packages. The implementation points of contact can provide detailed information about requirements and costs.’ (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	June 2012

3.4. Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP)	
Intervention description	'*CPP* is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. *CPP* examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.'
Population	'Children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse. Target Population: Children age 0-5 who have experienced a trauma, and their caregivers. For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child development • Child behaviour • Family functioning • Safety and physical wellbeing • Support networks
Intervention details	• 'Focus on the parent-child relationship as the primary target of intervention.

Child-Parent Psychotherapy (CPP)	
	• Focus on safety: a) Focus on safety issues in the environment as needed; b) Promote safe behavior; c) Legitimize feelings while highlighting the need for safe/appropriate behavior; d) Foster appropriate limit setting; e) Help establish appropriate parent-child roles. • Affect regulation: a) Provide developmental guidance regarding how children regulate affect and emotional reactions; b) Support and label affective experiences; c) Foster parent's ability to respond in helpful, soothing ways when child is upset; d) Foster child's ability to use parent as a secure base; e) Develop/foster strategies for regulating affect. • Reciprocity in Relationships: a) Highlight parent's and child's love and understanding for each other; b) Support expression of positive and negative feelings for important people; c) Foster ability to understand the other's perspective; d) Talk about ways that parent and child are different and autonomous; e) Develop interventions to change maladaptive patterns of interactions. • Focus on the traumatic event: a) Help parent acknowledge what child has witnessed and remembered; b) Help parent and child understand each other's reality with regards to the trauma; c) Provide developmental guidance acknowledging response to trauma; d) Make linkages between past experiences and current thoughts, feelings, and behaviors; e) Help parent understand link between her own experiences and current feelings and parenting practices; f) Highlight the difference between past and present circumstances; g) Support parent and child in creating a joint narrative; h) Reinforce behaviors that help parent and child master the trauma and gain a new perspective. • Continuity of Daily Living: a) Foster prosocial, adaptive behavior; b) Foster efforts to engage in appropriate activities; c) Foster development of a daily predictable routine. • Reflective supervision’ Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Assessment • Individual plan

Child-Parent Psychotherapy (CPP)	
	• Discussion Content: • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Home environment and child safety • Use of reinforcement/rewards for child/ behaviour charts • Emotional regulation • Reciprocity in relationships • Trauma focused • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • School
Dose	'Recommended Intensity: Weekly 1 to 1.5-hour sessions Recommended Duration: 52 weeks (one year)'
Staffing	• 'Practitioners: Master's level training. • Supervisors: Master's degree plus minimum of 1 year training in the model. Training is obtained: There are a number of different training models. Training occurs can be arranged through the Child Trauma Research Program by contacting the individual above. Training also occurs through

Child-Parent Psychotherapy (CPP)	
	the Learning Collaborative model of the National Child Traumatic Stress Network. In general, training is tailored to the needs of the organization. Number of days/hours: Typically training involves an initial 3-day workshop and then quarterly (3 more times in a year) 2-day additional workshops. In addition, training involves bi-monthly telephone-based case consultation of ongoing treatment cases involving children aged 0-5 who have experienced a trauma.'
Resources or supporting tools	'No specific room requirements are needed as the program is often implemented through a home-visiting model.'
Cost information	• 'Psychotherapy With Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment (manual): $35.79 for hardcover, $28 for paperback, or $21.95 for Kindle edition. Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy With Young Witnesses of Family Violence: $24.95 each. • 1-year full-time internship at specialized NCTSN sites (includes intensive didactic training, clinical practice, and weekly supervision by multiple supervisors): Free. • 1.5-year training through the NCTSN Learning Collaborative Model (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly phone consultation): Free, except for travel expenses. • 1.5-year training for a learning community (i.e., multiple agencies sharing the cost of training) or an individual agency (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly clinical consultation in person, by phone, or by video chat): $1,500-$3,000 per day of training (depending on trainer experience) for up to 30 participants, plus travel expenses. • Additional phone, email, or in-person consultation: $150-$350 per hour (depending on trainer experience), plus travel expenses if necessary. • Intervention fidelity checklist, training checklist, and supervision checklist: Free.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	June 2012

3.5. Functional Family Therapy (FFT)

Functional Family Therapy (FFT)	
Intervention description	'FFT is a family intervention program for dysfunctional youth. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.' 'The overall phase-based goals of Functional Family Therapy (FFT) are: • Engage and motivate youth and their families by decreasing the intense negativity (blaming, hopelessness) so often characteristic of these families. Rather than ignoring or being paralyzed by the intense negative experiences these families often bring (e.g., cultural isolation and racism, loss and deprivation, abandonment, abuse, depression), FFT acknowledges and incorporates these powerful emotional forces into successful engagement and motivation through respect, sensitivity, and positive reattribution techniques. • Reduce and eliminate the problem behaviors (e.g., conduct disorder, violent acting-out, and substance abuse) and accompanying family relational patterns through individualized behavior change interventions. • Generalize changes across problem situations by increasing the family's capacity to utilize multisystemic community resources adequately, and to engage in relapse prevention.'
Population	'Target Population: 11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse

Functional Family Therapy (FFT)	
	For children/adolescents ages: 11 – 18’
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	‘Functional Family Therapy (FFT) consists of four distinct intervention phases: • Engagement: Introduction/Impression (Pre-Intervention) • Motivation: Induction/Therapy (Early sessions) • Behavior Change (Middle sessions) • Generalization (Later sessions) Each phase has its own unique goals, risk and protective factors addressed, assessment focus, and therapist skills and intervention focus. Engagement: • Goal: Maximize family initial expectation of positive change • Risk and Protective Factors Addressed: • Negative perception about or experiences with treatment • Reputation of treatment agency • Transportation • Therapist availability • Intake staff skills and attitudes • Assessment Focus: Superficial qualities inferred from referral source and initial screening

Functional Family Therapy (FFT)	
	• Therapist Skills/Intervention Focus: • High availability • Manage intake processes to present agency, self, and treatment in a way that matches to inferred family characteristics • Enhance perception of credibility Motivation: • Goal: Create a motivational context for long-term change • Risk and Protective Factors Addressed: ▪ Family negativity and blame ▪ Hopelessness ▪ Level of motivation • Assessment Focus: ▪ Behavioral (presenting problem) ▪ Relational risk and protective factors • Therapist Skills/Intervention Focus: ▪ Interpersonal skills (validation, positive reattribution, reframing, relational) ▪ Build balanced alliances ▪ Reduce negativity and blame ▪ Create hope ▪ Enhance motivation to change Behavior Change: • Goal: Facilitate individual and interactive/ relational change

Functional Family Therapy (FFT)	
	• Risk and Protective Factors Addressed: • Youth temperament • Parental pathology • Beliefs and values • Developmental level • Parenting skills • Conflict resolution/negotiation skills • Level of family support • Peer refusal skills • Assessment Focus: • Individual skills • Quality of relational skills • Relational problem sequence • Compliance with behavior change plans • Therapist Skills/Intervention Focus: • Directive/teaching /structuring skills • Modelling • Setting up, leading, and reviewing in-session tasks • Assigning homework Generalization: • Goal: Maintain individual and family change, and facilitate change in multiple systems • Risk and Protective Factors Addressed

Functional Family Therapy (FFT)	
	• Youth bonding to school • Parent attitudes about school, peers, drugs, etc. • Level of social support • Assessment Focus: • Access to and utilization of community resources • Maintenance of change • Therapist Skills/Intervention Focus: • Interpersonal and structuring skills • Family case manager • Accessing appropriate formal and informal community resources • Anticipate and plan for future extra-familial stresses'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • School
Dose	Dose 'Recommended Intensity: One-hour weekly sessions unless needed more frequently Recommended Duration: 8 to 12 sessions for mild cases and up to 30 sessions for difficult situations taking on average 3-4 months'
Staffing	'Qualifications can vary for therapists, but to become an onsite Program Supervisor a minimum of Master's level education is required.'

Functional Family Therapy (FFT)	
Resources or supporting tools	'Sites must provide each therapist with on-going computer and internet access so they can record progress notes and complete the other assessment, adherence and outcome instruments that are utilized during the course of the intervention. Meeting space and a speaker phone are needed for weekly consultation with an offsite program consultant.'
Cost information	• 'Functional Family Therapy for Adolescent Behavior Problems (book): $59.95 each. • Functional Family Therapy for Adolescent Substance Use Disorders: Training Manual (includes client handouts and quality assurance forms): Free. • Functional Family Therapy for Adolescent Substance Use Disorders (book chapter): Free. • Functional Family Therapy for Adolescent Substance Abuse and Dependence (PowerPoint slides): Free. • Stage 1 Training (includes 2 on-site trainings and guided practice): $26,000-$43,500, plus trainer travel expenses, for 3-8 therapist participants. • Stage 2 Training (includes 2 on-site trainings and guided practice): $13,000, plus trainer travel expenses, for 1 supervisor participant. • Stage 3 Training (includes 1 on-site training): $5,000, plus trainer travel expenses, per site. • Therapist certification: $500 per therapist.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	September 2013

3.6. Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)	
Intervention description	It includes specific clinical and training for staff designed to address: '(1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness. *MST-Psychiatric* teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in prosocial activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family's natural environment (e.g., home, school, community) daily when needed and for approximately 6 months. A *MST-Psychiatric* team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.'
Population	'Youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity' 'Ages: 6-12 (Childhood), 13-17 (Adolescent)'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	The program includes specific clinical and training for staff designed to address: '(1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.'

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)	
Delivery setting	• Home • School • Other community settings
Dose	'The intervention is delivered daily when needed and for approximately 6 months'
Staffing	'A *MST-Psychiatric* team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings'
Resources or supporting tools	Information not available
Cost information	• 'Program development start-up fees (includes site readiness visit and 7-day, on-site orientation training): $15,000 plus travel expenses. • Annual program support and service fees (includes annual agency/team license fees, start-up kit, manuals, training materials, weekly case consultation, supervisor support calls as needed, quarterly on-site booster trainings, and use of Web-based adherence monitoring and outcome tracking system): $96,500 per site plus travel expenses. • 2-day supervisor orientation training: $350 per participant plus travel expenses. • Tape coding: About $7,920. • Adherence data collection: About $3,600 per year.'
PRC rating	Promising
Primary source	SAMHSA
Date last reviewed	November 2008

3.7. Parenting with Love and Limits (PLL)

Parenting with Love and Limits (PLL)	
Intervention description	‘*PLL* combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. The program also has been used with teenagers with less extreme behaviors. *PLL* is also used to serve as an alternative to a residential placement for youth as well as with youth returning back from residential placement such as commitment programs, halfway houses, group homes, or foster homes. *PLL* teaches families how to re-establish adult authority through consistent limits while reclaiming a loving relationship. The goals of Parenting with Love and Limits (*PLL*) are to: • Treat children and adolescents who have severe emotional and behavioral problems • Teach families how to re-establish adult authority through consistent limits while reclaiming a loving relationship’
Population	‘Youth aged 10 – 18 years with severe emotional and behavioral problems and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation.’
Target outcomes	• Child behaviour • Family functioning • Safety and physical wellbeing
Intervention details	• ‘Combining both group and family therapy together over a six- to eight-week period • Having a recommended 6 to 8 adolescents and their families per group • Using the Stages of Readiness Scale as an overlay to break parental resistance • Assessing fidelity using the following 4 scales plus a manualized curriculum: ▪ Video supervision using Interpersonal Process Recall (IPR)- Expert Rating Scale ▪ Group Fidelity Checklist - (Therapist Adherence Measure)

Parenting with Love and Limits (PLL)	
	▪ Family Therapy Fidelity Checklist - (Therapist Adherence Measure) ▪ Monthly *PLL* Report - (Therapist Adherence Measure)'
Delivery setting	• 'Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • Residential Care Facility'
Dose	'Recommended Intensity: 2-hour weekly group sessions with 1 hour of parents and teens meeting together and 1 hour of the parents and teens meeting separately, and 1-2 hour weekly family sessions, as needed Recommended Duration: 6 weeks for group sessions, and 4 to 20 sessions for family sessions'
Staffing	'Master's level degree in counseling related field for clinician. Bachelor's degree for co-facilitator or case manager.'
Resources or supporting tools	'There is a manual that describes how to implement this program, and there is training available for this program. Training is obtained: • Initial 5-day onsite clinical training • Semimonthly quality assurance and clinical adherence telephone consultations (2 hours each supervision session) • Motivational Interview Training (*PLL* Specific) • Outcome research and analysis that includes an independently conducted, published program evaluation on recidivism rates and clinical effectiveness, if qualify

Parenting with Love and Limits (PLL)	
	• One annual onsite visit, if needed, to observe delivery of the model for quality assurance purposes • Videotape supervision of therapist to facilitate treatment fidelity • Monthly 1-hour session for Community Based Action Team (Case Management) supervision (Reentry Teams Only) • Ongoing consultations as needed to answer questions outside the weekly telephone consultations Number of days/hours: Five days of clinical training, 48 weeks of telephone consultations'
Cost information	No information provided
PRC rating	Promising
Primary source	CEBC
Date last reviewed	July 2012

3.8. Safe Environment for Every Kid Model (SEEK)

Safe Environment for Every Kid Model (SEEK)	
Intervention description	'*SEEK* utilizes pediatric primary care as an opportunity to help prevent child maltreatment in families who may have risk factors for child maltreatment. Most children receive this care and there are frequent visits in the first 5 years. Also, the generally good relationship between health professionals and parents offers an opportunity to identify and help address prevalent psychosocial problems. *SEEK* begins with training professionals to play this role. Online videos and other materials are available on the *SEEK* website. Continuing Medical Education (CME) credit is offered as well as Maintenance of Certification (MOC) Categories 2 and 4 credit (through the American Board of Pediatrics and the American Board of Family Medicine). The *SEEK* Parent Questionnaire (PQ) is a tool to screen for the targeted

Safe Environment for Every Kid Model (SEEK)	
	problems: parental depression, substance abuse, major stress, intimate partner violence, food insecurity, and harsh punishment. It is completed in advance and given to the professional at the start of a regular check-up. The trained professional then briefly assesses and initially addresses identified risk factors and makes necessary referrals to community resources, ideally with the help of a mental health professional. Principles of Motivational Interviewing have been incorporated into *SEEK* and parent handouts are available as adjuncts to advice offered in the visit.'
Population	'Target Population: Families with children aged 0-5 years who have risk factors for child maltreatment such as parental depression or substance abuse For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child maltreatment • Support networks • Safety and physical wellbeing • Child development
Intervention details	• 'Health Professional Training: *SEEK* recognizes the importance of preparing child health professionals to assess and address problems such as parental depression. In addition to the initial training via online videos and other materials, ongoing training and support is offered. Continuing Medical Education (CME) credit is available, and Maintenance of Certification Categories 2 and 4 credit is available through the American Board of Pediatrics and the American Board of Family Medicine. • Motivational Interviewing (MI): *SEEK* incorporates principles of Motivational Interviewing to improve upon the traditional prescriptive approach to more effectively work with parents in planning and engaging in services. • The *SEEK* Parent Screening Questionnaire (PQ): The PQ is a brief screening tool parents complete in the pediatrician's office before seeing the pediatrician. It has 15 questions, takes 2-3 minutes to complete, and is currently available in English, Spanish, Chinese, and Vietnamese. It can be completed on paper or computer. • *SEEK* Parent Handouts: User-friendly, one-page handouts are available for all of the targeted problems, with space to list local resources and customized information about the practice. It is critical that

Safe Environment for Every Kid Model (SEEK)	
	professionals know what is available in the community to help address identified problems, such as substance abuse. • Mental Health Professional: It is recommended that medical professionals work with a mental health colleague, such as a social worker. The *SEEK* Model, however, has been designed to be deliberately flexible regarding who does what in addressing problems. Some health professionals are interested in playing a substantial role, others less so. Some parents may prefer discussing sensitive matters with the professional they know and trust. Thus, many health professionals do address psychosocial problems, with office or clinic staff helping to facilitate referrals. Nevertheless, a mental health colleague is a valuable asset.'
Delivery setting	Paediatric Primary Care Setting
Dose	'Recommended Intensity: It is recommended that the Parent Questionnaire be administered at many of the regular check-ups in the first 5 years, such as at 2, 9, 15, 24, 36, 48, and 60 months. There is no set intensity for the response or treatment; this hinges on the specific situation. Recommended Duration: Until the child reaches 5 years of age'
Staffing	'Medical professionals should be licensed to practice as pediatricians, family medicine physicians, nurse practitioners, or physician assistants. Mental health professionals need at least a Master's degree in a relevant field and to be licensed to provide clinical services' 'Training is obtained: Online, electronically, webinars, phone Number of days/hours: Initial training: 2-3 hours; Ongoing training: Variable, depending on needs and interest; Maintenance of Certification (MOC) Category 4: 12 hours'
Resources or supporting tools	Resources or supporting tools. 'The typical resources for implementing the program are: • A "champion" to lead implementation of the *SEEK* Model • Buy-in from the health professionals in the practice • 1 hour to train office staff • Access to a mental health professional is ideal, but not essential'
Cost information	Information not available

Safe Environment for Every Kid Model (SEEK)	
PRC rating	Promising
Primary source	CEBC
Date last reviewed	April 2014

3.9. Teaching Kids to Cope (TKC)

Teaching Kids to Cope (TKC)	
Intervention description	'*Teaching Kids to Cope (TKC)* is a cognitive-behavioral health education program, based on stress and coping theory, for adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation. This group treatment program teaches adolescents a range of skills designed to improve their coping with stressful life events and decrease their depressive symptoms. Participants are guided through a process to discover their distorted thinking patterns and to test their thinking against reality using suggested approaches. They also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways of reacting. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks. Activities also include group discussion, role-play, group projects, and the use of worksheets, handouts, films, and audiotapes. Homework assignments provide an opportunity for the adolescents to practice using new skills.'
Population	'Adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation'
Target outcomes	• Child behaviour • Safety and physical wellbeing
Intervention details	'Participants are guided through a process to discover their distorted thinking patterns and to test their thinking against reality using suggested approaches. They also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways of reacting. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family

Teaching Kids to Cope (TKC)	
	relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks.' 'Homework assignments provide an opportunity for the adolescents to practice using new skills.'
Delivery setting	Schools, hospitals, outpatient clinics, churches, summer camps, or other community-based settings.
Dose	Ten weekly 1-hour group sessions
Staffing	'Professional with a bachelor's degree in education, social work, child development, nursing, psychology, or other health-related field, and 1 year of experience working with children or adolescents.'
Resources or supporting tools	Includes 1-day on-site training and an implementation manual. Activities include the use of '….worksheets, handouts, films, and audiotapes'.
Cost information	• '1-day, on-site training (includes five implementation manuals, rights for use and duplication, and ongoing technical assistance): $1,000 plus travel expenses. • Additional implementation manuals: $15 each.'
PRC rating	Promising
Primary source	SAMHSA
Date last reviewed	February 2010

4. Emerging

4.1. AVANCE Parent-Child Education Program (PCEP)

AVANCE Parent-Child Education Program (PCEP)	
Intervention description	‘*AVANCE*’s philosophy is based on the premise that education must begin in the home and that the parent is the child’s first and most important teacher. The *PCEP* fosters parenting knowledge and skills through a nine-month, intensive bilingual parenting curriculum that aims to have a direct impact on a young child’s physical, emotional, social, and cognitive development. Parents/primary caregivers are taught how to make toys out of common household materials and how to use them as tools to teach their children school readiness skills and concepts. Monthly home visits are also conducted to observe parent-child interactions and provide guidance in the home on learning through play.’ Along with parenting education, ‘parents/primary caregivers are supported in meeting their personal growth, developmental and educational goals to foster economic stability. While parents/primary caregivers attend classes, their children under the age of three are provided with early childhood enrichment in a developmentally appropriate classroom setting which aims to build the academic, social, and physical foundation necessary for school readiness.’ ‘Program Goals: Using a two-generation approach, the goals of the *AVANCE Parent-Child Education Program (PCEP)* are to: • Increase parents’ understanding of child development so they are better able to foster optimal development of their children • Empower parents to view themselves as their child’s first and most important teacher and the home as the first classroom *PCEP* achieves these goals by targeting the following outcomes: • Increased school readiness in children from birth to age three • Increased family engagement in the development and education of young children • Increased civic engagement, including knowledge of how to advocate for themselves and their families • Increased knowledge of community resources’

AVANCE Parent-Child Education Program (PCEP)	
Population	'Parents with children from 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education levels.'
Target outcomes	• Child development
Intervention details	'Participants: • Voluntary • Parents/primary caregivers and their children from birth to age three • Pregnant mothers and their partners Intervention context: • Theoretical framework: • Human ecology • Attachment • Weekly three-hour small group sessions: • Toy-making • Parenting Education • Community Resource Speakers/Group Activities • Recommended adult class size: 15 to 25 participants; if more than 25 families wish to enrol in the program, recommend scheduling an additional class day to maintain the optimal group size that is conducive for learning • Early childhood education • Provided while adult participants attend weekly three-hour class • Size of child class depends on the age of the child and the recommended caregiver-to-child ratio for that age group • Monthly home visits

AVANCE Parent-Child Education Program (PCEP)	
	• Ongoing advocacy and support • Additional services (optional): • Transportation—provided as needed to help eliminate barriers to participation in the program • Food services—nutritious meals for children and nutritious snacks for parents/primary caregivers during the parenting class Program delivery staff: • Complete initial *AVANCE* orientation and biannual recertification training Program monitoring and use of data: • Data collected by Parent Educators and Home Educators as directed by the *AVANCE* National Office and sent data to the National Office for entry and analysis • Reports issued to *PCEP* providers by *AVANCE* National Office issues reports and used to evaluate and guide program implementation • Reports used by providers to monitor, identify and improve variances, and assure fidelity to the *AVANCE* model Partnerships: • Partnerships highly encouraged both to provide additional support services to families and to off-set program costs through in-kind support • Examples of partnerships include local school districts; children's museums; food banks, grocery stores and restaurants; medical and dental clinics; women's shelters (needs assessment and mental health counseling); colleges and universities (the adult continuing education of *PCEP*, program research and interns); places of worship (classroom space); discount stores (home and hygiene products, books and toys, etc. to use as incentives for program participation for parents/caregivers)'
Delivery setting	• Birth Family Home • Community Agency

AVANCE Parent-Child Education Program (PCEP)	
	• School
Dose	‘Recommended Intensity: Parent/primary caregiver contacts: Once per week for three hours - Child contacts: Once per week for three hours (early childhood education provided while parents are in class) - Parent-Child contacts: Once per month for 30-45 minutes (minimum) in the home Recommended Duration: Families participate in the voluntary program for nine months. Upon completion of a minimum of 75% of classes, parents/primary caregivers graduate and participate in the commencement ceremony with their children, Parents/primary caregivers are encouraged to return for a second year in which they are assisted with adult education and job training’
Staffing	‘All positions are required to complete initial *AVANCE* training and obtain biannual refresher training. All staff must be able to read and speak the language of the families they serve. *AVANCE* parent graduates are to be considered for staff positions. Generally, staff are from the community or very familiar with the area being canvassed. They are trained to be culturally sensitive, alert, enthused, self-confident, and self-assured and to present themselves in a caring and genuine manner. Because many staff members tend to be program graduates, they can relate firsthand experiences on the benefits of participation and can calm newcomers who may be nervous about enrolling in the program. 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

AVANCE Parent-Child Education Program (PCEP)	
	Preferred skills/training: • Bilingual (in English and in the preferred language of participants; traditionally Spanish) • Experience working with adults and children or in a family support services environment *PCEP* graduate • Experience in management and supervision'
Resources or supporting tools	'The typical resources for implementing the program are: • Personnel (based on number of families served): Parent Educator, Home Educator, Toy-making Instructor, Early Childhood Educator • Adequate space for parents/primary caregivers and children (child classrooms should follow general ratio requirements) • Computer and telecommunication capabilities • A/V equipment (projector and speakers) • Toy-making materials/supplies • Early childhood development furniture/toys/books/supplies • Community resource materials and books • Transportation compliant with child safety standards (for families unable to travel to classes) • Nutritious meals/snacks • Strong, stable, and sustainable funding for agency operations In addition, a community advisory board is recommended to help develop partnerships that are integral to the *AVANCE* Parent-Child Education Program.'
Cost information	No information provided
PRC rating	Emerging

AVANCE Parent-Child Education Program (PCEP)	
Primary source	CEBC
Date last reviewed	September 2013

4.2. Coping And Support Training (CAST)

Coping And Support Training (CAST)	
Intervention description	‘*CAST (Coping And Support Training)* is a high school-based suicide prevention program targeting youth 14 to 19 years old. *CAST* delivers life-skills training and social support in a small-group format (6-8 students per group *CAST* serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as *CARE (Care, Assess, Respond, Empower)*, but other evidence-based suicide risk screening instruments can be used. *CAST*'s skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group-generated implementation plan for the *CAST* leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.’
Population	‘ Youth who have been identified through screening as being at significant risk for suicide’ Youth aged 12-18 years.
Target outcomes	• Child behaviour • Safety and physical wellbeing

Coping And Support Training (CAST)	
Intervention details	‘Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults.’
Delivery setting	School
Dose	Twelve 55-minute group sessions administered over 6 weeks in a small-group format (6 – 8 students per group).
Staffing	‘Trained high school teachers, counselors, or nurses with considerable school-based experience.’
Resources or supporting tools	‘*CAST* curriculum, student notebooks, 4-day training, an online *CAST* tutorial, 2-day advanced training, 1-day on-site follow up consultation, evaluation materials and services.’
Cost information	• ‘*CAST* curriculum: $425 each. • Student notebooks: $16 each or $115.20 for eight. • 4-day, on- or off-site training workshop for *CAST* leaders and coordinators: $8,800 per group of five to eight participants, or $9,900 per group of nine participants, or $1,100 per participant to attend an open training. • Self-paced online *CAST* tutorial for administrators: $49 per person for unlimited access. • 2-day, on- or off-site advanced training for *CAST* coordinators: $800 per person. • Unlimited phone consultation: Free. • 1-day, on-site follow-up consultation: Varies depending on site needs and location. • Evaluation materials and services: Varies depending on site needs.’
PRC rating	Emerging
Primary source	SAMHSA
Date last reviewed	February 2007

4.3. Child FIRST

Child FIRST	
Intervention description	'*Child FIRST* is a system of care that targets children aged between 6 months and 3 years with emotional and behaviour problems where the parents are at psychosocial risk.' 'The intervention commences with a child and family assessment conducted in partnership between a clinician, a care coordinator and the parents, with other service providers involved as needed. A family plan is developed outlining supports and services for all family members and this is focused on family priorities, strengths, culture and needs. The home visiting component of the service is guided by parental need rather than a set curriculum. Families are also linked in with appropriate services, such as mental health, health and early care, early intervention, education, child protection and social and concrete services'
Population	'Children aged between 6 months and 3 years with emotional and behaviour problems where the parents are at psychosocial risk'. Psychosocial risk can be due to maltreatment or parent mental illness.
Target outcomes	• Child Development • Child Behaviour • Safety and Physical Wellbeing • Child Maltreatment Prevention • Family functioning • Systems Outcomes
Intervention details	• 'Assessment of child and family. • Individualised plan. • Linkage to other services, such as mental health, health and early care, early interventions, education, child protection and social and concrete services. • Based on family priorities, strengths, culture and needs. • Collaboration with families. • Home visiting components are guided by parental need rather than a fixed curriculum.

Child FIRST	
	• Observations of child's emotional, cognitive and physical development. • Observation of parent-child interactions. • Psychoeducation including developmental stages, expectations and means of typical behaviours. • Reflective functioning to understand the child's feelings and the meaning of the child's unique and challenging behaviours. • Psychodynamic understanding of the mother's history, feelings and experience of the child. • Alternative perspectives of child behaviour and new parental responses. • Positive reinforcement of both parents' and child's strengths to promote parents self-esteem.' (appendix 6, p.10) Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Service linkage • Assessment • Individual plan • Collaboration with family • Based on strengths, needs, resources Content: • Individualised home visiting component rather than fixed curriculum • Child behaviour and behaviour management • Parent-child interactions

Child FIRST	
	• Child health and development • Reinforcement of parents strengths
Delivery setting	Home
Dose	'Delivered by a professional in 24 weekly home-based sessions to individual parents'
Staffing	A professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Macvean *et. al.* (2013)
Date last reviewed	2013

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

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
Intervention description	'*Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program*: School-Age Group is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems: • The program is an outpatient group treatment program for children ages 6 to 12 years and their parents or other caregivers. • Program can be provided to individual families when group is not an option. • The treatment is provided as an open-ended group, with children able to graduate in 4-5 months.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	• Collaboration with child protective services, juvenile court personnel, school personnel, and others involved is highly recommended. The children acknowledge the previous breaking of sexual behavior rules, learn coping and self-control strategies, and develop a plan of how they were going to keep these rules in the future. Caregivers were taught how to supervise the children, teach and implement rules in the home, communicate about sex education, and reduce behavior problems utilizing behavior parent training strategies. The goals of *Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program*: School-Age Group are to: • Eliminate or reduce problematic sexual behavior • Improve child behavior via better parental monitoring, supervision, and behavior management skills • Improve parent-child interaction and communication • Improve coping, self-control, and social skills'
Population	Children aged 6 – 12 years with problem sexual behaviours and their parents
Target outcomes	• Child behaviour • Family functioning
Intervention details	• 'Modelling, observing, and providing constructive and corrective feedback on skills • Structured program and providers who use a directive approach' Addressing components with Children and Caregivers • 'Rules about sexual behavior • Boundaries • Abuse prevention skills • Emotional regulation and coping skills • Impulse control and problem solving skills • Sex education

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	• Social skills and peer relationships • Acknowledge, apology, and amends' Addressing additional components for caregivers • 'Behavior parent training to prevent and respond to sexual behavior problems as well as other behavior problems • Sexual development and child development including moral development • Dispelling misconceptions regarding the behavior and implications to the child • Support' 'Separating out the groups by age: • 6-9 year olds with 5 to 8 children per group • 10-12 year olds with 5 to 8 children in each group. • One caregiver group for children of the combined age ranges can be used – or separate caregiver group depending on program decisions.'
Delivery setting	Outpatient Clinic
Dose	'Recommended Intensity: 60-90 minute weekly session Recommended Duration: 4 to 5 months depending on meeting graduation criteria'
Staffing	'Supervisor and lead therapists are recommended to be licensed mental health practitioners with previous experience in treatment for children and their caregivers for children with behavior problems and children who have been maltreated'
Resources or supporting tools	'The typical resources for implementing the programs are: Group rooms including one room large enough to hold all the families for the parent-child group component. Chalk or dry erase board.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	Co-therapists for each child group (recommended). One therapist for the caretaker/parents group. Personnel to conduct the intake assessments. Supervisor/director of the program. Therapeutic materials, such as books.'
Cost information	No information provided
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

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

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	
Intervention description	'The *Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)* is intended for families with parents with significant mood disorder. Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression.'
Population	'Families with parents with significant mood disorder' 'Ages: 6-12 (Childhood), 13-17 (Adolescent), 26-55 (Adult)'
Target outcomes	• Support networks • Family functioning • Child behaviour

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	
Intervention details	'The core elements of the intervention are (1) an assessment of all family members, (2) teaching information about affective disorders and risks and resilience in children, (3) linking information to the family's life experience, (4) decreasing feelings of guilt and blame in children, and (5) helping children to develop relationships within and outside the family to facilitate their independent functioning in school and in activities outside the home. In family meetings, parents talk about their own sessions, their treatment, and how they are working to build resilience and protect their children'
Delivery setting	• Outpatient • Home • Other community settings
Dose	' The intervention consists of 6-11 modules that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals'
Staffing	' Sessions are conducted by trained psychologists, social workers, and nurses'
Resources or supporting tools	Includes 2-day initial training, online training, a training CD, an implementation manual and ongoing supervision and consultation.
Cost information	• 'Implementation manual: Free. • Online training: Free. • Training CD: $10 each. • 2-day initial training: $500 per day. • Ongoing biweekly supervision and consultation: $100 per hour.'
PRC rating	Emerging
Primary source	SAMHSA
Date last reviewed	October 2006

4.6. Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
Intervention description	'*CBT-SAP* is a program for 3 to 6 year old children with a history of maltreatment…The intervention targets child development, child behaviour, parent-child relationships and family relationships and is delivered in a clinical setting. Twelve sessions are delivered to individual parent-child dyads on a weekly basis by professionals. As the name suggests, this intervention involves the provision of cognitive behavioural therapy to parents and children. Delivery takes the form of cognitive reframing, thought stopping, positive imagery and contingency reinforcement. Parenting management training is also provided, as well as problem solving, psychoeducation and supportive interventions. Intervention content for the parents covers ambivalence about belief in the sexual abuse, ambivalence towards the perpetrator, attributions regarding the abuse, feelings that the child is damaged, the provision of appropriate emotional support to the child, management of child fear and anxiety, management of appropriate behaviours, and dealing with the parents' issues in relation to their own abuse. Intervention content for the children covers similar concerns such as attributions regarding the abuse and ambivalent feelings towards the perpetrators, but also child safety and assertiveness training, appropriate versus inappropriate touching, inappropriate behaviour and issues of fear and anxiety.' (p.33-34)
Population	Parents and their children aged 3 – 6 years with a history of maltreatment.
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning
Intervention details	'Delivery takes the form of cognitive reframing, thought stopping, positive imagery and contingency reinforcement. Parenting management training is also provided, as well as problem solving, psychoeducation and supportive interventions.' (p.33-34)

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
	Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Structured sessions • Cognitive re-framing • Thought stopping • Positive imagery • Parent management training • Psycho-education • Supportive interventions Content: • Problem solving skills • Child behaviour and behaviour management • Home, environment and child safety • Emotional regulation • Ambivalence in belief of abuse, ambivalence toward perpetrators, feeling the child is damaged, emotional support for child, parental issues regarding their own abuse • Child assertiveness training, appropriate vs inappropriate touching
Delivery setting	Clinic
Dose	12 weekly sessions with parent and child. '90 minutes (50 mins with parent and 30-40 mins with child)' appendix 6, p.20.

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
Staffing	Delivered by a professional
Resources or supporting tools	Information not provided.
Cost information	Information not provided.
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.7. Community Advocacy Project (CAP)

Community Advocacy Project (CAP)	
Intervention description	'The *Community Advocacy Project* involves providing home-based and community-based advocacy services for survivors of intimate partner abuse. Highly trained paraprofessionals, receiving intensive supervision, work with survivors of domestic abuse (and their children), helping them obtain the community resources and social support they desire. This is an empowerment-based, strengths-focused intervention designed to increase women's quality of life and decrease their risk of re-abuse.' • 'Increase children's self-competence • Decrease women's depression • Increase women's quality of life • Increase women's access to resources • Increase women's social support • Increase women's and children's safety' 'Services offered are community-based and home-based. • Activities are driven by the women, not the advocates.

Community Advocacy Project (CAP)	
	• Advocates are proactive and engaged in linking women with community resources. • Advocates are knowledgeable about available community resources and effective strategies for obtaining them. • Advocates focus on enhancing women's social support. • Advocates should be highly trained in empathy and active listening.’
Population	‘Target Population: Designed for and tested with survivors of domestic abuse who have utilized shelters. Can be expanded to non-shelter users.’ Includes their children.
Target outcomes	• Family functioning • Support networks • Systems outcomes
Intervention details	‘ The intervention is composed of five phases: • Assessment. The advocate gathers important information regarding the needs and goals of each participant and her child. The participant, not the advocate, guides the direction and activities of the intervention by identifying issues that are important to her. • Implementation. The advocate and the participant actively work together to generate, mobilize, and access community resources. For women, resources often involve legal assistance, housing, employment, education, transportation, child care, social support, and/or material goods. For children, advocacy often focuses on participation in recreational activities (e.g., joining a Boys and Girls Club, getting on a sports team, going to camp), help with school, and/or material goods. • Monitoring. The advocate checks in with the participant regularly to determine whether her unmet needs have been fulfilled. • Secondary implementation. If the community resources were ineffective in satisfying the participant's original needs, the advocate suggests alternative strategies to generate, mobilize, or access other resources. • Termination. This phase occurs during the last few weeks of the intervention, when the advocate focuses even more intensively on the transfer of skills and knowledge to the participant, ensuring that she no longer needs the advocate at the end of the intervention.’ (SAMHSA)

Community Advocacy Project (CAP)	
	• ‘Services offered are community-based and home-based. • Activities are driven by the women, not the advocates. • Advocates are proactive and engaged in linking women with community resources. • Advocates are knowledgeable about available community resources and effective strategies for obtaining them. • Advocates focus on enhancing women's social support. • Advocates should be highly trained in empathy and active listening. ‘(CEBC)
Delivery setting	Adoptive Home Birth Family Home
Dose	‘Recommended Intensity: 4-6 hours per week Recommended Duration: 10 weeks’
Staffing	‘Advocates must be highly trained in strengths-based philosophy, domestic abuse dynamics, safety planning, and obtaining community resources. Advocates need ongoing, intensive supervision to ensure they are maintaining fidelity of the model.’ ‘Supervisors should have at least two years’ experience providing domestic abuse services, ideally in community settings. They should be highly trained in empathy, active listening, strengths-based services, and safety planning.’
Resources or supporting tools	No specific resources are needed to implement the intervention. It occurs in women's homes and communities
Cost information	‘Advocate logbook for weekly activities: $5 each. The Community Advocacy Project: Advocate Manual (includes weekly progress report forms): Free. The Community Advocacy Project: Instructor Manual: Free.

Community Advocacy Project (CAP)	
	Training handouts: Free. Training PowerPoint slides: Free. Why Does He Do That? Inside the Minds of Angry and Controlling Men (book by Lundy Bancroft): $8.80 each. Safety Planning With Battered Women: Complex Lives/Difficult Choices (book by Jill Davies, Eleanor Lyon, and Diane Monti-Catania): $59.99 each. In Her Shoes: Economic Justice Edition (kit from the Washington State Coalition Against Domestic Violence): $125 each. StarPower (kit from Simulation Training Systems): $249 each. Bafa'Bafa' (kit from Simulation Training Systems): $289 each. The Story of Rachel (DVD from Praxis International): $49 each. 40-hour, on-site training: $9,000 for an unlimited number of participants, plus trainer travel expenses, if training is provided by the developer. Free, if training is provided by a local qualified trainer. 40-hour, on-site train-the-trainer workshop: $9,000 for an unlimited number of participants, plus trainer travel expenses. Online technical assistance and consultation: Cost varies depending on site needs (free for simple inquiries). CAP Fidelity Measure (includes process and outcome measures, CAP Fidelity Coding Sheet, and Fidelity Coding Framework): Free.' (SAMHSA)
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	April 2014

4.8. Early Start

Early Start	
Intervention description	'*Early Start* is a program for children aged up to 3 months who are at risk of maltreatment'
Population	'Children aged up to 3 months who are at risk of maltreatment' Risk of maltreatment can be due to family circumstances including domestic, family or intimate partner violence and parental substance abuse.
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'The program commences with an assessment of family needs, issues, challenges, strengths and resources. Individualised service plans are developed. There is a focus on relationship development between the worker and the family, in which there is collaborative problem solving focused on family challenges. Families receive support, teaching, mentoring and advice to assist them to use their strengths and resources. Content of the intervention includes information about child health and safety, such as timely medical visits, compliance with immunisation and wellbeing checklists and home safety. Parenting skills information is also provided including parental sensitivity, positive parenting and non-punitive parenting. There is support for parental physical and mental health such as reductions of unplanned pregnancies and early detection and treatment of depression/anxiety/substance abuse. Other content includes information about family economic and material wellbeing (budgeting, employment), positive adult relationships and crisis management.' Components identified by PRC (Macvean *et. al.*, 2013)

Early Start	
	Delivery level: Individual Delivery: • Assessment • Individual plan • Based on family strengths, needs, resources • Collaborative relationship with family Content: • Parent mental and physical health • Child health and development • Planning ahead for high risk situations/crisis management • Positive parenting • Non-punitive parenting • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships • Positive adult relationships
Delivery setting	Home
Dose	'intervention. Individual families participant for up to 3 years, with the number of visits varying from a maximum of one per week to a minimum of one per month'
Staffing	'Professional-delivered'
Resources or supporting tools	Information not available
Cost information	Information not available

Early Start	
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.9. Family Connections

Family Connections	
Intervention description	'*Family Connections* is a service model evaluated in the USA with an intervention focus. It draws on Ecological/Systems Theory. The service is delivered in the home to child-caregiver dyads by trained social workers in up to 40 sessions that last one-and-a-half hours each. The approach has shown good fidelity.'
Population	'Children targeted in this service model are aged 5–11 years and have been exposed to neglect, domestic or family violence, parental substance misuse or parental mental illness.'
Target outcomes	• Child behaviour • Child maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'Individual family support, Community outreach, tailored interventions, helping alliance, empowerment, strengths-based, cultural competence, developmental appropriateness, & outcome-driven service plans.' (appendix 2, p.20)
Delivery setting	Home
Dose	'up to 40 sessions that last one-and-a-half hours each'

Family Connections	
Staffing	Trained social workers
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013)
Date last reviewed	2013

4.10. Families Facing the Future

Families Facing the Future	
Intervention description	'The *Families Facing the Future* parent training curriculum consists of one five-hour family retreat and 32 hour-and-a-half parent training sessions. Sessions are conducted twice a week over a 16-week period. Children attend 12 of these sessions to practice the skills with their parents. Parent sessions are conducted with groups of six to eight families.' It is necessary to provide practice opportunities as well as skill areas that address recurring problem behaviors specific to the needs of the parents. 'The parent training format combines a peer support and skill training model. The training curriculum teaches skills using the 'guided participant modelling.' Skills are modelled by trainers and other group members, then discussed by participants. Skills steps are reviewed and then parents practice the steps. Video-tape is frequently used in modelling the skills or during practice of the skills. The training focuses on affective and cognitive as well as behavioral aspects of performance.'
Population	'Target Population: Parents receiving methadone treatment and their children ages 5 – 14. For children/adolescents ages: 5 – 14 For parents/caregivers of children ages: 5 – 14'
Target outcomes	• Child development

Families Facing the Future	
	• Family functioning • Child behavior • Safety and physical wellbeing • Support networks
Intervention details	• ‘Groups consist of 6 to 8 families per group • Session topics are targeted at specific risk and protective factors and include: ▪ Family Goal Setting: This five-hour session focuses on bringing a variety of families together to share a common, trust-building experience. Families work together to develop goals for their participation. ▪ Relapse Prevention: These four sessions include identification of relapse signals or triggers, anger and stress control, and creating and practicing a relapse plan in the event of relapse. The primary focus during these sessions is the impact of relapse on the client's children and skills to prevent and cope with relapse situations. ▪ Family Communication Skills: The skills of Paraphrasing, Open Questions, ‘I’ Messages are taught during these sessions. Families practice using the skills during two practice sessions. Families also practice and use Family Involvement Skills to develop family expectations and plans for regular family meetings or family play and fun time. All subsequent groups reinforce the use of the communication skills taught in these early sessions. Families are asked to conduct weekly family meetings to practice the skills learned in the training. ▪ Family Management Skills: Parents learn and practice setting clear and specific expectations, monitoring expectations, rewarding for positive behaviors, and instilling consequences for negative behaviors. Parents practice implementing ‘the law of least intervention,’ using the smallest intervention to get the desired behavior from their child. A variety of discipline practices are learned and practiced by parents. These include, praise, ignoring, expressing feelings, if-then messages, time-outs, and privilege restrictions. ▪ Creating Family Expectations about Drugs and Alcohol: Families work together to define and clarify expectations about drugs and alcohol in their families. ▪ Teaching Children Skills: Parents learn how to teach their children two important skills, Refusal Skills and Problem Solving Skills, using a five-step process. ▪ Helping Children Succeed In School: Parents build on the previously learned skills to create, monitor, and consequence a home learning routine for their children.

Families Facing the Future	
	• The curriculum allows for participant practice in situations they currently face with their own children. Parents complete home extension exercises after each session to generalize the skills from the training setting to the home setting. After parents learn and practice skills, family sessions are conducted where parents and children practice using their new skills together. ▪ The *Families Facing the Future* case management intervention comprehensively addresses important aspects of family life. The case management intervention is designed to test the effectiveness of: ▪ Helping families to identify their goals and empowering them to work toward those goals ▪ Building on families' strengths to stabilize their household through providing tangible services and skills ▪ Working directly with clients and their families to reduce post-treatment relapse factors and risk factors for later drug abuse by children ▪ Motivating and encouraging continuation with the parenting skills training ▪ Further reinforcing, practicing, and generalizing parenting skills to the home environment • Case managers approach these tasks by providing families with a pro-social model, offering them opportunities for involvement in pro-social activities, networking them into needed services, and changing their reward structure through coaching and reinforcement of their new skills. Case managers also work with families to accomplish the family goals established in the initial parent training session.'
Delivery setting	• Outpatient clinic
Dose	'Recommended Intensity: Parents: 1.5 hour sessions, twice a week; Children: 1.5 hour session, approximately once a week Recommended Duration: Parents: One 5-hour session, then 32 sessions (16 weeks); Children: 12 sessions (12 weeks)'
Staffing	'Training in chemical dependency and parenting, Master's level education. Training is obtained: Onsite; travel expenses must be reimbursed Number of days/hours: 3 days at 8 hours per day'
Resources or supporting tools	'The typical resources for implementing the program are: • 1 meeting room

Families Facing the Future	
	• Cost of two full to half-time staff are needed for group work and home visits • Childcare • DVD or VHS player • TV’
Cost information	Information not available
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

4.11. Home Instruction for Parents of Preschool Youngsters (HIPPY)

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
Intervention description	‘*HIPPY* is a home-based and parent-involved school readiness program that helps parents prepare their children ages three to five years old for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books, and materials designed to strengthen their child’s cognitive and early literacy skills, as well as their social, emotional, and physical development. *HIPPY* believes that parents play a critical role in their children’s education. The *HIPPY* program seeks to support parents who may not feel sufficiently confident to prepare their children for school, and is designed to remove barriers to participation in education.’
Population	‘Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents’
Target outcomes	• Child development • Child behaviour

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
Intervention details	• ‘The developmentally appropriate curriculum • Role play as the method of instruction • Staff consisting of coordinators and home visitors • parent engagement through home visits and group meetings • Parent and child educational interactions encouraged through the use of the HIPPY curriculum • Designed to support parents with limited formal education • Scripted curriculum that serves as a lesson plan for parents • Curriculum based on exposure to skills, rather than mastery’
Delivery setting	• Adoptive Home • Birth Family Home • Foster/Kinship Care
Dose	‘Recommended Intensity: Home visitors engage their assigned parents on a weekly basis. Service delivery is primarily through home visits. A home visit consists of a one-hour, one-on-one interaction between the home visitor and their assigned parents. Parents then engage their children in educational activities for five days per week for 30 weeks. At least six times per year, one or more cohorts of parents meet in a group setting with the coordinator and their assigned home visitor(s). Group meetings feature enrichment activities for parents and their children and last approximately two hours. Recommended Duration: A minimum of 30 weeks of interaction with the home visitor; curriculum available for up to three years of home visiting services’
Staffing	‘The home visitors live in the community they serve and work with the same group of parents for three years. They receive weekly comprehensive training to well equip them to serve their assigned families effectively. The training also encourages them to seek further education. Many home visitors earn degrees in early childhood education. Educational requirements are established by the implementing agency and are usually a

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
	high school diploma or GED. Home visitors must be able to read in and speak the language of the families they serve. The coordinator, who trains the home visitors and oversees the local program, is required to have the minimum of a Bachelor's degree.'
Resources or supporting tools	'The typical resources for implementing the program are: • Office space, furniture and basic furnishing, and a computer for administrative functions of program • Supplies for home visitation part that are not always commonly found in a home setting are provided by the program, such as coffee stirrers, sand paper, screws, etc. • Group meetings are held in the program office or community settings, such as a church, school, community center, etc.'
Cost information	No information provided
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	April 2014

4.12. Homebuilders®

Homebuilders®	
Intervention description	'*Homebuilders*® is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the

Homebuilders®	
	physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.'
Population	'Target Population: Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. For children/adolescents ages: 0 – 17 For parents/caregivers of children ages: 0 – 17'
Target outcomes	• Child behavior • Support Networks • Child maltreatment prevention • Child development • Family Functioning • Systems outcomes
Intervention details	• 'Engagement: Use a collaborative and collegial approach to engage and motivate families. • Assessment and Goal Setting: Use client-directed assessment across life domains, ongoing safety assessment and planning, domestic violence assessment, suicide assessment, and crisis planning. • Behavior Change: Use cognitive and behavioral research-based practices and behavioral interventions. • Skills Development: Teach parents and children a wide variety of "life skills." Use "teaching interaction" process including practice, feedback, and homework. • Concrete Services: Provide and/or help the family access concrete goods and services that are directly related to achieving the family's goals, while teaching them to meet these needs on their own. • Community Coordination and Interactions: Coordinate, collaborate, and advocate with state, local, public, and community services and systems affecting the family, while teaching clients to advocate and access support for themselves. • Immediate Response To Referral: Accept referrals 24 hours a day, 7 days a week. Therapist and back-up are available 24-hours a day, 7 days a week.

Homebuilders®	
	• Service Provided in the Natural Environment: Provide services in the families' homes and community. • Caseload Size: Carry caseloads of two families at a time on average, but it can be as high as five. • Flexibility and Responsiveness: Tailor services to each family's needs, strengths, lifestyle, and culture.’
Delivery setting	• Adoptive home • Birth family home
Dose	‘Recommended Intensity: Three to five 2-hour sessions contacts per week; an average of 8 to 10 hours per week of face to face contact, with telephone contact between sessions. Recommended Duration: An average of four to six weeks. Two aftercare 'booster sessions' totalling up to five hours are available in the six months following referral’
Staffing	‘A team of 2-5 therapists, 1 supervisor (carries a partial caseload) and 1 secretary/support staff • Therapist: Master's degree in psychology, social work, counseling, or a related field, or Bachelor's degree in same fields plus two years of experience working with families. • Supervisor: Master's degree in psychology, social work, counseling or a related field, or Bachelor's degree in same fields plus two years of experience providing the program, plus one year supervisory/management experience.’
Resources or supporting tools	• ‘A small amount of staff work/office space, supplies, telephone, copier, etc. • Pagers and /or cell phones • Clinical staff use their own vehicles for home visits, mileage is paid for all client and program related travel • Access to a computer and Internet for client records and data collection’
Cost information	‘*HOMEBUILDERS* site development and implementation readiness consultation (in person or by phone): Varies depending on site needs and travel expenses. • 4-day, on-site *HOMEBUILDERS* Core Curriculum Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $120 per participant for materials.

Homebuilders®	
	• 1-day, on-site Goal Setting and Paperwork Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 2-day, on-site Motivational Interviewing Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $40 per participant for materials. • 1-day, on-site Relapse Prevention Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Utilizing Cognitive Strategies With Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Utilizing Behavioral Principles and Strategies With Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Teaching Skills to Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 2-day, on-site Improving Decision Making Through Critical Thinking Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $25 per participant for materials. • 2- to 5-day, on-site Fundamentals of Supervising HOMEBUILDERS: Intensive Family Preservation Services Training (2-part training): $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $275 per participant for materials. • 2- to 3-day, on-site Program Consultation and Quality Assurance Skills for HOMEBUILDERS Supervisors Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $75 per participant for materials. • 1.5- to 2-day, on-site Online Data Manager Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials.

Homebuilders®	
	• 2-day, on-site Addressing Domestic Violence: Strategies for In-Home Practitioners Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $45 per participant for materials. • 1-day, on-site Ethical Issues in In-Home Services Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 1-day, on-site Self-Advocacy Skills for Families: A Territorial Model of Assertiveness Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $10 per participant for materials. • 1-day, on-site Working With Parents With Cognitive Limitations Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 1-day, on-site Substance Exposed Newborns Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • Phone consultations (held weekly in the first 2 years of implementation, monthly in year 3, and quarterly thereafter): $100 per hour. • 3- to 4-day, on-site visits (2 times per year): $1,250 per day, plus travel expenses. Technical assistance as needed via phone or email: $100 per hour. File and fidelity reviews (2 times per year): $100 per hour. • Access to the Online Data Manager, a Web-based client information and data system that includes assessments, service plans, service summaries, contact logs, referral information, and other quantitative data tools for program fidelity: $4,900 activation fee (year 1 only). $350 monthly fee. $980 annual upgrade fee.' (SAMHSA)
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

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

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
Intervention description	'*MST-CAN* is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. *MST-CAN* clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of 4 families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between CPS and the family. Empirically-based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, Cognitive Behavioral Therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and Reinforcement Based Therapy for adult substance abuse.'
Population	'Target Population: Families who have come to the attention of Child Protective Services within the past 180 days due to the physical abuse and/or neglect of a child in the family between the ages of 6 and 17; where the child is still living with them or is in foster care with the intent of reunifying with the parent(s). Other criteria may apply. For children/adolescents ages: 6 – 17 For parents/caregivers of children ages: 6 – 17'
Target outcomes	• Systems outcomes • Family functioning • Child maltreatment prevention • Child behaviour • Safety and physical wellbeing • Child development
Intervention details	'Clients

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Youth between the ages of 6 and 17. • Youth who have come to the attention of child protective services due to physical abuse and/or neglect and for whom the abuse report was filed within the last 180 days. • Youth who are currently in foster care or another out-of-home placement and will be reuniting with their family. Intervention Context • Services are provided in the family's home or other places convenient to them and at times convenient to the family. • Services are intensive, with intervention sessions being conducted from three times per week to daily. • A 24/7 on-call roster is utilized to provide round-the-clock services for families. • Treatment is provided to multiple children in the family and one or both parents, with a greater emphasis on parent treatment than standard *MST*. Therapists and Supervisors • *MST-CAN* staff work on a clinical team of 3 therapists, a crisis caseworker, a part-time psychiatrist, and a full-time supervisor. • The *MST-CAN* supervisor must have an understanding of the child protective services system, experience with family therapy and cognitive behavioral therapy for posttraumatic stress disorder (PTSD)/trauma. The supervisor must have experience in managing severe family crises that involve safety risk to the children or entire family. The supervisor must also have a thorough understanding of state mandated abuse reporting laws. The supervisor must have a PhD or Master's degree in counseling, social work, or a related field. • Supervisors must be full-time and may supervise a single team only. • The *MST-CAN* therapist must have a Master's degree in counseling, social work, or a related field. • The *MST-CAN* Team must have access to an appropriate percentage of a psychiatrist's time that has been trained in the *MST* and *MST-CAN* treatment models. This psychiatrist must be integrated into the clinical team and should be able to serve adults and children.

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• The *MST-CAN* team must include one full-time crisis caseworker. This staff member should be at least a Bachelors-prepared professional. Application of the Intervention • Interventions are developed along an analytical model that guides the therapist to assess factors that are driving clinical problems and then interventions are applied to the driving factors or "fit factors." • All interventions are those that are evidence-based or evidence-informed. • Each therapist carries a maximum caseload of 4 families and case length is 6-9 months. Program Fidelity and Quality Assurance • Each team member completes a 5-day *MST* orientation training, a 4-day *MST-CAN* training, and 4 days of training in adult and child trauma treatment. • Weekly on-site group supervision. • Weekly telephone consultation with an *MST-CAN* expert. • Quarterly on-site booster trainings conducted by the *MST-CAN* expert. • Measurement of model adherence through monthly phone interviews with the parent or caregiver. Program Monitoring and Use of Data • Agencies collect data as specified by MST Services and all data are sent to the MST Institute (MSTI) which is charged with keeping the national database system. • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the MST model. • There must be a formal Memorandum of Agreement (MOA) in place regarding access to abuse and placement data prior to implementation'
Delivery setting	'This program is typically conducted in a(n):

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Adoptive Home • Birth Family Home • Foster/Kinship Care • School’
Dose	‘Recommended Intensity: Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation of a specific number of contact hours, as staff contact waxes and wanes according to the needs of the families. Session length depends on the needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving). Recommended Duration: Treatment length ranges from 6-9 months.’
Staffing	‘*MST-CAN* Supervisor: • Must be assigned to *MST-CAN* 100%. • Must have a Master's degree in counseling, social work, or a related field. • Must be independently licensed. • May only supervise a single team. • May not carry their own caseload. • Must 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. • Should have experience implementing Standard MST or *MST-CAN*. • Should have knowledge and experience in the *MST-CAN* Supervision Model. • Should have experience with family therapy and Cognitive-Behavioral Therapy (CBT) for Post-traumatic Stress Disorder (PTSD).

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	MST-CAN Therapist: • Must be assigned to a single *MST-CAN* team 100%. • Must have a Master's degree in counseling, social work, or a related field. • Should have a background in child development. • Should have an understanding of family violence. • Should have skills in engaging families reluctant to participate. • Should have experience in crisis intervention where homicidal or suicidal risk is present. • Should have knowledge of the child welfare system. *MST-CAN* Crisis Caseworker: • Must be assigned to a single *MST-CAN* team 100%. • Must have a minimum of a Bachelor's degree. • Should have knowledge, of interventions related to practical life skills such as employment seeking, budgeting, and housing. • Should have experience in the child welfare system. • Should have knowledge of child development. *MST-CAN* Psychiatrist: • Must be available to team at least 8 hours per week. • MD or DO, board certification eligibility in Child and Adolescent Psychiatry. • Must be trained in the *MST* treatment model and the *MST-CAN* adaptations by MST, Inc. • Must have a thorough understanding of state and national mandated abuse reporting laws. • Should have a thorough understanding of existing ethical guidelines and laws concerning clinical situations that may occur in crisis treatment (i.e., restraints, commitments, reporting abuse or neglect).

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Should have experience with both child and adult populations. • Should have experience in trauma treatment for youth and adults. • Should have experience working in local organizations and systems.' 'Training is obtained: Training is only available to staff who will be implementing *MST-CAN* in a licensed program. With regard to the initial 5-day *MST* orientation, organizations can access the training in one of two ways. New staff can come to Charleston, SC and participate in one of the quarterly open-enrolment trainings provided by MST Services Inc. Alternatively, providers can elect to have MST Services Inc. conduct an additional 5-day initial training at their site. *MST-CAN* training and the 4-day trauma training are provided on site by *MST-CAN* experts at this time. After start-up, training continues through weekly telephone *MST-CAN* consultation and on-site quarterly booster trainings for each team of *MST-CAN* clinicians. Number of days/hours: All trainees complete the Standard MST 5-day orientation. Then each team member completes a 4-day *MST-CAN* specific training and 4 days of training in adult and child trauma treatment. All training is open to CPS caseworkers who will be working with the *MST-CAN* team. After start-up, training continues through weekly telephone *MST-CAN* consultation for each team of *MST-CAN* clinicians aimed at monitoring treatment fidelity and adherence to the *MST-CAN* treatment model, and through quarterly on-site booster trainings (1 1/2 days each). Trained *MST-CAN* experts will teach the *MST-CAN* supervisor to implement a manualized *MST* supervisory protocol and collaborate with the supervisor to promote the ongoing clinical development of all team members. The *MST-CAN* expert will also assist at the organizational level as well as needed.'
Resources or supporting tools	'The typical resources for implementing the program are: Office space to house the team and conduct consultation and supervision is required as well as laptops and mobile phones for all staff.'
Cost information	Information not available
PRC rating	Emerging
Primary source	CEBC

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
Date last reviewed	September 2013

4.14. Parent Training Prevention Model (not the name of an intervention; description only)

Parent Training Prevention Model (not the name of an intervention; description only)	
Intervention description	'This parent training program is for children aged 18 months to 4 years of age who are at risk of maltreatment and have parents who have a low SES status or who are disadvantaged. The main focus of the program content is on child behaviour management, such as positive parenting techniques including child-let play, distraction, "catching child being good" and effective compliance strategies, as well as the use of time out for managing difficult child behaviour. Problem solving, time management and anger management skills are also included, as well as child health and safety content.'
Population	'Children aged 18 months to 4 years of age who are at risk of maltreatment and have parents who have a low SES status or who are disadvantaged'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning
Intervention details	'The program is delivered in a non-didactic format in which there is continuous interaction between group members and group facilitator. Written materials are provided that outline the group curriculum. Group sessions start with one or more women sharing a positive experience with their child that happened over the week. There is also a review of previous week's curriculum. During sessions, Socratic dialogue is used, as well as role-play, modelling and homework tasks. Barriers to the use of the curriculum are discussed.' 'The main focus of the program content is on child behaviour management, such as positive parenting techniques including child-let play, distraction, "catching child being good" and effective compliance strategies, as well as the use of time out for managing difficult child behaviour. Problem solving, time management and anger management skills are also included, as well as child health and safety content.'

Parent Training Prevention Model (not the name of an intervention; description only)	
	Components identified by PRC (Macvean *et. al.*, 2013) Delivery level : individual Delivery: • Structured sessions • Written material • Discussion • Modelling • Role-play • Sharing stories of positive interactions with child • Review the course curriculum • Socratic dialogue Content: • Problem solving skills • Child behaviour and behaviour management • Child health and development • Time out • Home, environment and child safety • Parent time management • Emotional regulation • Positive parenting

Parent Training Prevention Model (not the name of an intervention; description only)	
Delivery setting	15 weekly home based sessions for individuals. Groups.
Dose	'Professionals deliver the program in 15 weekly sessions to individual parents, plus there are sessions for groups of parents.'
Staffing	Delivered by a professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.15. Parents Under Pressure (PUP)

Parents Under Pressure (PUP)	
Intervention description	'The overarching aim of the *PuP* program is to help parents facing adversity develop positive and secure relationships with their children. Within this strength-based approach, the family environment becomes more nurturing and less conflictual and child behavior problems can be managed in a calm non punitive manner. Program aims: Strengthen the parent's view that they are competent in the parenting role Help parents develop skills in coping with negative emotional states through use of mindfulness skills Positive parenting skills including praise, rewards for good behaviour, and child-centred play skills Non-punitive child management techniques such as time-out Coping with lapse and relapse (to use of alcohol and drugs)

Parents Under Pressure (PUP)	
	Extending social networks Life skills: practical advice on diet and nutrition, budgeting, health care and exercise Relationships (effective communication between partners)'
Population	Families of children aged 2 – 8 years who are at risk of child abuse and neglect due to problems such as parental mental illness, substance misuse, family conflict and severe financial stress. 'Parents of children aged 2-8 years with substance abuse issues'
Target outcomes	• Child behaviour • Safety and physical wellbeing • Family functioning • Support networks • Child maltreatment Prevention
Intervention details	• 'Begins with assessment and individualised case planning in collaboration with parents • Additional case management can occur outside treatment session (e.g., housing, legal advice, school intervention) • 10 modules • Strengthen the parent's view that they are competent in parenting role • Help parents develop skills in coping with negative emotional states through use of mindfulness skills • Positive parenting skills including praise, rewards for good behaviour, and child-centred play skills • Non-punitive child management techniques such as time out • Coping with lapse and relapse (to use of alcohol and drugs) • Extending social networks • Life skills: practical advice re -diet and nutrition, budgeting, health care and exercise • Relationships (effective communication between partners)' (appendix 6, p.53).

Parents Under Pressure (PUP)	
	Components identified by PRC (Macvean et. al. 2013) Delivery level: Individual Delivery: • Assessment • Individual plan • Structured sessions Content: • Descriptive for child behaviour/descriptive/labelled praise for child • Praise for desired child behaviour • Use of reinforcement/rewards for child/behaviour charts • Planning ahead for high risk situations/crisis management • Emotional regulation • Positive parenting • Non-punitive parenting • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships • Positive adult relationships • Mindfulness
Delivery setting	Home
Dose	10 sessions over 10 – 12 weeks

Parents Under Pressure (PUP)	
Staffing	'In order to use the *PuP* program in clinical settings, a clinician is required to have training and clinical supervision in the *PuP* model. This will lead to accreditation as a *PUP* therapist. Formal qualifications are not required in order to become a *PuP* therapist.'
Resources or supporting tools	No information provided
Cost information	'The cost of the training and clinical supervision is $3,000 per clinician (excluding travel) where clinical supervision is conducted in pairs and includes a combination of telephone and face-to-face clinical supervision.'
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.16. Project Support

Project Support	
Intervention description	'Project support targets children aged 3–8 years who are at risk of or exposed to child abuse, neglect or domestic/family violence. It aims to reduce child conduct problems among families departing from domestic violence shelters.' P. 35.
Population	'Children aged 3–8 years who are at risk of or exposed to child abuse, neglect or domestic/family violence.'
Target outcomes	• Child behaviour • Child maltreatment prevention • Family functioning • Systems Outcomes

Project Support	
Intervention details	'Designed to decrease coercive patterns of aggressive discipline & increase positive parenting, by: 1. teaching mother's child management skills; 2. Providing instrumental & emotional support to mothers. A very intensive, hands-on approach.' (appendix 2, p. 22) Draws on CBT and attachment/relational theory as a theoretical paradigm.
Delivery setting	Delivered in the home
Dose	'Sessions are between one and one-and-a-half hours in duration and last for up to eight months.' P. 35.
Staffing	Unclear
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013)
Date last reviewed	2013

5. References

Australian Centre for Posttraumatic Mental Health and Parenting Research Centre. (2013). *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications. Report prepared for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs*. Australian Centre for Posttraumatic Mental Health and Parenting Research Centre: Authors.

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NSW GOVERNMENT Family & Community Services

Review of the evidence for intensive family service models

Appendix 1: Additional information regarding methodology and findings

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.

Report commissioned by the NSW Government Department of Family and Community Services

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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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Contents

1. Clearinghouse searches

As indicated in the report, four international clearinghouses were searched for relevant interventions. The majority of the interventions were sourced through California Evidence-Based Clearinghouse (CEBC), a comprehensive clearinghouse that is updated regularly. If an intervention had already been identified through CEBC, it was not assessed via the other clearinghouses unless they provided more up to date analyses.

1.1. California Evidence-Based Clearinghouse (CEBC)

CEBC includes a large number of interventions relevant to child and family welfare. To narrow down the scope, all interventions listed under the following topics were screened for inclusion:

- behavioural management programs for adolescents in child welfare
- child welfare initiatives
- disruptive behaviour treatment
- domestic/Intimate partner violence: batterer intervention programs
- domestic/intimate partner violence: services for victims and their children
- educational interventions for children and adolescents in child welfare
- family stabilisation
- higher levels of placement
- home visiting programs for child well-being
- home visiting programs for prevention of child abuse and neglect
- infant and toddler mental health programs (Birth to 3)
- interventions for neglect
- parent partner programs for families involved in the child welfare system
- parent training programs
- permanency enhancement interventions for adolescents
- placement stabilisation programs
- post-permanency services
- prevention of child abuse and neglect (secondary) programs
- programs for working with parents with cognitive disabilities
- programs for reducing racial disparity and disproportionality in child welfare
- reunification programs
- substance abuse treatment (adolescent)
- substance abuse treatment (adult)

- teen pregnancy services
- trauma treatment (child and adolescent)
- treatment of sexual behaviour problems in adolescents
- treatment of sexual behaviour problems in children
- youth transitioning into adulthood programs

1.2. National Center for Community-Based Child Abuse Prevention

National Center for Community-Based Child Abuse Prevention (CBCAP) published a directory in which a range of interventions relevant to this review were rated. All interventions in this document were screened for inclusion in the review (http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory).

1.3. Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices

Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices (SAMHSA) was searched by selecting the advanced search option, then selecting all of the age boxes for infants, children and adolescents. This resulted in 211 interventions, all of which were screened for inclusion.

1.4. Blueprints for Violence Prevention

Blueprints for Violence Prevention (Blueprints) has a list of programs that they consider to be Model or Promising programs (n = 55). All 55 interventions were screened for inclusion.

2. Top-up searches

2.1. Targeted searches for specific interventions

The gap analysis found that eight interventions had not received updated searches or ratings since 2011 or earlier. Year limits were imposed on the searches based on the year each intervention was last evaluated on the clearinghouse:

- 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 (TKC) (2010 onwards)
- Coping and Support Training (CAST) (2007 onwards)
- Be Proud! Be Responsible! (2007 onwards)

Searches were conducted to identify new randomised controlled trials (RCTs) of these interventions using the following databases: PsycINFO, MEDLINE, Embase Classic and Embase, and Social Work Abstracts. Searches were restricted to the English language. A separate search was conducted using each intervention name, in conjunction with search terms that assist in the identification of rigorous designs such as RCTs:

(RCT or randomi* or randomised controlled trial or randomized controlled trial or random* assign* or random* allocate* or random* group* or experimental design or experimental study or quasi-experimental or quasi experimental)

Targeted searches for three interventions (CAST, MST-Psychiatric, TKC) identified no results. There were no new studies to add to the weight of the evidence for these interventions. The current evidence for CAST and TKC is unknown. While MST, MST-PSB and MST-CAN remain in use and have been regularly updated on CEBC, MST-Psychiatric has not been separately evaluated on CEBC and rating updates occur less frequently on SAMHSA (in this case 2010). The current evidence for this intervention is not known.

Eight RCTs were identified that could be used to assess the evidence for the remaining five interventions. The analysis of the new evidence for DARE to be You (Rattenborg, 2010), ParentCORPS (Brotman et al., 2013), Project Success (Clark, Ringwalt, Shamblen, & Hanley, 2011; Clark et al., 2010) and Be Proud! Be Responsible! (Borawski et al., 2009) found support for the effectiveness of these interventions and no evidence of harm. These four interventions were already rated Supported, and as a suitable systematic review had not been identified to increase the ratings to Well Supported, their current ratings remain.

The other three RCTs identified assessed the effectiveness of Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk), currently rated Emerging. One study was not relevant as the population was parents with cancer

(Niemela, Repo, Wahlberg, Hakko, & Rasanen, 2012). One study found no improvements for Family Talk Participants (Punamaki, Paavonen, Toikka, & Solantaus, 2013) and one found improvements for the Family Talk group and the comparison group, although the improvements were observed faster in the Family Talk group (Solantaus, Paavonen, Toikka, & Punamaki, 2010). Although no harm was observed, the findings of these studies cannot be used to add further support to the Family Talk intervention. The results of these RCTs are not strong enough to suggest that the intervention fails to demonstrate effect, but rather that the rating must remain at Emerging for the time being.

2.2. Screening of documents received from FACS

Unfortunately, only one RCT was identified among three evaluations recommended by FACS, and four from the intensive services literature search provided. While some of these interventions may have benefits for families, the study designs were insufficiently rigorous to make clear determinations and so they were not included in the review. Brief details of sources and interventions are provided in the following sections.

2.2.1. Domestic violence perpetrator programs: Steps towards change

FACS provided the final report of Project Mirabal as a potential source of interventions for inclusion (Kelly & Westmarland, 2015). The evaluation reported here, while detailed and of some relevance to the review, was a matched comparison study rather than an RCT.

2.2.2. Community Services Intensive Family Support and Intensive Family Preservation Final Evaluation Report

This evaluation (NSW Department of Family and Community Services [DoCS], 2013) reports quantitative and qualitative data from a pilot of IFS/IFP services delivered by sub-contracting NGOs across NSW from 1 July 2011 to 31 March 2013. The evaluation adds new measures to those previously available for the Homebuilders® model on which IFS/IFP is based; however, due to the constraints of service provision the pilot was evaluated using a quasi-experimental research design using eligibility criteria to generate a matched control, rather than an RCT.

2.2.3. Keep Them Safe outcomes evaluation

We identified three interventions of interest in the literature review appendix for this evaluation (Katz & Smyth, 2014). They were Scotland's Child Protection Reform Programme/Getting it Right for Every Child; the North Carolina Multiple Response System, and the Ohio Alternative Response Pilot Project.

Of these, only the Ohio Alternative Response Pilot Project used an RCT design. However, this project involved assigning families to either traditional CPS investigation, or to an alternative response which avoids identification of victim and perpetrator and determining fault. Other than diversion to a non-adversarial approach, it is not clear how the services accessed by families differ systematically from the control group. In any case, this alternative pathway assignment is more of a process than an intervention in itself and was therefore not suitable for inclusion in this review.

2.2.4. Intensive services literature search

Of the 69 studies identified in the intensive services literature search provided by FACS (NSW Department of Family and Community Services [DoCS], undated), four were RCTs. Three pertained to interventions already included in the review and one was about a relatively new intervention.

Jordan, Tseng, Coombs, Kennedy, and Borland (2014) reports the intervention details and evaluation plan for an RCT of The Early Years Education Plan (EYEP) currently underway in Melbourne. Findings are not reported as the study is ongoing, with recruitment commencing in 2011 and expected to conclude in 2015. The intervention is for children aged three years old who are at risk of maltreatment and are referred by child serving agencies. The intervention extends for three years, until school entry. There is a follow-up assessment six months after school entry, as well as assessment periods during the course of the intervention. The evaluation will assess changes in child health and development, academic achievement and ability, emotional and behavioural regulation, and parenting. The findings of this study may be of interest to FACS.

The remaining three RCTs reporting further evidence for ABC (Lind, Bernard, Ross, & Dozier, 2014) and Healthy Families (Cluxton-Keller et al., 2014; Green, Tarte, Harrison, Nygren, & Sanders, 2014). The findings of these RCTs are positive and add support to the evidence for these interventions. There are no indications of harm. As these interventions are already rated Supported and no suitable systematic reviews have been identified to elevate them to Well Supported, the ratings of Supported remain.

2.3. Search for studies evaluating interventions for parenting with intellectual disabilities

Since the searches for high quality Cochrane systematic review conducted by Coren, Hutchfield, Thomae, and Gustafsson (2010) were performed in 2009 an updated search for RCTs evaluating the effectiveness interventions for parents with intellectual disabilities has been carried out. A search was conducted for English language studies published from 2009 using the same databases and study design search terms identified above, in conjunction with the following search terms:

((intellectual* adj3 (disabilit* or disabl* or difficult* or impair* or retard* or deficien* or challenge* or handicap* or disorder* or disadvantage* or devian*)) adj3 (parent* or mother* or father*))

OR

((learning adj3 (special or disabilit* or disabl* or difficult* or impair* or retard* or deficien* or challenge* or problem* or handicap* or disorder* or disadvantage* or devian*)) adj3 (parent* or mother* or father*))

OR

((cognit* adj3 (disabilit* or disabl* or difficult* or impair* or retard* or deficien* or challenge* or handicap* or disorder* or disadvantage* or devian*)) adj3 (parent* or mother* or father*))

OR

((mental* adj3 (disabilit* or disabl* or difficult* or impair* or retard* or deficien* or challenge* or handicap* or disorder* or disadvantage* or devian*)) adj3 (parent* or mother* or father*))

Findings of the additional search efforts for interventions involving parents with an intellectual disability appear in the report.

3. Drawing on the work of high quality systematic reviews for rating interventions

Systematic reviews remain the gold standard for evaluating the effectiveness of interventions. The work of high quality systematic reviews was drawn on in order to rate interventions at the highest level; to distinguish the Well Supported interventions from the Supported interventions. Systematic reviews relevant to this review were sought from:

- The Cochrane Collaboration Library (http://www.cochrane.org)
- The Campbell Collaboration Library (http://www.campbellcollaboration.org)
- Child Family Community Australian (CFCA) Information Exchange (https://www3.aifs.gov.au/cfca/)
- Australian Institute of Health and Welfare (AIHW) (http://www.cochrane.org)
- Child Welfare Information Gateway (https://www.childwelfare.gov/)
- Australia's National Research Organisation for Women's Safety Resource Database http://resourcesdb.anrows.org.au/ais/AccessItLibrary;jsessionid=338h1oivq9h42
- Closing the Gap Clearinghouse (http://www.aihw.gov.au/closingthegap/)

The Cochrane Collaboration and Campbell Collaboration Libraries were searched for systematic reviews on these topics:

- Parental substance abuse
- Parental mental health
- Domestic violence
- Family violence
- Intimate partner violence
- Maltreatment
- Abuse
- Neglect
- Trauma
- Low income or socio-economic status (SES) parents
- Youth substance abuse
- Teenage parenting
- Youth self-harm and suicide
- Youth delinquency, offending, juvenile justice and criminal behaviour
- Youth mental illness

- Youth mental illness
- Placement prevention
- Family preservation

Child Family Community Australian (CFCA) Information Exchange, which combines three AIFS clearinghouses: National Child Protection Clearinghouse, Australian Family Relationships Clearinghouse, and Communities and Families Clearinghouse Australia, was searched for by entering the search terms 'systematic review' and 'meta-analysis' into the search box.

Australian Institute of Health and Welfare (AIHW) publications listing was searched under the following headings:

- adoptions
- alcohol and other drugs
- child health, development and wellbeing
- child protection
- children's services
- homelessness
- mental health
- youth health and wellbeing
- youth justice

Entering the term 'systematic review' into the search box on Child Welfare Information Gateway resulted in 154 papers. All were screened to identify relevant systematic reviews.

ANROWS Resources Database has taken on the former Australian Domestic and Family Violence Clearinghouse. The term 'systematic review' was entered into the search box, yielding 23 results. All were screened for relevant systematic reviews.

The term 'systematic review' was entered into the search box on the Closing the Gap Clearinghouse. All 75 results were screened.

In addition, the names of interventions rated Supported, along with the term 'systematic review', were searched via Google Scholar.

The combined search strategies resulted in 36 reviews relevant to the current review. These reviews were assessed for quality. Reviews meeting the following criteria were considered:

- They addressed a clearly defined question;
- There was an *a priori* search strategy and clearly defined inclusion and exclusion criteria;
- They searched a minimum of three databases;
- Grey (unpublished) literature was specifically searched for; and
- There was more than one rater for extraction of study information.

All systematic reviews meeting the above criteria were also checked to determine if they included meta-analyses. The 36 reviews are listed in Table ones, along with an indication of those meeting the criteria.

Table 1: Assessment of the quality of reviews related to child and family vulnerabilities

Review	Systematic criteria met and involved meta-analysis
Adler-Tapia, R., & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in Iidividual psychotherapy: A aeview of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research*, 3(4), 232-247. doi: 10.1891/1933-3196.3.4.232	No
Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & Van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, 34, 1472-1479	Yes
Austin, A. M. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice*, 15(2), 67-83. doi: 10.1177/1049731504271606	No
Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect (Review). Cochrane Database of Systematic Reviews(3). doi: 10.1002/14651858.CD005463.pub2	No
Barlow, J., Smailagic, N., Bennett, C., Huband, N., Jones, H., & Coren, E. (2011). Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children. Cochrane Database of Systematic Reviews(3). doi: 10.1002/14651858.CD002964.pub2	Yes
Bayer, J., Hiscock, H., Scalzo, K., Mathers, M., McDonald, M., Morris, A., . . . Wake, M. (2009). Systematic review of preventive interventions for children's mental health: what would work in Australian contexts? *Australian and New Zealand Journal of Psychiatry*, 43(8), 695-710. doi: 10.1080/00048670903001893	No
Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review*, 34, 748-757.	Yes
Coren, E., Hutchfield, K., Thomae, M., & Gustafsson, C. (2010). Parent training support for intellectually disabled parents (Review). Cochrane Database of Systematic Reviews(6). doi: 10.1002/14651858.CD007987.pub2	No
Davis, M. K., & Gidycz, C. A. (2000). Child sexual abuse prevention programs: A Meta-Analysis. *Journal of Clinical Child Psychology*, 29(2), 257-265.	Yes

Davis, R. C., Weisburd, D., & Taylor, B. (2008). Effects of second responder programs on repeat incidents of family abuse. Campbell Systematic Reviews. doi: 10.4073/csr.2008.15	Yes
Engle, B., & Macgowan, M. J. (2009). A critical review of adolescent substance abuse group treatments. *Journal of Evidence Based Social Work*, 6(3), 217-243. doi: 10.1080/15433710802686971	No
Field, A., & Cottrell, D. (2011). Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: a systematic review of the evidence for family therapists. *Journal of Family Therapy*, 33(4), 374-388. doi: 10.1111/j.1467-6427.2011.00548.x	No
Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents (Review). Cochrane Database of Systematic Reviews(12). doi: 10.1002/14651858.CD006726.pub2.	Yes
Goesling, B., Colman, S., Trenholm, C., Terzian, M., Moore, K. (2013). ASPE Report: Programs to reduce teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors: A systematic review. USA: Department of Health and Human Services. http://aspe.hhs.gov/hsp/13/Reduce-TeenPregnancy/rpt_tppevidence.cfm	No
Gray, E., & Halpern, R. (1989). Early Parenting Intervention to Prevent Child Abuse: A Meta-Analysis: National Council of Jewish Women Center for the Child.	Yes
Hopfer, S., Davis, D., Kam, J. A., Shin, Y., Elek, E., & Hecht, M. L. (2010). A Review of Elementary School-Based Substance Use Prevention Programs: Identifying Program Attributes. *Journal of Drug Education*, 40(1), 11-36. doi: 10.2190/DE.40.1.b.	No
Johnson, M. A., Stone, S., Lou, C., Ling, J., Claassen, J., & Austin, M. J. (2006). Assessing Parent Education Programs for Families Involved with Child Welfare Services: Evidence and Implications: Bay Area Social Services Consortium and the Zellerbach Family Foundation.	No
Lawrence, C. N., Rosanbalm, K. D., & Dodge, K. A. (2011). Multiple Response System: Evaluation of Policy Change in North Carolina's Child Welfare System. *Children and Youth Services Review*, 33(11). doi: 10.1016/j.childyouth.2011.08.007.	No
Littell, J. H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services Review*, 27(4), 445-463. doi: 10.1016/j.childyouth.2004.11.009.	Yes
Macdonald, G., Higgins, J. P. T., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P., . . . Taylor, M. (2012). Cognitive-behavioural interventions for children who have been sexually abused (Review). Cochrane Database of Systematic Reviews(5). doi: 10.1002/14651858.CD001930.pub3.	Yes
MacLeod, J., & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta analytic review. *Child Abuse and Neglect*, 24(9), 1127-1149.	Yes

McCloskey, L. A. (2011). A systematic review of parenting interventions to prevent child abuse tested with RCT designs in high income countries: South African Medical Research Council.	No
Menting, A. T., Orobio de Castro, B., & Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: a meta-analytic review. *Clinical Psychology Review*, 33(8), 901-913. doi: 10.1016/j.cpr.2013.07.006.	No
Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, 87, 353-361.	No
Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J., Smith, A., & Liu, J. (2010). Maternal substance use and integrated treatment programs for women with substance abuse issues and their children: a meta-analysis. *Substance Abuse Treatment, Prevention, and Policy,* 5(21).	Yes
Niccols, A., Milligan, K., Smith, A., Sword, W., Thabane, L., & Henderson, J. (2012). Integrated programs for mothers with substance abuse issues and their children: A systematic review of studies reporting on child outcomes. *Child Abuse and Neglect*, 36, 308-322.	No
Parker, B., & Turner, W. (2013). Psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. Cochrane Database of Systematic Reviews(7). doi: 10.1002/14651858.CD008162.pub2.	Yes
Petrie, J., Bunn, F., & Byrne, G. (2007). Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review. *Health Education Research*, 22(2), 177-191. doi: 10.1093/her/cyl061	No
Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psycholollgy Review*, 30(6), 635-641. doi: 10.1016/j.cpr.2010.04.007	No
Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M., & Stams, G. J. (2009). Efficacy of EMDR in children: a meta-analysis. *Clinical Psychology Review*, 29(7), 599-606. doi: 10.1016/j.cpr.2009.06.008	No
Thomas, R., & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: a review and meta-analysis. *Journal of Abnormal Child Psychology*, 35(3), 475-495. doi: 10.1007/s10802-007-9104-9	No
Trask, E. V., Walsh, K., & DiLillo, D. (2011). Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *Aggression and Violent Behaviour*, 16, 6-19.	Yes
Underhill, K., Operario, D., & Montgomery, P. (2007). Systematic review of abstinence-plus HIV prevention programs in high-income countries. PLoS Med, 4(9), e275. doi: 10.1371/journal.pmed.0040275	Yes
van der Stouwe, T., Asscher, J. J., Stams, G. J., Dekovic, M., & van der Laan, P. H. (2014). The effectiveness of Multisystemic Therapy (MST): a	No

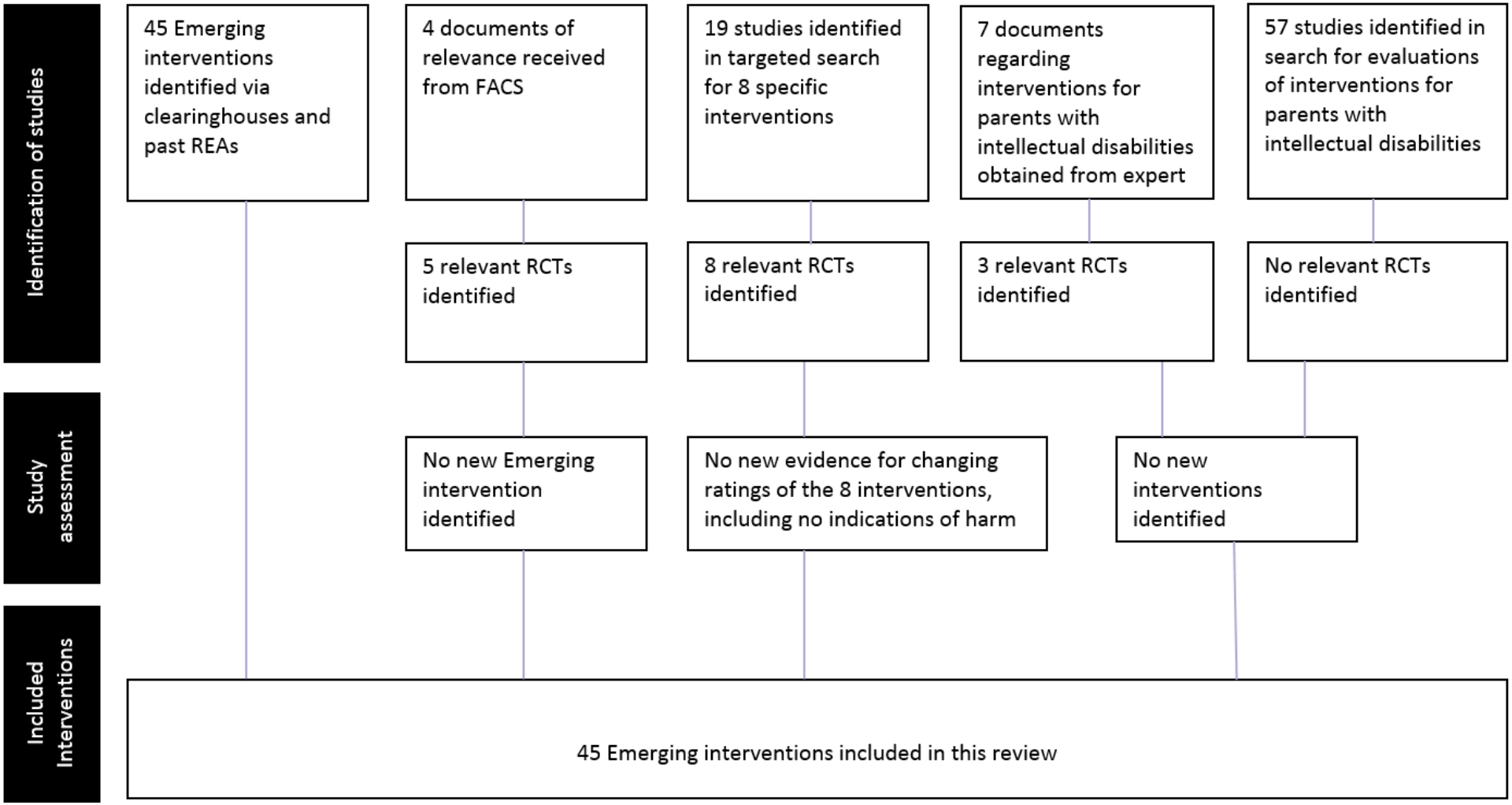
meta-analysis. Clin Psychol Rev, 34(6), 468-481. doi: 10.1016/j.cpr.2014.06.006	
Wethington, H. R., Hahn, R. A., Fuqua-Whitley, D. S., Sipe, T. A., Crosby, A. E., Johnson, R. L., . . . Task Force on Community Preventive Services. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: A systematic review. *American Journal of Preventive Medicine*, 35(3), 287-313.	Yes
Woolfenden S, Williams K J, & J, P. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. Cochrane Database of Systematic Reviews(2). doi: DOI:10.1002/14651858.CD003015.	Yes

Of the 36 relevant reviews, 15 were considered high quality systematic reviews with meta-analyses. These reviews were then read to see if any of the interventions rated Supported were included in a meta-analysis. This process enabled the rating of Well Supported interventions, as defined in the rating scale presented in the report. Only interventions found to be effective in a meta-analysis in a high quality systematic review were upgraded from Supported to Well Supported.

One of the interventions included in this review, Nurse Family Partnership (NFP), had previously been assessed against these stringent criteria in an earlier REA by the PRC (NZ review). One further intervention, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), was upgraded from Supported to Well Supported based on the supporting evidence for this intervention found in a high quality systematic review.

4. Flow of interventions through the review process

Figure 1. Flow chart of interventions through the selection process in this review



5. List of interventions rated Pending

Ninety-one interventions were rated Pending in this review. Some of these were taken from previous REAs and some intervention names were not stated in the studies from upon which ratings were based.

1. Across Ages
2. Adolescent prenatal home-visited group (description not name)
3. Aggressors, Victims, and Bystanders: Thinking and Acting To Prevent Violence
4. Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
5. Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children with PTSD
6. Child and Family Traumatic Stress Intervention (CFTSI)
7. Child and Youth Program
8. Child Parent Enrichment Project (CPEP)
9. Child Protection Services and Family Preservation Services
10. Circle of Security-Home Visiting-4 (COS-HV4)
11. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
12. Cognitive Behavioral Therapy
13. Combined Parent-Child Cognitive Behavioural Therapy (CPC-CBT)
14. Comforting and interaction techniques (description not name)
15. Community health nurse prenatal home visits (description not name)
16. COPE intervention
17. Curriculum-Based Support Group (CBSG) Program
18. Domestic Abuse Intervention Project - The Duluth Model (DAIP)
19. Early Head Start
20. Early home visiting based on Family Partnership Model
21. Early Intervention Program (EIP) delivered by Public Health Nurses (PHN) (description not name)
22. Enhanced Healthy Start
23. Exchange Parent Aide
24. Eye Movement Desensitization and Reprocessing for Children and Adolescents (EMDR)
25. Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach)
26. Families First
27. Family Assessment Response (FAR)
28. Family Group Decision Making (FGDM)

29. Family Intervention for Suicide Prevention (FISP)
30. Family Spirit
31. Group parent training with individualised home-based training (description not name)
32. Healthy and Safe (also known as Home Learning Program)
33. Helping the Noncompliant Child
34. Hip-Hop 2 Prevent Substance Abuse and HIV (H2P)
35. Home intervention for drug-abusing mothers, based on the Infant Health and Development Program (IHDP) (description not name)
36. Home visits (description not name)
37. Home visits for prenatal prevention for out-of-home-placement (description not name)
38. Home visits, play groups and parent groups (description not name)
39. Home-based parent training (description not name)
40. Infant-Parent Psychotherapy (IPP)
41. Infant–parent psychotherapy (IPP), Psychoeducational parenting intervention (PPI)
42. In-hospital and after-care services by trained student nurses (description not name)
43. Kids Club & Moms Empowerment
44. Kids FAST – Families and Schools Together
45. Legacy for Children
46. Maltreatment prevention home visits by interdisciplinary team (description not name)
47. Mellow Babies
48. Miller Early Childhood Sustained Home Visiting (MECSH)
49. Mother and Toddlers Program
50. MOtherS Advocates in the Community (MOSAIC)
51. Motivation Adaptive Skills Trauma Resolution (MASTR)
52. My Baby and Me
53. Parent and newborn rooming-in postpartum (description not name)
54. Parent mentoring based on the Touchpoints approach (description not name)
55. Parent-Child Activities Interview
56. Parent-Child Assistance Program (PCAP)
57. Parenting Fundamentals
58. Parenting Wisely
59. Parents as Teachers

60. Partners with Families and Children: Spokane
61. Period of PURPLE Crying
62. Prenatal and paediatric health services program (description not name)
63. Preschool PTSD Treatment (PPT)
64. Preschooler-parent psychotherapy (PPP), Psychoeducational home visitation (PHV)
65. Sanctuary Model
66. Seeking Safety for Adolescents
67. Short-term Attachment Based Intervention
68. SOS Signs of Suicide
69. SOS! Help for Parents
70. STAR Parenting Program
71. Step-by-Step Parenting Program
72. Storytelling for Empowerment
73. Structured Sensory Intervention for Traumatized Children, Adolescents and Parents SITCAP-ART
74. Students Taking A Right Stand (STARS) Nashville Student Assistance Program
75. Support for Students Exposed to Trauma
76. Supports to Access Rural Services (STARS)
77. The Parent-Child Home Program
78. The Pride in Parenting Program
79. The Seattle Model of Paraprofessional Advocacy
80. The Teaching-Family Model (TFM)
81. Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET)
82. Trauma Focused ARC (attachment, self-regulation & competency) Intervention Model
83. Trauma Focused Art Therapy Intervention
84. Trauma Intervention Program for Adjudicated and At-Risk Youth (SITCAP-ART)
85. Traumatic Incident Reduction
86. Triple P - US Triple P System Population Trial
87. Vicarious Sensitization (VS)
88. Webster-Stratton Parenting Program (an early iteration of Incredible Years)
89. “What Do I Say Now?”
90. Wraparound
91. Young Parenthood Program (YPP)

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