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BETA VERSION FOR TESTING & FEEDBACK

Supporting healthy relationships among parents with mental health difficulties

November 2022

Dr James Mulcahy, Dr Virginia Ghiara, Simran Motiani, Dr Anna Greenburgh, and Ben Lewing

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We are grateful for expert input from focus group participants and EIF expert group members.

Beta version for testing & feedback

This beta version of our evidence guide on supporting healthy relationships among parents with mental health difficulties will be tested and adapted through our work with local areas.

We would welcome any feedback on the content or structure of the guide – let us know what you think by emailing info@eif.org.uk.

EARLY INTERVENTION FOUNDATION

Evidence Quarter, Albany House, Petty France, Westminster, London SW1H 9EA
W: www.EIF.org.uk | E: info@eif.org.uk | T: @TheEIFoundation | P : +44 (0)20 3542 2481

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INTRODUCTION

Definitions

Mental health

The term mental health is broad but can be defined as a 'state of complete physical, mental, and social well-being and not merely the absence of disease or injury'.[S1,1] Mental health is determined by multiple biological, psychological, social, cultural and environmental factors that interact in complex ways.[S2] These factors are commonly referred to as risk and protective factors because they influence the mental health of individuals and populations.[S3] In this guide, we use the term mental health difficulties to refer to both diagnosed and undiagnosed mental health difficulties.

Some of the most common mental health difficulties can be categorised as emotional disorders, which refer to 'anxiety disorders (characterised by fear and worry), depressive disorders (characterised by sadness, loss of interest and energy, and low self-esteem), mania and bipolar affective disorder.[S3,S4] and behavioural disorders, defined as 'disorders characterised by repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated'.[S3,S4]

Parental conflict

Parental conflict can be reflected in a wide range of behaviours, from constructive (helpful) to destructive (harmful) behaviours. Harmful behaviours in a relationship that are frequent, intense, and poorly resolved can lead to a lack of respect and a lack of resolution. Behaviours such as shouting, becoming withdrawn or slamming doors can be viewed as destructive.

1 Throughout the text, studies referenced in this review are denoted by **S1–S60**, which correspond to the **full reference list** at the end of this document.

Parental conflict is common among families in England. Official data from 2018 shows that almost one in eight children in couple-parent families were living with a parent who reported relationship distress. When parental conflict is frequent, intense, and poorly resolved, it can put children's mental health and long-term health and wellbeing at risk. However currently little attention is paid to how parents with mental health difficulties experience parental conflict in the UK, and the impact this has on their children. Given how common mental health problems amongst adults are, as illustrated in table 1 below, understanding the relationship between parental mental health and parental conflict is important.

Table 1. Prevalence estimates of common mental health problems in England.

Mental health problem	Year	Age	Country	Prevalence
Long-term mental health problem	2018/2019	16+	England	9.9%
Depression	2020/21	18+	England	12.3%
Generalised Anxiety Disorder	2021	16–74	England	4.7%
Mixed Anxiety and Depressive Disorder	2021	16–74	England	9.26%

Figures taken from Office for Health Improvement and Disparities [OHID] Fingertips public health data which is a large public health data collection.[S5]

In parenthood, while exact prevalence is unknown, perinatal mental health problems affect between 10 and 20 per cent of women during pregnancy and the first year after having a baby.[S6] Depression and anxiety are estimated to be the most common mental health problems during pregnancy, with an estimated prevalence of 12 per cent and 13 per cent respectively, and evidence suggests that many women experience both.[S7]

However, it is not just mothers who suffer from mental health problems as parents. Estimates show that one in 10 fathers (10 per cent) suffer from postnatal depression and an average of 10.4 per cent of fathers are depressed both pre- and postnatally.[S8]

Worryingly, fathers with perinatal mental health problems are 47 times more likely to be rated as a suicide risk than at any other time in their lives.[S9] The effect of having a partner with depression may also compound the risk of fathers suffering from depression, with 24–50 per cent of new dads with partners suffering from depression also affected by depression themselves.[S10]

Mental health problems are clearly a profound issue and the research evidence shows that mental health problems may be made worse by parental conflict,[S11–S20] or vice versa.[S11, S15, S16, S21–S27] Children may therefore be at greater risk of poor outcomes if their parents are suffering from mental health problems, an association that may be explained or compounded by the presence of parental conflict.

With that in mind, this guide has been developed for local leads, commissioners and practitioners to provide:

- an overview of the research evidence of the factors that can increase the risk of parental conflict among parents with mental health difficulties, and the impact of parental conflict on child outcomes
- advice on how research evidence can be put into practice to inform your local strategy
- recommendations on how to engage parents with mental health difficulties
- a summary of evidence-based healthy relationship and parenting interventions that can be used with parents with mental health difficulties
- a summary of measurement tools that can be used to measure parental conflict, parental stress and co-parenting with parents with mental health difficulties.

This is not a prescriptive guide, meaning that it does not recommend one particular intervention, measurement tool or engagement strategy. The guide is intended to provide practical advice to local authorities with an interest in reducing parental conflict and improving their understanding, local offer and evaluation in relation to children of parents with mental health difficulties.

REVIEW

An overview of the research

This section explains what research evidence can tell us about parental conflict among parents with mental health difficulties, risk factors associated with parental conflict and its impact on children.

Research evidence is important for local planning. It can help you to make the case for the importance of promoting healthy relationships and persuade local stakeholders to commit to local work on reducing parental conflict. It should also inform the choices you make in your local strategy, both in terms of priorities for change and the practical ways of taking action.

There is very limited UK research on how parental conflict can affect outcomes for children of parents with mental health difficulties, and much of the research focuses only on anxiety and depression: two of the most common mental health problems. This overview includes the best available UK and international research evidence. More information on the studies can be found in the **appendix**.

This overview explains what research evidence can tell us about key risk factors and child outcomes. We then show how the findings connect in practice to how you collect data and develop your strategy for reducing parental conflict.

The relationship between parental mental health and parental conflict

- Research evidence consistently shows that **destructive parental conflict is associated with increased parental mental health problems**,[S11–S20] including depression,[S11–S14, S17] anxiety[S12, S16] and stress.[S28]
- **Parental mental health problems are also consistently associated with increased parental conflict**,[S11, S15, S16, S21–S27] with parenting stress,[S24] anxiety,[S16, S21, S23] depression[S11, S15, S22] and postpartum depression[S22, S25, S26] all predicting parental conflict.
- **Conflict characteristics can impact mothers' and fathers' depressive symptoms differently.** Longitudinal evidence suggests that conflict characterised by paternal hostility and defensiveness predicts a higher rate of paternal depressive symptoms, whereas conflict characterised by maternal withdrawal and anxiety predicts a higher rate of maternal depressive symptoms.[S14]
- **The relationship between parental mental health and relationship quality is dynamic**, and parental conflict might impact parental mental health and vice versa over the life course.[S22]

Family experiences that strain parental mental health and the parental relationship

- **Research shows that there are a range of family-related risk factors associated with mental health outcomes.** This includes for example, financial difficulties, previous experiences of domestic violence, lack of support from the father or the family network, father's substance abuse and having a sick baby or the death of a baby, which have all been noted as risk factors for postpartum depression.[S29, S30] Similarly, family history of depression and a disturbed family environment (such as parental absence or separation from a biological parent before age 18) increase the risk of parents' anxiety disorders and major depressive disorder.[S31]

- In accordance with The Family Stress Model,[S32] research evidence shows that **financial stress (including low family income, unemployment and housing costs), is associated with a decrease in relationship satisfaction and an increase in both parental conflict and parental depressive symptoms**.[S11, S33-S36]
- Similarly, international evidence suggests that **parents with lower family income and lower education levels are more likely to have destructive parental conflict and to use negative parenting practices**, and are less likely to have constructive marital conflict and to use positive parenting practices.[S33]
- UK and international research evidence shows that **Covid-19 restrictions and pandemic-related stressors negatively impacted parental mental health and family relationships**, with higher levels of parenting irritability and parental conflict. Evidence suggests that younger parents, families experiencing increased financial pressure or housing dissatisfaction, and parents with pre-existing physical and mental health conditions experienced more strained family relationships.[S37]

The risk of mental health difficulties and parental conflict among different groups of families

- **There is mixed research evidence on whether separation can increase the risk of mental health difficulties among parents** across a range of outcomes including anxiety, depression, and suicidal ideation and attempt. However, evidence suggests that couples who had depressive disorders before separation are more likely to experience a future depressive episode after separation, compared to both those who also separated but had no history of depression, and those with a history of depression who did not separate.[S38]

- **Some parents of children with behaviours that challenge might experience poorer mental health and consequently, lower relationship quality.** International evidence suggests parents of children with some intellectual and developmental disabilities (namely autism or cerebral palsy) exhibit higher levels of depression.[S39] Among parents of autistic children specifically, anxiety, depression and lower wellbeing have been linked with lower relationship quality and satisfaction.S[39, S40,] [2]
- UK data from 2014 shows that parents **in some minority ethnic groups are more vulnerable to experiencing a mental health disorder**.[S41] For example, even though psychotic disorder remains relatively uncommon among people from all ethnic groups, Black men are 10 times more likely than White men to experience a psychotic disorder. Relatedly, women from Black, Mixed other, and Asian ethnic groups are more likely to experience a common mental health disorder, such as depression or anxiety, when compared with White women.[S42,] [3]

2 See: https://www.eif.org.uk/resource/supporting-healthy-relationships-among-parents-of-children-with-behaviours-that-challenge

3 See: https://www.eif.org.uk/resource/supporting-healthy-relationships-minority-ethnic-parents

The impact of poor parental mental health and parental conflict on child outcomes

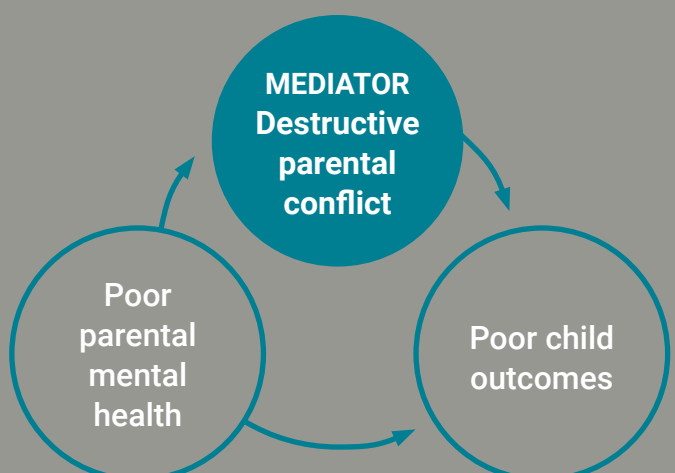
- **Poor parental mental health is consistently associated with worse outcomes for children.** Parent depressive, stress and anxiety symptoms are associated with both internalising problems in children[S43–S46] including anxiety, emotional reactivity, depression, and withdrawal,[S21, S28, S47–S49] and externalising problems,[S44–S46, S50, S51] including hostility, aggression, and conduct, behaviour and attention problems.[S21, S28, S50, S52]
- **Parental conflict might play a key role in the relationship between poor parental mental health and adverse child outcomes.** Some evidence suggests that poor parental mental health can increase parental conflict, or vice versa, which in turn negatively affects child outcomes.[S21, S44, S45, S53, S54] Other evidence also shows that the combined effect of mental health problems and parental conflict can worsen outcomes for children.[S27, S43] There is however a small body of evidence that suggests parental conflict may not explain the relationship between poor parental mental health and poor child outcomes.[S47, S48]
- Research evidence suggests that **having parents with mental health difficulties in combination with poor parental relationship can have a longer-term negative impact on children's substance use later in life**. One long-term study found that low family cohesion in depressed parents resulted in a nearly four-fold increased risk of substance use disorder in their children 10 years later at age 27 years.[S55]
- **Youth perception of parental conflict among families with poor parental mental health can also impact later youth mental health outcomes.** One study found that when young people between age 9–15 with depressed parents perceived their parents' conflict as intense, they were more likely to exhibit internalising problems.[S43] This relationship however may be the same for children with parents with good mental health.[S56]

The difference between mental health difficulties in mothers and fathers, the role of parental conflict, and the impact on children

- **Depressive symptoms in mothers and fathers can impact young children's outcomes differently.** One study found that in fathers the majority of the association between parental depression and psychological problems in young children (at age 3.5 years and 7 years) is explained (mediated) by parental conflict: depression leads to increased parental conflict which in turn increases child psychological problems. The mediating role of parental conflict has not been found in mothers, and the authors suggest that depression in mothers might impact child outcomes in different ways, perhaps through mother-infant interactions.[S53] We found no evidence examining this relationship in older children.
- Research suggests that **maternal post-partum depression can impact fathers' parenting practices and level of caregiving**. One US study found that when new mothers exhibit depressive symptoms, fathers engage in more caregiving activities such as feeding and nappy changing, but do not engage in more play behaviours.[S57]
- Findings from that study also suggest **that when a family experiences both poor maternal mental health and parental conflict, this can negatively impact on father play behaviours**, with fathers less engaged and increasing their involvement in play at a slower rate. The authors consider that this could be a direct consequence of experiencing parental conflict, or the result of a situation when mothers act as a gatekeeper, preventing fathers from engaging with their children in play contexts.[S57]

What do we mean by mediation?

A mediator explains the 'how' or 'why' of a relationship between two factors and can help to understand a mechanism through which one factor (such as poor mental health) can impact another factor (such as poor child outcomes). In the case below, for instance, poor parental mental health impacts parental conflict (the mediator), which in turn negatively impacts child outcomes.



The role of protective factors

- **The use of constructive conflict, characterised by open communication, demonstrations of support and resolution strategies, is associated with lower depressive symptoms in fathers and mothers.**[S14] One study suggests that while both fathers' and mothers' constructive conflict is associated with less depressive symptoms in fathers, mothers' depressive symptoms are lower only when fathers' constructive conflict is present, but not when mothers alone use constructive conflict behaviours.
- Preliminary research during the Covid-19 pandemic suggests that **family identification, measured by how well a person identifies with other members of their family, can help UK families to better cope financially, and in turn, have lower financial stress and better wellbeing**.[S37]
- **Supportive parenting can protect against the negative affect that parental conflict can have on adolescent depressive symptoms.**[S58] High-level supportive parenting can disrupt mechanisms that link parental conflict in married couples with adolescent depressive symptoms, whereas low-level supportive parental behaviour may increase adolescent vulnerability to the negative effect of these parental relationship behaviours.

PLAN

Using research evidence and data to inform your strategy

This section shows how the research evidence and data outlined in the previous section connect to important questions for your local data collection and strategy development.

The research findings can be used to:

- support **population needs assessment** by identifying relevant data you might need to collect, or informing your Joint Strategic Needs Assessment
- inform local planning to support healthy parental relationships
- identify links with other strategies such as local mental health strategies and those on early help, domestic abuse and Supporting Families
- identify workforce training and development needs
- guide a focus on reducing parental conflict as part of the development of Family Hubs in your local area.

While the table below provides some examples of how the research can help you to develop strategic questions and inform what local data you collect, there are some initial actions you might want to take in your local area:

- Discuss the research evidence with the Early Help Board and with those responsible for adult mental health services.
- Ask your local Mental Health Support Team how many parents with mental health difficulties they are supporting and what relationship support they offer.

Research evidence and data	Strategic questions	Questions informing data collection
Destructive parental conflict is associated with parental mental health difficulties, and mental health difficulties are associated with increased parental conflict.	How involved are adult mental health services in local work on reducing parental conflict? How aware are adult mental health practitioners of parental conflict and the impact on children? How effective is information sharing between adult mental health services and children's services?	What local data is collected by adult mental health services, or children's early help and social work services: on the number of parents with mental health difficulties; and parents with mental health difficulties who are experiencing relationship conflict? What proportion of adult mental health practitioners have received reducing parental conflict training?
There are known risk factors, including financial difficulties and pre-existing physical and mental health conditions, which are associated with parental mental health difficulties and poorer parental relationships.	Are key partner agencies which support adults, such as housing, homelessness or welfare organisations: • aware of parental conflict and the impact on children; and • aware of local support pathways for mental health and relationship conflict?	What does the Joint Strategic Needs Assessment say about the prevalence of risk factors which are associated with poor parental mental health and poorer parental relationships? What local data is collected by key partner agencies about parents with mental health difficulties and the prevalence of relationship conflict? What local data is collected on the impact of poverty on family life and relationships?

TABLE CONTINUED ON NEXT PAGE ▸

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Research evidence and data	Strategic questions	Questions informing data collection
Some groups of families, such as parents of **children with behaviours that challenge** or families from **minority ethnic backgrounds**, are at increased risk of experiencing mental health difficulties, and possibly lower levels of relationship quality.	How aware are key partner agencies of the links between child behaviour problems, parental conflict and the needs of particular vulnerable groups? How well represented are the needs of particular vulnerable groups in local planning and delivery of relationship support? Who champions the needs of diverse families? How well do specialist relationship support interventions match the needs of diverse groups, including taking account of cultural appropriateness and language use?[4]	What proportion of practitioners in key partner agencies have received reducing parental conflict training? What do existing datasets say about parental conflict, for example those on specific population groups such as children with behaviours that challenge, or those collected for specific purposes such as OFSTED inspections? Could monitoring parental conflict be integrated into future data collection processes? What data is available from parent forums and diverse community groups on relationship support services and mental health? What data is available about the use of specialist relationship support services by parents and families with protected characteristics?
Parental mental health difficulties are associated with worse outcomes for children and parental conflict can compound this impact.	How far are key partner agencies which support children or families, such as early years settings, schools and CAFCASS: • aware of the negative impacts that poor parental mental health and parental conflict can have on children; and • taking action to support these children, including accessing wider local support.	What data is being collected by Mental Health in Schools practitioners which might further inform a response to reducing parental conflict in schools? What mechanisms are in place to record and act on the views and experiences of children and young people who have experienced parental conflict, or who have parents with mental health difficulties? What data do, or should, universal services for children such as schools, early years settings or youth services collect to inform how they support children of parents with mental health difficulties, including those going though separation or divorce?

4 See: https://www.eif.org.uk/resource/talking-with-families-about-parental-relationships-practical-tips-and-guiding-questions

ENGAGE

Engaging parents with mental health difficulties

This section covers recommendations on how to engage parents with mental health difficulties, which have been developed from research evidence produced as part of previous EIF evidence reviews, and professional experience from diverse experts.

Supporting parents with mental health difficulties depends on whether services can engage well with families and identify what support can meet their needs. Engagement should consider:

- **recruitment:** how families are approached to take part in an intervention or service
- **retention:** how well an intervention or service keeps families involved and avoids drop out
- **involvement:** how families take part in an intervention or service, as well as how their lived experience informs local planning and delivery.

Below we discuss some of the key challenges and barriers to engaging parents with mental health difficulties, recommended strategies for communicating with parents, as well as some key facilitators to engagement. This section combines research evidence produced as part of previous EIF evidence reviews[S59, S60] and a summary of professional experience from diverse experts.

What are the key challenges and barriers in engaging parents with mental health difficulties?

Research suggests that there are some common issues in engaging parents in interventions to reduce parental conflict, which may apply to parents with mental health difficulties, including:

- **awareness barriers**, which include not recognising the need for support
- **accessibility barriers**, which include cost and location of interventions, as well as timing. (at what time the intervention is delivered but also at what point the intervention is offered within the relationship conflict)
- **acceptability barriers**, which include feelings of personal failure associated with seeking help
- **specific barriers** for accessing relationship support, such as the perception that interventions can be unsuitable or detrimental to people's needs, or the notion that relationships are private and should be managed only by the couple.

Key challenges and barriers to engagement: what local experts say

1. Parents with mental health difficulties often struggle with their day-to-day tasks and might not feel ready to engage

Experiencing mental health difficulties can be difficult for parents with caring responsibilities, and they might feel they are not able to adequately engage with services or to complete an intervention, especially if it's a group-based intervention.

> *'These parents often struggle just to manage their day-to-day tasks of getting their children to school, getting the basic care needs met. Expecting them sometimes to participate in groups when they're not*

managing those basic daily tasks, without a high level of support, is quite a high expectation.' Family intervention worker, East of England

'A lot of parents with mental health problems don't leave the home alone, or only leave the home with a family member or someone they trust. Sometimes, it's just trying to get someone who has mental health difficulties to even leave the home and feel comfortable, and just walking through the door of the centre might be just too much for them.' Family support worker, South West England

2. Parents might feel blame or guilt about their mental health difficulties, and this feeling could be emphasised in particular cultures

Different parents might have different feelings about their mental health difficulties and talking about them in the context of parental conflict can be challenging for both parents and practitioners.[5]

'I'm just thinking about some of the resources that we've got when we talk about mental health and parental conflict…that can be quite triggering for parents, can't it? We have to make sure that the focus remains on the relationship rather than having them think that you're placing all the blame on the fact that they've got a mental health condition or that they're putting their children in a difficult position because of the mental health difficulties.' **RPC development worker, East Midlands**

'Some cultures don't recognise mental health difficulties. I've had experiences with families that think a person is weak because they can't cope with this. It's about understanding where they're coming from in terms of their culture, especially if there are different generations living in the house.' **Intensive family support worker, North West (England)**

5 See: https://www.eif.org.uk/resource/talking-with-families-about-parental-relationships-practical-tips-and-guiding-questions

3. Lack of trust can be a main barrier for parents, as they might not trust services and may be reluctant to share information that they feel is too private

Some families might have had negative experiences with previous services, or might fear their personal information would be shared with other services. These considerations could hinder engagement if not properly addressed.

> *'Some of the parents fear what we are you going to do with the information, and might fear the other (separated) parent might accuse them.'* **Parenting group work coordinator, South East (England)**

> *'A good majority of people will start from a place of distrust. Very few will say yes, I need this help to move forward, especially if there is the fear of losing their children to social care or that their mental health difficulties have an impact on the conflict.'* **Case work consultant, Mental Health in Families Team, Yorkshire and the Humber**

Strategies to recruit and retain parents with mental health difficulties to relationship interventions: what local experts say

1. Do not make assumptions on what it means to have a mental health difficulty

Avoid making any assumptions about how a person with a certain mental health difficulty or disorder experiences it. Alternatively, consider unpacking families' mental health difficulties with the perspective that mental health difficulties manifest differently for different people.

> *'He just kind of came out with it and said, "oh, just to let you know, I've got schizophrenia", and I think the best thing I've ever probably said in my role was saying: "So what does that mean for you?"'*
> **Senior learning and development officer, Reducing Parental Conflict, South West (England)**

'It's important to ensure that you're not making sweeping generalisations, you know, just not going in and assuming. It's also about being careful with the language that we can come in with, since that can alienate, exclude them or make them feel uncomfortable.' **Parenting group work coordinator, South East (England)**

2. Provide accessible information during first meetings with the parents

Discussing what will happen during the intervention and how the collected data will be used can help parents to set clear expectations. This will also facilitate discussions to ensure parents are comfortable with how they are supported.

'In terms of recruitment strategies, it is about having that open, honest dialogue with families, explain what the practitioners are going to deliver or do and discuss parents' expectations. In this way parents can understand what they are taking on, what they 're not comfortable with, what sort of participation they going to be involved in.' **Case work consultant, Mental Health in Families Team, Yorkshire and the Humber**

'I've sometimes found, when I work with families where there's a mental health problem, that it's important to clarify who 'needs to know', for instance why I would need to inform school. It's getting parents to understand that actually we can support you in the short term and then step out of the picture, while schools can be your sort of ongoing support, they can look at what support can be in place with you or your child.' **Senior learning and development officer, Reducing Parental Conflict, South West (England)**

3. Be sensitive to the day-to-day needs of parents with mental health difficulties, and try to accommodate them when possible

When supporting parents with mental health difficulties, it is important to sensitively ask about their needs, providing options that might help them feel more comfortable and checking in regularly.

> *'Sometimes you might get halfway through a session and you can just feel that parents are going backwards. It's making sure we ask them "Do you want to carry on this today? Would you like to reschedule?"'* **Senior family support worker, South East (England)**

> *'I think it's also important to let the parents know that they have those choices as well. If they are attending a virtual session that they can keep the camera off, they don't necessarily have to speak because, especially if they suffer from anxiety, we don't want to be making them feel uncomfortable. And also, if it is a group session face to face, where can they go if they just feel overwhelmed? Where can they go if they feel they want to settle for a while? It's having plans in place so that they're comfortable and they're more able to engage in the sessions.'*
> **Family support worker, South West (England)**

> *'With some parents is very important to be consistent in terms of times…keeping to your appointments as much as possible because some parents really do prefer to stick to a routine.'*
> **Parenting group work coordinator, South East (England)**

4. Be mindful of the dynamics between both parents

When discussing parental conflict with parents with mental health difficulties, it is crucial to recognise the role and the experience of both parents.

> *'It's recognising that that other person could have a lot on and it could be really difficult. They might feel that they're having to take on that role of guiding that other person through the process, but also they can sit back and let it get lost a little bit in the process and let the focus be on the other partner. We need to recognise that and not just focus on one person in the conflict because the conflict is obviously working both ways for some reason.'* **RPC development worker, East Midlands**

> *'When dealing with parental conflict, some parents might blame each other, so it's important to bear in mind you might have to do individual sessions to unpick and then bring the two people together further up the line.'* **Intensive family support worker, North West (England)**

5. Ensure parents can discuss parental relationship support with professionals they trust

Using existing relationships with those already in trusted positions, as well as establishing a good therapeutic alliance is key to ensure parental engagement.

> *'It's about making sure resources are available at all levels across all services, because some families might have better relationships with certain workers. This works better than the approach "if you need this support, you have to go to x person". This might be effective mainly because these topics are sensitive and it's easier to communicate with someone you already have a relationship with.'* **RPC development worker, East Midlands**

> *'For me a particular couple springs to mind, they both had mental health disorders and I had some annual leave, and they really struggled because they didn't feel they could contact anybody else. Since then, if there's somebody who is presenting quite severe mental health conditions, I try to include another member of staff on the odd occasion. So, it's another face to a name that they can trust.'* **Intensive family support worker, North West (England)**

6. Reflect on how and when fathers are approached

Removing practical challenges to receiving support, such as providing meetings outside of working hours, has proven helpful in engaging fathers. However, the frequency and intensity with which fathers are contacted, in comparison to mothers or other carers, can still vary and may consequently negatively impact fathers' engagement. Reflecting on how and when fathers are approached, therefore, could be a first step to ensure the approach is unbiased and effective.

> *'We've been trying to engage fathers more and we kind of looked at our own bias as workers. There was a general thing that mums would be contacted and would pass the message on to dads because dads would be at work. So, what we started to do is to contact mums, but also contact dads if we've got their contact details. And I think just something as simple as that really improved engagement, making sure that if both numbers are available then both people get the same call.'* **RPC development worker, East Midlands**

> *'For various reasons fathers may not have the opportunity to give their voice until right at the end of the intervention. Or I think sometimes automatically the first visit is with mums. So, as long as obviously the child's having contact with the father and is safe to do so, it's about getting the fathers' views and actually involving them. How often do we go into a family and we ask the mum about the children? Dynamics within the families are all different.'* **Senior learning and development officer, Reducing Parental Conflict, South West (England)**

BUILD

Building a relationship support pathway for parents with mental health difficulties

This section identifies nine evidence-based healthy relationship and parenting interventions which may be helpful as part of local support pathways for parents with mental health difficulties.

In every local area there are some services and interventions that can help parents with mental health difficulties to build and maintain healthy relationships, as well as improve their mental health and wellbeing. This support might be universal, providing relationship support to all parents regardless of their mental health, or support might be more targeted, such as services that provide support to parents with mental health problems or parents who are at risk of developing mental health problems.

An effective support pathway starts with the first services that parents turn to when they're struggling with relationship issues and describes how wider support services fit together to address parental conflict and reduce the impact it has on children. A support pathway can include services and interventions that do not directly target parental relationships (for instance community health services, primary care, and housing) but that can build a trusted relationship with families, identify parental conflict, provide information and self-help resources, and refer to targeted support.

The Early Intervention Foundation's support pathway model[4] shows how the local relationship support offer can be constructed for families with different needs, taking account of research evidence. You can use the support pathway model to build in support for parents with mental health difficulties, taking account of the recommendations below:

- **Consider existing local services and interventions across the continuum of needs**

  Parents with mental health difficulties may experience multiple mental health problems, or they may be facing other problems in life, such as financial stress, including low income or unemployment, a lack of support from a family network, or recent stressful life events, all of which are associated with a higher risk of parental conflict. To create a comprehensive support pathway, you should consider whether support in relation to such risk factors is available and accessible for parents, and if there are arrangements to promote healthy relationships through existing local services.

- **Understand the needs and characteristics of your local population**

  When building your support pathway, it is important to reflect on variations across families in terms of type and level of needs. For instance, as mentioned in the ENGAGE section, referrals to relationship support may be burdensome for some parents with mental health difficulties, who often struggle with their day-to-day tasks, and some parents may not trust services, meaning they are reluctant to engage and share information they feel is private. Additionally, parents with different mental health difficulties with children of different ages may have different needs. A tailored approach may be required to engage families, remembering that the content of interventions and means of engagement is key in helping these families feel embraced and supported for who they are. EIF's guide on conducting a population needs assessment[5] offers a structure to collect and analyse population needs data.

4 Available at: https://www.eif.org.uk/resource/developing-a-relationship-support-pathway-for-families-a-support-pathway-model

5 Available at: https://www.eif.org.uk/resource/conducting-a-needs-assessment-on-parental-conflict

- **Consider evidence-based interventions to strengthen your support pathway**

  Intervention evaluation evidence is a good place to start when reviewing and considering how to strengthen a local support pathway for parents with mental health difficulties. Interventions which have been through a structured evaluation process are likely to be specific about their theory of change and implementation and delivery process. This means their learning about delivery and effectiveness can be helpful in wider context, even if a local commissioner is looking to adapt a local approach rather than invest in a new intervention.

  For the purposes of this guide we have identified nine parenting and relationship interventions which may be helpful as part of local support pathways for parents with mental health difficulties. Some interventions are specifically designed to meet the needs of parents with mental health difficulties, others have shown to be effective with diverse families. We recommend that you consider data on local needs, the reach of existing interventions and gaps in provision to choose which intervention best suits your local area.

For each intervention we have set out the following:

- **Description:** the key characteristics of the intervention, to help you to understand whether this could fit your local context.
- **Level of provision:** this information can be used to reflect on the match with the level of need of your local population. Some families will respond initially to a targeted intervention and may then only need universal services and light-touch support, such as a supportive conversation with a health visitor, or signposting to online self-help resources. Other families will go on to have a more persistent need for support, requiring specialist services, such as an intensive intervention on parental conflict and parenting or psychological therapy from a local mental health service.
- **Quality of evidence:** to help you to understand how confident you can be that an intervention will work.
- **Training and cost:** all the interventions included from the **EIF Guidebook** have a low (<£100 per unit) or medium-low (£100-£499 per unit) cost. For Interventions not on the Guidebook, the cost is unknown.
- **Delivery and setting:** to help you to understand whether an intervention is a good match with your local context. For instance, based on the data collected on your local population, you might prioritise an intervention that can be delivered in a variety of different settings to allow more flexibility.
- **Duration:** information on how long it takes to complete an intervention will help you to understand if it is appropriate for your local population. For instance, based on the data collected locally about dropout rates for other interventions, you might prioritise short interventions that have been shown to be effective in improving outcomes.
- **EIF Guidebook evidence rating:** For interventions assessed as part of the Guidebook, we have included the Guidebook rating that has been established through reviewing all evidence of impact.

EIF Guidebook interventions for parents with mental health difficulties

The first table includes eight interventions for parents of children aged 3–5 for which EIF has conducted a full assessment of the evidence. You can find more information on these interventions and the assessment process in the **EIF Guidebook**.

Note: Evidence of impact on one group of families (for instance with parents with a specific mental health problem) does not ensure that the same intervention will work with a different group. It is therefore important to reflect on your population when choosing an intervention.

Universal interventions: interventions that are available to all children or families.

Targeted selective interventions: interventions that target or 'select' children or families who may be at greater risk of experiencing problems, such as families struggling with economic hardship.

Targeted indicated interventions: interventions that target children or parents with a pre-identified issue or diagnosed problem requiring more intensive support.

Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Child-Parent Psychotherapy	Child-Parent Psychotherapy (CPP) is a psychoanalytic intervention targeting mothers and preschool children (aged 3 to 5) who may have experienced trauma or abuse (e.g., domestic violence), or are otherwise at risk of insecure attachment and/or other behavioural and emotional problems. Specifically, CPP aims to improve children's representations of their relationship with their parent and reduce maternal and child symptoms of psychopathology.	Target indicated	**Level 3 (Robust) evidence of:** • reduced traumatic stress disorder symptoms • improved child behaviour. **Level 2+ (Promising) evidence of:** • improved representations of the mother-child relationship • improved expectations of the mother-child relationship.	**Level 3 (Robust) evidence of:** • reduced symptoms of PTSD • reduced depressive symptoms.	92 hours of programme training: seven days' face-to-face training with 36 hours of phone consultation. Booster training of practitioners is recommended.	Unknown	Delivered by a practitioner with a Masters (or higher) qualification in psychology or social work to mothers and children individually in homes, outpatient settings, children's centres, schools, community centres or inpatient health settings.	The programme lasts 32 sessions of approximately one to one and a half hours' duration each. Mothers and their child might attend weekly sessions for a period of 12 months or longer.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Enhanced Triple P	Enhanced Triple P (Level 5) targets individuals, couples or families. The programme aims to (1) increase parents' competence in managing common behaviour problems and developmental issues; (2) reduce parents' use of coercive and punitive methods of disciplining children; (3) improve parents' personal coping skills and reduce stress; (4) improve parents' communication about parenting issues and help parents support one another in their parenting role; and (5) develop parents' independent problem-solving skills. With regards to children, the programme aims to: (1) reduce behavioural and emotional problems; and (2) reduce the intensity of disruptive child behaviour.	Targeted selective	**Level 3 (Robust) evidence of:** • improved child behaviour.	**Level 3 (Robust) evidence of:** • reduced use of dysfunctional parenting • improved sense of parental competency in mothers.	Practitioners have 25 hours of programme training. Booster training of practitioners is not required.	Medium to Low	Delivered by one practitioner to individuals, couples or families in outpatient health settings, home, children's centres or early years setting	Three–11 sessions of between 40 to 90 minutes duration each

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Triple P Family Transitions	Family Transitions Triple P (FTTP) Level 5 was designed as an intensive intervention programme for parents experiencing difficulties as a consequence of separation or divorce. Working with parents, FTTP aims to: (1) improve parents' personal coping skills in managing transition through separation or divorce; (2) increase parents' competence and confidence in raising children; (3) reduce parents' level of emotional distress (including depression, stress, anxiety, anger); (4) improve parents' communication about co-parenting issues; (5) reduce the use of coercive and punitive methods of disciplining children; (6) improve the parent-child relationship.	Targeted selective	**Level 3 (Robust) evidence of:** • reduced problem behaviour • reduced behavioural intensity.	**Level 3 (Robust) of evidence of:** • improved parenting style • reduced parental stress • reduced anger.	Practitioners have 37.5 hours of programme training. Booster training of practitioners is not required.	Low	Delivered by one practitioner, to groups of approximately eight families at community centres, homes, out-patient health settings or children's centres or early years settings.	Five two-hour sessions.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Family Foundations	This is a group-based programme for all couples expecting their first child, delivered any time during the mother's pregnancy. Parents learn skills to better cope with the transition to parenthood, improved communication skills and better conflict resolution. Parents also learn strategies for responding to their child in a sensitive way. Parents learn through a variety of group exercises, role play and group discussion. **Note:** This intervention does not directly aim to improve parental wellbeing or mental health but shows evidence of positive impact on parental mental health outcomes.	Universal	**Level 3 (Robust) evidence of:** • improved infant soothability • improved duration of orienting • improved self-soothing • improved prosocial behaviour • reduced internalising problems • reduced externalising problems.	**Level 3 (Robust) evidence of:** • improved co-parental support • improved mothers' depressive symptoms and anxiety • improved fathers' parenting-based closeness and parent-child dysfunctional interaction.	The practitioners have 24 hours of programme training. Booster training of practitioners is not required.	Low	Two facilitators deliver this intervention in outpatient health settings, community centres or sixth form/FE colleges.	Eight two-hour sessions.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Incredible Years Preschool BASIC + ADVANCE Parent Training Curriculum	This intervention is designed for families after they have received the Incredible Years Preschool and School Age BASIC programmes, particularly where child risk factors or parent risk factors (including mental health problems) are present. The programme specifically aims to improve protective factors (including parental emotion and mood regulation and partner relationship) to enhance parents' ability to parent effectively, to model and regulate their own emotions, and to teach emotion regulation and problem-solving skills to their children.	Targeted indicated	**Level 3 (Robust) evidence of:** • improved behaviour at home • reduced negative behaviours • improved positive behaviour • improved peer interactions • increased positive affect in children's interactions with fathers.	**Level 3 (Robust) evidence of:** • reduced negative parenting • improved positive parenting • reduced commands and criticisms (mother only) • increased praise • increased positive affect with child • decreased negative valence with child • reduced spanking (mother's behaviours only).	The practitioners have 18 hours of programme training for the Incredible Years BASIC programme plus 16 hours of programme training for the Incredible Years ADVANCE programme. Booster training of practitioners is recommended.	Medium-low	This intervention is delivered by two practitioners to groups of five to eight families (eight to 12 parents) in children's centres or early years settings, primary schools, community centres and outpatient health settings.	Incredible Years BASIC is delivered in 12–16 two-hour long sessions. Incredible Years ADVANCE is nine to 12 additional two to two and a half hour long sessions.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Incredible Years School Age BASIC + ADVANCE Parent Training Curriculum	This intervention is designed for families after they have received the Incredible Years Preschool and School Age BASIC programmes, particularly where child risk or parent risk factors (including mental health problems) are present. The programme specifically aims to improve protective factors (including parental emotion and mood regulation and partner relationship) to enhance parents' ability to parent effectively, to model and regulate their own emotions, and to teach emotion regulation and problem-solving skills to their children.	Targeted selective	**Level 2 (Promising) evidence of:** • Reduced child conduct problems.	**Level 2 (Promising) evidence of:** • increased positive involvement of parents with children • decrease in parents' use of negative discipline.	The practitioners have 18 hours of programme training for the Incredible Years BASIC programme plus 16 hours of programme training for the Incredible Years ADVANCE programme. Booster training of practitioners is recommended.	Medium-low	This intervention is delivered by two practitioners to groups of five to eight families (eight to 12 parents) in children's centres or early years setting, primary schools, community centres and outpatient health settings.	This intervention is delivered in 12–16 two-hour long sessions. Incredible Years ADVANCE is nine to 12 additional two to two and a half hour long sessions.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Parents Forever	The Parents Forever programme is designed for parents who are divorced or separated, or who are going through that process, who have children between the ages of 0 and 18. The programme focuses on addressing parental wellbeing, the coparenting relationship, and the parent-child relationship, as a mechanism by which to improve child and family outcomes post-separation. It is a skills-based intervention that teaches parents specific strategies for communicating and interacting with one another, to reduce the conflict to which their children are exposed. Parents Forever seeks to improve children's outcomes by improving the quality of interparental relationships.	Targeted selective	**Level 2 (Promising) evidence of:** • improved child emotional symptoms • reduced child peer problems • reduced child conduct problems.	**Level 2 (Promising) evidence of:** • improved self-efficacy • improved physical and psychological health • improved adult environmental health and positive parenting • reduced inconsistent discipline and poor supervision.	The practitioners have four hours of programme training. Booster training of practitioners is not required.	Low cost		There are four different versions of this intervention: 1) eight-hour version that is delivered in three sessions of varying duration by facilitators to groups of 15 parents; 2) a shorter in-person four-hour version delivered to 15 parents in groups; 3) Two sessions of two hours' duration; 4) and online versions of four and eight hours.

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Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Family check-up for Children	This is a strengths-based, family-centred intervention that motivates parents to use parenting practices to support child competence, mental health, and risk reduction. The intervention has two phases: a brief programme with three one-hour sessions: interview, assessment, and feedback; and a family-management training programme. Note. This intervention does not directly aim to improve parental wellbeing or mental health but shows evidence of positive impact on parental mental health outcomes.	Targeted selective	**Level 2+ (Promising) evidence of:** • reduced disruptive behaviour (boys only) • improved behaviour • decreased emotional and behaviour problems. **Level 3 (Robust) evidence of:** • reduced externalising behaviours • reduced problem behaviour • reduced internalising behaviours • reduced defiant behaviour.	**Level 2+ (Promising) evidence of:** • increased maternal involvement. **Level 3 (Robust) evidence of:** • Reduced maternal depression.	The practitioners (often a therapist or social worker) have 35 hours of training. Booster training of practitioners is recommended.	Medium-low	This intervention is delivered to individual families in secondary schools, community centres, inpatient health settings and outpatient health settings.	Nine sessions of 50–60 minutes.

Interventions for parents with mental health difficulties with provisional ratings

The second table includes one intervention for parents with mental health difficulties for which EIF has conducted a light-touch assessment of the evidence. You can find more information on these interventions and the assessment process in the **appendix**.

Note: Evidence of impact on one group of families with children with behaviours that challenge (for instance with a specific condition) does not ensure that the same intervention will work with a different group. It is therefore important to reflect on your population when choosing an intervention.

Universal interventions: interventions that are available to all children or families.

Targeted selective interventions: interventions that target or 'select' children or families who may be at greater risk of experiencing problems, such as families struggling with economic hardship.

Targeted indicated interventions: interventions that target children or parents with a pre-identified issue or diagnosed problem requiring more intensive support.

Intervention	Description & adaptations	Level of provision	Evidence of impact on children	Evidence of impact on parents	Training	Cost	Delivery and setting	Duration
Behavioural couple therapy for depression (BCT-D)	Behavioural couple therapy for depression (BCT-D) is a psychoanalytic intervention targeting couples where at least one partner is depressed (as per clinical diagnosis).BCT-D seeks to equip couples with the knowledge to address depressive symptoms directly and manage partners' depression together. The intervention utilises cognitive behavioural therapy (CBT) perspective, seeking to improve both relationship functioning and depression symptoms.	Targeted Indicated	No or limited evidence	**Preliminary evidence of:** • decreases in anxiety and depression for both partners • increase in relationship satisfaction for depressed or 'client' partners.	High intensity therapists previously trained in individual CBT for depression undergo a five-day workshop, followed by 12 months of clinical supervision under a BCT-D supervisor.	Unknown	Delivered to couples in clinics as a part of mental health services within the National Health Service (NHS).	There are no fixed number of sessions for all couples. It is dependent on the treatment plan formulated with the therapist and the couple. Current evidence shows number of sessions can range from two to 26.

MEASURE

Measuring parental conflict in parents with mental health difficulties

This section outlines different types of measurement tools that can be used to measure parental outcomes with families with parents with mental health difficulties.

A key question for a relationship support pathway is: how do you know how effective it is? We do know that on balance, families and children who receive interventions shown through rigorous testing to have improved outcomes are more likely to benefit, and to a greater degree, than those who receive other services. However, selecting evidence-based interventions does not guarantee that they will work well in every local context, or even be implemented in the way that they were intended. Local monitoring and evaluation are essential to answering the question of effectiveness, and this calls for valid and reliable measurement tools.

Different types of measurement tools could be used for:

- **Eligibility purposes:** such as to determine whether parents with mental health difficulties may benefit from relationship support, and if so what type of support would best suit them.
- **Monitoring purposes:** such as to allow both the practitioner and participant to assess and reflect on how they are progressing while the intervention is being delivered.

- **Evaluation purposes:** such as to determine if families receiving support have better outcomes, and if services and interventions are working for the people they are designed to help.
- **Representation purposes:** such as to give intervention participants / children a voice and provide opportunities to discuss things from their own perspective

Measuring progress for individual families is one of the most challenging issues that local areas grapple with when delivering parental conflict support. It is difficult to decide what outcomes to measure as well as how to go about measuring them. Without valid and reliable measures, it is not possible to have confidence in any improvements in child and parent outcomes.

For the purposes of this guide we have identified 13 tools which are particularly relevant to measure outcomes for parents with mental health difficulties. For each tool we have set out the following:

- **Parental measures – outcomes assessed:** this information can help you understand if the measure is capable of assessing at least one of the anticipated outcomes specified in the intervention's theory of change. If you deliver and want to evaluate one of the interventions included in the tables above, a practical way of selecting your measure(s) would be to consider what outcomes have improved according to the evidence.
- **Respondent – who can complete the measure:** this information can be used to understand who will complete the measure and to decide if the measure is appropriate given your population.
- **Mode of administration:** whether the measure can be completed in-person or online.
- **Target population:** the group or population this measure is designed to be used for.

Common challenges when using measurement tools

'I want to use the Children's Perception of Interparental Conflict Scale (CPIC) but it is too long.'
Although it may be tempting to remove items to reduce its length and shorten its completion time, modifying a validated measure may compromise its ability to detect changes accurately and reliably. A better solution is to use only the subscale of the validated measure which is more relevant for your context. CPIC has three subscales: conflict, perceived threat, and self-blame.

'Some of the questions I would like to assess are not included in the measure.'
You can combine measures or subscales from different measures to tailor your tool. For instance, to assess the impact of the parental conflict interventions delivered as part of the national Reducing Parental Conflict Programme, the Department of Work & Pensions (DWP) developed a new measurement tool called the Referral Stage Questionnaire. This tool was, in fact, a sequence of validated measurement tools (including the O'Leary-Porter Scale) and specific subscales (such as the Satisfaction subscale of the Dyadic Adjustment Scale) that measure relevant outcomes, such as agreement between parents on how to deal with conflict.

Read more about practical tips in our short guide: **Using validated tools to measure parental conflict and its impact on children**

Parental outcomes measures

	Parental measures Outcomes assessed	Respondent	Target population	Psychometric features How valid and reliable is the measure?					Implementation features How practical is the measure?			
				Internal consistency (scale) Do the items designed to measure the same outcome relate to one another?	Internal consistency (subscales) Do the items designed to measure the same outcome relate to one another?	Test-retest reliability Are the outcomes stable over time?	Validity Does it measure what it claims to measure?	Sensitivity to change Can it detect important changes over time?	Brevity Does it take less than 15 minutes?	Availability Is it freely available?	Ease of scoring Is it easy to score and interpret?	Used in the UK Has it been used in the UK?
Marital satisfaction	**The Kansas Marital Satisfaction Scale** This measure is a three-item measure designed to quickly assess a person's satisfaction with their spouse, their marriage and their marital relationship.	Parents who are married.	Intact couples (married only)	✓	N/A*	?	✓	✓	✓	✓	✓	?
Parental stress	**The Parental Stress Scale (PSS)** This measure assesses the level of stress and feelings about parenthood, including both positive and negative aspects of parenthood (e.g. emotional benefits, demands on resources, feelings of stress).	Parents who are in a relationship or who are separated	Intact couples and separated parents with children	✓	N/A	?	✓	✓	✓	✓	✓	✓

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* Please note that some measures don't have subscales and therefore don't have information on internal consistency (subscales)

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	Parental measures Outcomes assessed	Respondent	Target population	Psychometric features How valid and reliable is the measure?					Implementation features How practical is the measure?			
				Internal consistency (scale) Do the items designed to measure the same outcome relate to one another?	Internal consistency (subscales) Do the items designed to measure the same outcome relate to one another?	Test-retest reliability Are the outcomes stable over time?	Validity Does it measure what it claims to measure?	Sensitivity to change Can it detect important changes over time?	Brevity Does it take less than 15 minutes?	Availability Is it freely available?	Ease of scoring Is it easy to score and interpret?	Used in the UK Has it been used in the UK?
Relationship quality	**Couples Satisfaction Index (CSI-16)** This measure assesses how satisfied a person is in their relationship and how they feel about it.	Adults in a relationship	Intact couples	✓	N/A	?	✓	?	✓	✓	✓	✓
Relationship quality	**Dyadic Adjustment Scale (DAS-32)** This measure assesses how satisfied a person is in their relationship, the feelings associated with the relationship, and the issues causing disagreements between partners.	Adults in a relationship	Intact couples	✓	✓	✓	✓	?	✓	✓	✓	✓
Relationship quality	**Dyadic Adjustment Scale (DAS-7)** This measure assesses how satisfied a person is in their relationship and the extent of agreement or disagreement amongst the couple over important aspects of life.	Adults in a relationship	Intact couples	✓	N/A	?	✓	✓	✓	✓	✓	✓

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	Parental measures Outcomes assessed	Respondent	Target population	Psychometric features How valid and reliable is the measure?					Implementation features How practical is the measure?			
				Internal consistency (scale) Do the items designed to measure the same outcome relate to one another?	Internal consistency (subscales) Do the items designed to measure the same outcome relate to one another?	Test-retest reliability Are the outcomes stable over time?	Validity Does it measure what it claims to measure?	Sensitivity to change Can it detect important changes over time?	Brevity Does it take less than 15 minutes?	Availability Is it freely available?	Ease of scoring Is it easy to score and interpret?	Used in the UK Has it been used in the UK?
Relationship quality	**Golombok Rust Inventory of Marital State (GRIMS)** This measure assesses how a person feels about their own and their partner's behaviour within their relationship as well as their attitudes and feelings about the relationship.	Adults in a relationship	Intact couples	✓	N/A	?	?	✓	✓	✓	✓	✓
	Marital Adjustment Test (MAT) This measure assesses how satisfied a person is in their marital relationship and the extent of agreement or disagreement amongst the couple over important aspects of life.	Adults who are married	Intact couples (married only)	✓	N/A	✓	?	✓	✓	✓	✓	✓
	Relationship Quality Index (RQI) This measure assesses how satisfied a person is in their relationship and the extent of agreement or disagreement amongst the couple over important aspects of life.	Adults in a relationship	Intact couples	✓	N/A	?	✓	✓	✓	✓	✓	✓

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	Parental measures Outcomes assessed	Respondent	Target population	Psychometric features How valid and reliable is the measure?					Implementation features How practical is the measure?			
				Internal consistency (scale) Do the items designed to measure the same outcome relate to one another?	Internal consistency (subscales) Do the items designed to measure the same outcome relate to one another?	Test-retest reliability Are the outcomes stable over time?	Validity Does it measure what it claims to measure?	Sensitivity to change Can it detect important changes over time?	Brevity Does it take less than 15 minutes?	Availability Is it freely available?	Ease of scoring Is it easy to score and interpret?	Used in the UK Has it been used in the UK?
Parental conflict	**Children's Perception of Interparental Conflict Scale (CPIC)** This measure assesses parental conflict from the child's point of view, particularly in terms of the frequency, intensity resolution and perceived threat of the conflict. It also focuses on how the child responds to the conflict, including questions around self-blame and coping mechanisms.	Children aged 9–17 years with intact or separated parents	Intact couples and separated parents with children	✓	✓	✓	?	?	✗	✓	✓	✓
	O'Leary Porter Scale (OPS) This measure assesses the frequency of couple hostility observed by the child, including quarrels, sarcasm and physical abuse.	Parents in a relationship	Intact couples with children	✓	N/A	?	?	✓	✓	✓	✓	✓

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	Parental measures Outcomes assessed	Respondent	Target population	Psychometric features How valid and reliable is the measure?					Implementation features How practical is the measure?			
				Internal consistency (scale) Do the items designed to measure the same outcome relate to one another?	Internal consistency (subscales) Do the items designed to measure the same outcome relate to one another?	Test-retest reliability Are the outcomes stable over time?	Validity Does it measure what it claims to measure?	Sensitivity to change Can it detect important changes over time?	Brevity Does it take less than 15 minutes?	Availability Is it freely available?	Ease of scoring Is it easy to score and interpret?	Used in the UK Has it been used in the UK?
Co-parenting	**Parenting Alliance Measure (PAM)** This measure assesses how cooperative, communicative and mutually respectful parents are when caring for their children.	Parents who are in a relationship or are separated	Intact couples and separated parents with children	✓	✓	?	?	✓	✓	✗	✓	✓
Co-parenting	**Parent Problem Checklist (PPC)** This measure assesses the extent of agreement or disagreement between the parents over child-rearing issues.	Parents who are in a relationship or are separated	Intact couples and separated parents with children	✓	N/A	?	?	✓	✓	✓	✓	✓
Co-parenting	**Quality of Co-parental Communication Scale (QCCS)** This measure assesses the extent of mutual support and hostility over child-rearing issues with the former spouse.	Parents who are separated	Separated parents with children	✓	✓	?	✓	?	✓	✓	✓	?

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