Foundations
What Works Centre for Children & Families

Department for Education

PARENTING THROUGH ADVERSITY

Parents of babies & children 0 to 10

Practice Guides support the Children's Social Care National Framework (CSCNF).[1] They set out the best available evidence to support senior leaders in local authorities to drive the conditions for effective practice and improve how services are commissioned, developed and delivered.

Senior leaders include but are not limited to Directors of Children's Services, Directors of Public Health, Local Authority Chief Executives, Elected Members (including Lead Members for Children's Services), children's services commissioners, heads of services, and other senior leaders involved in developing and commissioning services.

This Practice Guide relates to all outcomes of the CSCNF. The enablers of the CSCNF (leadership, workforce, multi-agency working) have a role in supporting delivery of the Guide's key principles and recommendations.

The Guide is also relevant to agencies that can commission, fund, and deliver parenting support in local areas, such as NHS Integrated Care Boards and voluntary, community and faith sector organisations.

1 See: https://www.gov.uk/government/publications/childrens-social-care-national-framework

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INTRODUCTION

This Practice Guide sets out key principles and recommendations on evidence-based parenting support for parents experiencing adversity who have babies and children aged between 0 and 10 years old, based on the best available evidence.

All children deserve responsive and nurturing parenting. Parents and carers should be supported in providing this care. The parent-child relationship is fundamental to children and foundational for their emotional, social, and cognitive development. Effective parenting programmes can help to strengthen families' response and resilience in the face of challenges and improve both parent and child outcomes in families facing adversities. The core purpose of parenting support is to strengthen parenting capacity and support parents to make lasting change to improve child outcomes.

This Practice Guide focuses on support to parents where their circumstances include adversities in the family and wider environment which undermine parents' skills, abilities and resources. These adversities can include poverty, substance misuse, intimate partner violence, conflict in the couple's relationship, and parent mental health challenges. Adversity can create challenges for effective parenting, therefore increasing the risk of child abuse and neglect. Effective parenting support recommended in this Guide can improve parenting skills, parent-child relationships, and child behaviour, and support parenting stress and parent mental health.

The children of these parents include those defined under section 17 of the Children Act 1989 as being unlikely to achieve or maintain a reasonable level of health or development without additional support and/or under section 47 as suffering or likely to suffer significant harm. Parents in England can interact with the end-to-end system of support and protection, ranging from universal services (e.g. family hubs) through Family Help to the edge of care.

This Practice Guide is based on findings from two systematic reviews, which collate evidence on parenting programmes. You can read the full systematic reviews on the quantitative evidence and on the qualitative evidence.[2]

2 See: Quantative review: https://foundations.org.uk/wp-content/uploads/2025/02/systematic-review-interventions-practices-parents-complex-multiple-needs.pdf; Qualitative review: https://foundations.org.uk/wp-content/uploads/2025/02/rapid-qual-synthesis-implementation-interventions-parents-multiple-complex-needs.pdf

Who are the families this Practice Guide focuses on?

This Practice Guide focuses on parenting support for **those experiencing multiple adversities**, who have children aged 0 to 10 years. A fuller explanation of the families in scope for this Practice Guide and the parenting programmes included can be found in the extended definitions.[3]

Throughout the Practice Guide, we are referencing this particular group of parents, not all parents. We appreciate that families are diverse, including nuclear, single parent, or adoptive and foster. Much of the evidence underpinning this Practice Guide is on single parents or male/female couples, and biological birth parents.

Foundations will be publishing separate future Practice Guides on:

- Parenting support for parents/carers of children and young people with disabilities or severe mental illness
- Parenting interventions for families experiencing adversity with children aged 11 to 19 years
- Interventions to support adoptive and foster parents/carers
- Reunification interventions and practice.

We have already published a Practice Guide focused on kinship carers. The above Practice Guides will be published steadily over the next two years, making recommendations for supporting different groups of parents and carers.

What do we mean by parenting support?

For the purposes of this Practice Guide, we are referring to **parenting interventions** with defined eligibility criteria that have a clear structure and set of activities. We use the World Health Organization definition of a parenting intervention.

Although interventions with a flexible structure are included, completely unstructured interventions are not included (for instance, home visits or therapies that do not have a structured approach). Parenting interventions of all durations are included.

3 See: https://foundations.org.uk/parenting-through-adversity-pg-0-10-extended-definitions/

This Practice Guide focuses on parenting interventions (as defined by the World Health Organization), It does **not** cover interventions such as specialist adult mental health support for parents experiencing mental health problems, nor does it provide specialist support to parents needs, such as substance misuse. NICE guidelines on mental health and wellbeing[4] and on substance misuse[5] should be consulted for recommendations on evidence-based services.

A fuller explanation of the families in scope for this Practice Guide and the parenting programmes included can be found in the extended definitions.[6]

UNDERSTANDING THIS PRACTICE GUIDE

This Guide contains two sections:

- **Key Principles:** These summarise the circumstances, experiences, and preferences of families in scope for this Guide and evidence on how to engage and work with them. They also cover evidence on effective implementation and design of parenting interventions. The principles are drawn from quantitative and qualitative research, evaluations of implementation, and common features of effective parenting interventions. This evidence helps to ensure accessible, acceptable interventions can be effectively implemented.
- **Recommendations:** These summarise the best-evidenced interventions for improving a range of child and parent outcomes. We only make recommendations where at least one rigorous impact evaluation has evidenced that the intervention achieves positive outcomes for parents or children and young people, either in the UK, or in countries similar to the UK.

4 See: https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing
5 See: https://www.nice.org.uk/guidance/health-protection/drug-misuse and https://www.nice.org.uk/guidance/conditions-and-diseases/liver-conditions/alcohol-use-disorders
6 See: https://foundations.org.uk/parenting-through-adversity-pg-0-10-extended-definitions/

For Recommendations, the Guide identifies the strength of the evidence of interventions using the following scoring system:

STRONG EVIDENCE	This rating is given if: the evidence is from a meta-analysis or a narrative synthesis of at least two randomised controlled trials or quasi-experimental studies that were conducted in the UK or comparable high-income country; and have scored low on risk of bias assessment, with a minimum sample size of 20 in each group (the intervention and comparison group); and demonstrates effectiveness of the intervention(s).
GOOD EVIDENCE	This rating is given if: the evidence is from a meta-analysis or a narrative synthesis of at least two randomised controlled trials and/or quasi-experimental studies that were conducted in the UK or a comparable high-income country; and have scored at least moderate on risk of bias assessment, with at least 20 participants in the intervention group and less or more than 20 participants in the comparison group; and demonstrates efficacy of the intervention(s).
PROMISING EVIDENCE	This rating is given if: the evidence is from one randomised controlled trial or quasi-experimental study that was conducted in the UK or a comparable high-income country; and has scored low or moderate on risk of bias assessment, with less or more than 20 participants in each group (the intervention and comparison group); and demonstrates efficacy of the intervention(s).

The Practice Guide includes case studies of effective interventions, drawing from the quantitative systematic review and our Guidebook. These refer to delivery models, workforce requirements, and how interventions can be implemented.

In the Key Principles section, we distil evidenced 'common elements' from across different evidence-based interventions. These elements are features of intervention content and their implementation that were associated with effectiveness. These could be useful for incorporating into day-to-day interactions and casework with families to complement evidence-based interventions. In children's social care, practitioners can use common elements and other advice and strategies to support parenting, recognising that some parents also benefit from a more intensive and prescriptive approach.

A summary grid is included later in the Guide on the strength of evidence underlying each recommendation. Technical information on the underlying evidence behind each recommendation can be found in the evidence annex.[7] We have also produced a technical annex detailing the approach to assessment of the strength of evidence on interventions.[8]

7 See: https://foundations.org.uk/wp-content/uploads/2025/02/evidence-annex-parenting-through-adversity-0-10.pdf
8 See: https://foundations.org.uk/wp-content/uploads/2025/02/technical-annex-parenting-through-adversity-0-10.pdf

KEY PRINCIPLES

Key Principles are grouped into three themes:

- Working with families
- Programme design
- Local system integration

WORKING WITH FAMILIES

Key Principle 1: Tailor parenting support to ages and stages of child development.

Programmes are more effective if they are specific to a child's developmental needs and tailored to parents' abilities and capabilities.

Local leaders and commissioners should be clear about the role and purpose of parenting interventions across the ages and stages of child development. This includes opportunities for engaging at key times and transition points in the life of the family and child, such as the transition to parenthood, when a child begins school, and/or in relation to the couple relationship and co-parenting (including where parents are separated).

Local leaders, practice supervisors and practitioners should ensure that opportunities are available for early identification of needs and clear referral pathways. These opportunities include when families are in contact with maternity and antenatal services, through primary care (e.g. GPs, local health services), in education and childcare settings, or in settings such as family hubs or children's centres. This should lead to opportunities to refer parents for engaging with parenting support.

Supporting parents and parent child relationships in the critical first 1001 days

The 1,001 days are a critical time for a child's development.[9] Effective programmes supporting parents of children in the earliest years of life (from conception to 2 years) are typically underpinned by the science of early child development. They usually work with

9 See: The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

parents and children together and may support parents with babies or toddlers who are at particular risk of serious harm, especially from physical abuse.

Practitioners should be aware and responsive to families presenting with a range of adversities and needs. These adversities can include poverty, substance misuse, intimate partner violence, conflict in the couple's relationship, and parents' mental health challenges. Practitioners should work relationally with parents, offering a safe space for them to reflect on their experiences and support for strengthening parent-child relationships, and providing information and guidance to parents on child development and health.

For example, practitioners can support parents' understanding of their babies' behaviour as communication, including babies who are unsettled, difficult to soothe, have developmental delay, and feeding or sleeping problems. Practitioners can also support parents' understanding of their toddlers or young child's behaviour as communication, for example frequent and persistent behaviours that challenge, such as aggressiveness, non-compliance with adult boundaries and rules, or frequent and persistent fearfulness, social withdrawal, sadness, upset, and worry.

Supporting parents to manage child behaviour from ages 2 to 10

The developmental needs of children, and the role of parents, change as babies become young children. At age 2 or 3, children have new ways of navigating their emotional world. They have new capabilities, such as walking and talking, and are responding to a world full of interest and learning about new challenges. Young children at this stage need distinct support from the adults caring for them.

Long-term studies consistently show that some behaviours that can challenge parents are common in toddlers at 17 months, but then gradually decrease by age 3. However, for a minority of children, behaviours that challenge (such as consistent resistance to boundaries and frequent aggression) increase from 2.5 years onwards, especially when parents are unsupported or adversities are ongoing.

Behavioural issues may, for a minority of children, become more chronic and entrenched as disorders that persist into adolescence and adulthood. In later life, these behavioural disorders are associated with increased risk of substance misuse, interpersonal violence and crime (e.g. Vergunst et al., 2023).[10]

Practitioners should be aware that children's behaviours that challenge can contribute to significant stress for parents and impact family functioning. Behaviours that challenge, when unaddressed and unsupported, are associated with increased economic and social pressures on families. These can include limiting daily activities, relationship conflict,

10 Vergunst, F., Commisso, M., Geoffroy, M., et al. (2023). Association of childhood externalizing, internalizing, and comorbid symptoms with long-term economic and social outcomes. JAMA Network Open, 6(1), e2249568.

exclusion from childcare or school, and reduced opportunities for spending time with family and friends.

Key Principle 2: Use strengths-based approaches to engage parents and offer parenting support across the end-to-end system.

Most parents want to do their best for their child. Parents can be reluctant to seek out help, to disclose difficulties, or to engage in interventions. This can be due to the presence of stigma, distrust in services or concerns about safeguarding procedures and children's social care involvement.

FAMILY NURSE PARTNERSHIP

Family Nurse Partnership (FNP) is a personalised home-visiting programme for young mothers expecting their first child. The programme is delivered by highly trained and supervised nurses or midwives.

The FNP programme has three goals:

1. To improve pregnancy health and behaviours
2. To improve child health and development by helping parents provide responsible and competent care
3. To improve economic self-sufficiency by helping parents plan for their own and their baby's future.

Mothers enrol in the programme early in their pregnancy and receive weekly visits from a family nurse before, and for the first six weeks after, the birth of their child. Visits continue fortnightly until three months before the child's second birthday when visits become monthly in preparation for the programme ending. In total, the nurse schedules 64 visits. During these visits, mothers learn about their young child's health and development, and receive support for their own wellbeing.

FNP in England continues to innovate as evidenced by the ADAPT (Accelerated Design and Programme Testing) project. This project has used rapid cycling testing to make strategic and clinical adaptations to the FNP across 20 FNP delivery sites in England. More information can be found here.*

* See: https://dartington.org.uk/fnpadapt

Promoting strength-based approaches

Practitioners should build personalised, trusting, and respectful relationships with parents, offering support which:

- Builds upon parents' strengths and improves their relationships with their child
- Highlights what parents are getting right in their parenting, and the positive impacts this has for their child
- Recognises the challenging circumstances parents can find themselves in, helps them to help themselves, and, where possible, attends to their various needs holistically or prioritises the most pressing needs for the family
- Gives opportunities for parents to reflect on their experiences of parenting, their own early childhoods and experience of being parented, and their desires and motivations towards positive change
- Allows parents to increase their understanding of the child's inner world, their behaviours as communication, and the back-and-forth of parent-child interactions. Parents who were interviewed said that these practices were particularly valued when adopted by those delivering interventions.

A strong local offer ideally includes a range of parenting support across the end-to-end system of support

Parents who are in scope for this Guide can benefit from parenting interventions across the end-to-end system, from settings such as family hubs, during Family Help and to edge of care, and in 'treatment' settings such as therapeutic spaces for those with a family social worker.

Evidence shows that where the level of need is high,[11] parenting interventions have a larger impact on reducing the risk of harm to children, reducing child behavioural problems, and improving positive parenting. This points to parenting interventions working particularly well for parents **most in need**.

Local leaders and commissioners should, therefore, work as much as feasible to offer interventions to meet parents' needs at the time and in the way that will best support their readiness to engage. They should also ensure that local parenting support reaches the parents most in need.

Evidence indicates that both shorter interventions (e.g. eight sessions, such as Level 4 Group Triple P) and longer ones (e.g. 12-16 sessions, such as Incredible Years School Age Basic) can be effective. For some parents, shorter programmes may be more sensitive to challenges like insecure housing, while others may benefit from longer-term support that allows relationship-building and change.

11 Parents who were offered an intervention based on scoring highly on child maltreatment instruments or parents who were referred by agencies (e.g., social services) to receive an intervention based on their levels of maltreatment

Interventions should promote the inclusion of fathers and male carers as part of whole-family working

Practitioners should be aware that support for parents can be stubbornly gendered, both in range and type of support offered, and in the workforce. Evidence shows that many fathers and male carers assume that parenting support is not for them or that they are not welcome to participate. However, fathers and male carers welcome opportunities to reflect on their parenting role, the perceived tensions between masculinity and warm and sensitive parenting, and the co-parenting relationship.

Local leaders must ensure parenting support actively includes fathers by addressing their unique needs and challenging assumptions that such programmes are only for mothers. This involves promoting father-focused initiatives, offering programmes like Fathering in Recovery, PuP4Dads, and Incredible Years, and emphasising whole-family approaches.

Practice supervisors and practitioners should adopt whole family approaches (where relevant to the family being supported). Father focused initiatives should be adopted to strengthen their skills and confidence in working with fathers and male carers. Fathers should be provided with opportunities to reflect on their parenting roles, explore sensitive parenting, and strengthen co-parenting relationships. Leaders must also equip practitioners with the skills and confidence to engage fathers effectively, fostering inclusive and meaningful participation.

Key Principle 3: Ensure that parents from minoritised ethnic backgrounds have equitable access to effective parenting interventions and that these are delivered in a way that fully meets their needs.

Practitioners should be confident that parenting interventions are particularly effective for parents from minoritised ethnic backgrounds. For outcomes associated with parenting, impacts were stronger in interventions that included more than 50% of parents from minoritised ethnic groups.

Local leaders and commissioners should consider the importance of family characteristics in relation to equity, diversity, equality and inclusion in the design and planning of services and work proactively to address barriers to access and inclusion.

Local leaders and commissioners designing parenting support should analyse and carefully consider the local population and community needs and preferences. Local leaders, practice supervisors, and practitioners should work with local communities and parents to ensure that the available support is equitable, accessible, culturally informed

and responsive. Practitioners should be equipped and supported to address racial inequalities.

Our evidence shows that parents' perceptions of services and barriers to seeking help are shaped by experiences of racism in addition to the stigma and pressures that all parents can experience.

Our findings highlighted accessibility barriers identified by parents and practitioners, including some who may struggle with literacy and written comprehension, and challenges when interventions are not culturally matched to parents' experiences. Practitioners should work to address these barriers.

Lack of cultural sensitivity, conscious/unconscious bias and racism can mean that parenting practices are judged harshly by practitioners, and that parents' own needs and experiences are not carefully explored and met.

Key Principle 4: Parenting interventions work well for families where the parent has poor mental health, and, when delivered successfully, support parents to improve parent and child outcomes.

Parenting interventions should be well integrated by local leaders and commissioners into the wider system of specialist mental health services – taking a 'think family' approach.[12]

Parenting interventions play an important role in supporting parental mental health by reflecting on experience, building parenting skills and strengthening parent-child relationships.

Reassure practitioners that they do not need to wait until mental health treatment begins before offering parenting interventions; they can still improve child and parenting outcomes.

Practitioners offering parenting interventions are likely to feel more confident in a parent's capacity to engage in parenting interventions when their mental health needs are supported by specialist services. Practitioners should, however, be reassured that parenting interventions do not need to wait for mental health support to start. Our evidence and wider research show parenting interventions work well to improve child and parenting outcomes, even where parents have untreated mental health problems. This evidence provides important reassurance for the benefits of parenting interventions where parents are experiencing mental health problems.

12 See: https://safeguarding-guide.nhs.uk/context-of-NHS-safeguarding/s2-05/

Prioritise perinatal mental health

Develop targeted strategies for managing mental health during and after pregnancy, incorporating parenting support as part of these interventions.

The management of mental health problems during pregnancy and in the postnatal period is necessarily different to management of these conditions at other times. This difference is due to the nature of this life stage and the potential impact of poor mental health and its treatments for the mother, partner, and the baby.[13] Evidence demonstrates a need for effective interventions, during and after pregnancy.

Strengthen multi-agency collaboration

Establish strong links with specialist clinical networks to streamline referrals and ensure continuity of care.

Local leaders and commissioners should establish strong links with specialist clinical networks and have a good understanding of the referral and management routes for mental health problems that can support effective collaboration and continuity of care across agencies.

Through multi-agency and multi-disciplinary coordination, local leaders, commissioners, practice supervisors and practitioners should ensure that all agencies and professionals interacting with parents are aware of the availability and type of parenting interventions locally. Those delivering parenting interventions should be aware of the wider mental health support available to parents.

Collaboration between organisations, settings and practitioners should strengthen the clarity of information, build confidence in different roles and responsibilities, and promote appropriate referrals to parenting interventions and effective onward referral to specialist services when needed.

13 See: https://www.nice.org.uk/guidance/cg110

PROGRAMME DESIGN

Key Principle 5: Prioritise face-to-face delivery.

Face-to-face delivery shows evidence of effectiveness in supporting outcomes for parents. This finding should be factored-in by local leaders and commissioners when designing services and by practice supervisors and practitioners when delivering services.

Practitioners should work with parents to build confidence and self-esteem through the coaching, modelling and practicing of parenting skills that is supported by face-to-face interactions. Parents build relationships with practitioners and peers by participating in face-to-face group-based programmes.

It is important that local leaders, commissioners, practice supervisors and practitioners are mindful of logistical and financial barriers of face-to-face delivery.

Barriers can include travel costs, the frequency and reach of public transport, and the distance and time needed to travel to intervention delivery settings. Barriers can also arise because of the timing of interventions and balancing work and childcare responsibilities. They can arise because of accessibility needs for parents with disabilities or mental health challenges.

Online and hybrid delivery is becoming increasingly common. It remains the case that there is not yet evidence of the effectiveness of digital or hybrid delivery methods, and more research is needed. There can also be barriers to digital modes of delivery, such as digital exclusion and meeting accessibility needs associated with online sessions.

Key Principle 6: Implement both fixed and flexible delivery models to support a mixed local offer. Prioritise more structured interventions to effectively reduce the risk of serious harm to children, directing resources where they are most needed.

A fixed delivery model refers to interventions that are relatively prescriptive in nature, with a set order of sessions/content. A flexible or modular delivery describes interventions which are more dynamic and adaptable in design.

For the families in scope for this Practice Guide, both fixed and flexible/modular approaches are effective, supporting the benefits of a mixed local offer. Local leaders and commissioners should reflect this in their design of local parenting support.

However, when we unpack the data, we can see that a fixed delivery model is associated with marginally higher impact in relation to harsh and violent parenting and positive parenting with families with greater need. Families who experience multiple adversities face challenges that can impact their parenting capacity. Nevertheless, consistently harsh and violent parenting has significant and long-term impacts on the development and health of children.

This finding supports the importance by local leaders and commissioners of careful targeting of resources to the families most likely to benefit from more structured support, which is reflected in Recommendation 1 of this Guide.

Key Principle 7: Tailor local programmes to meet the specific needs of families, offering both group and individual options to support engagement and provide parents with choice.

Overall, interventions that were group-based or one-to-one models had little difference in effectiveness.

Local leaders and commissioners should, therefore, have confidence in the benefits of a mixed local offer of group or individual support, which reflects local needs (e.g. geography, access to delivery sites, and population need).

Practitioners should be able to offer skilled facilitation of groups, supporting group process and dynamics, holding safer spaces and navigating challenging conversations. Practitioners offering group-based support can provide opportunities for parents to share experiences, reduce feelings of isolation and build support networks with other parents.

One-to-one delivery can support a more tailored approach and offer a confidential and focussed space for practitioners to build trust and relationships and to address individuals' experiences.

Key Principle 8: Focus on careful implementation, effective delivery, and ongoing quality assurance to ensure the success of interventions.

Implementation

Evidence-based interventions are crucial for providing effective support for parents. However, challenges remain in the uptake and quality of their implementation.

Strong leadership is essential throughout the implementation process, from assessing population needs and adopting interventions to embedding them and maintaining quality. Interventions should match local workforce skills, such as therapeutic expertise or the ability to facilitate groups and give coaching in parenting practices.

Practitioners should dedicate time to understanding parents' practical needs (e.g. childcare, accessibility), and offer encouragement and emotional support to foster motivation. Collaborating within local service partnerships can address accessibility, referral processes, and community engagement, helping to improve recruitment and retention in parenting programmes.

Interventions with the strongest evidence of impact provide comprehensive training and implementation support (e.g. through a programme manual, technical assistance with delivery, accreditation or certification). Where programmes specify staff qualification requirements, most require graduate or post-graduate level qualifications in mental health, social work, family support, early education, public health or related disciplines (e.g. family nurses, school nurses, and health visiting), or a medical/science degree.

Attention to delivery detail increases reach and engagement

Effective delivery of parenting interventions requires practitioners who are skilled, well-trained, and sensitive to the challenges families face. Parents value practitioners who build rapport, provide non-judgmental support, and foster stable relationships over time.

Leaders, commissioners and practice supervisors must ensure that practitioners receive initial and ongoing training, supervision, and access to resources to maintain high-quality delivery.

Multi-disciplinary teams are ideal for collaborative delivery, with roles tailored to intervention content, such as therapeutic expertise or skills in group facilitation. Local leaders and practice supervisors must also ensure sufficient technical support at every stage, from preparation and introduction to monitoring and adaptation during delivery.

Quality assurance

Quality assurance processes are essential to maintain the long-term effectiveness of parenting interventions. Local leaders, commissioners and practice supervisors should establish systems for ongoing monitoring of outcomes and delivery. Tools such as implementation checklists, supervision, and regular reviews of participant feedback can identify areas for improvement and ensure interventions meet parents' needs.

Continuous improvement requires testing, learning, and adapting delivery based on evidence. Regular testing of programme implementation ensures that interventions achieve the intended benefits.

LOCAL SYSTEM INTEGRATION

Key Principle 9: A strong local offer should start with a robust population needs analysis and involve place-based system leadership to develop a multi-agency offer.

Local leaders and commissioners should assess local population needs to inform decisions on the range and type of local evidence-based interventions. This process should consider parent preferences and schedules, community characteristics, the number of families requiring support, and the availability and proximity to delivery sites.

Effective parenting support requires strong place-based systems that coordinate services across organisational boundaries. Leaders should leverage existing workforce skills and address gaps by upskilling staff with evidence-based practices that are shown to improve outcomes. Parenting support can be delivered and funded by various agencies, including local authority children's services, Integrated Care Boards, and the voluntary and community sector, drawing on both local and national funding streams.

Costs can be impacted by local factors, such as training costs, practitioner turnover, the available workforce, delivery sites, and size of groups. There may be additional costs to ensure interventions are inclusive to all, including transport costs and those addressing low levels of literacy and digital exclusion.

Key Principle 10: Local areas should have effective referral routes into parenting interventions from a range of local services.

Leaders should collaboratively co-ordinate an effective multi-agency system and clearly communicate the local offer. Clear referral pathways are important to ensure that parents receive the appropriate support at the right time.

Families are typically referred to parenting programmes from across local public and voluntary sector services. These services include community health clinics, mental health clinics, hospitals, child protection services, schools, children centres and family hubs, substance-abuse centres, and other children's services organisations. Self-referral may also happen where programmes are advertised through flyers and newsletters.

All such agencies and their practitioners should be fully informed about the range, type and availability of local parenting interventions, eligibility criteria, and the means of referral and access for families. A clear and coherent local offer and a set of consistent messages for parents can help parents navigate a sometimes complex system of support. For parents, this complexity can be challenging and confusing, serving as a barrier to seeking help and/or receiving appropriate, timely support. It is important to have good communication and relationships between practitioner and parent to help parents navigate services.

Leaders, practice supervisors and practitioners who have an understanding of the evidence and local implementation needs are best placed to facilitate co-ordination between parenting interventions and the local system.

Key Principle 11. Effective parenting support requires a skilled and integrated workforce to deliver effective interventions.

Strengthening multi-agency collaboration requires commitment from local leaders to build connections and enhance workforce skills.

Leaders and practice supervisors should model multi-disciplinary collaboration, prioritising the needs of families over agency differences. Local leaders should embed this ethos in workforce planning and foster a culture of shared responsibility across agencies.

Leaders should bring together workforce plans into a single overarching approach including local Integrated Care Boards (ICBs), health providers, family hubs, children's services, and voluntary, community and faith sector (VCFS) organisations. Through integrated and place-based strategies, leaders can better facilitate access to the range of services families need and promote reach to families who could benefit most from programmes and services.

Integrated working reduces inappropriate referrals and prevents families from needing to frequently retell their stories. It also helps commissioners, practice supervisors and practitioners better understand family needs through service and workforce mapping, improving the efficiency and effectiveness of support.

Key Principle 12: Parenting support should form part of a wider system of support that strengthens the resources available to parents.

Not all parents have access to resources that support parenting. Issues like poor mental health, poverty, unemployment, homelessness, poor housing conditions, racism, and gender discrimination can all add to the burden of stress on parents.

Local leaders need to direct their efforts at tackling as best they can the wider contexts that underpin the demands on parents and that increase parents' vulnerability to adverse outcomes. Though it is recognised that local leaders alone cannot resolve systemic issues like poverty.

In addition to parenting interventions, families should ideally have access to other services and support. This may involve access to psychological therapies, domestic abuse services, medication, harm reduction support for substance misuse and well-integrated referral routes and signposting for other sources of support (e.g. housing, debt management, household goods, food, and employment support).

Parenting programmes can help to strengthen families' response and resilience in the face of challenges. Families have a preference for holistic, systemic, and material support, including early preventative community-based services and specialist support for issues like mental health and substance abuse that can be accessed without stigma or shame. Ideally, these programmes need to be part of local service provision and supported by efforts to address the structural and material contexts of family adversity. It is this combination of policies and practices, wrapped around high-quality implementation of effective parenting programmes, that is needed for radical improvement in the experiences and outcomes of the most vulnerable children.

RECOMMENDATIONS

Recommendation 1: Evidence-based parenting interventions should be made available to families as part of integrated strategies to reduce the risk of more serious harm to children.

PROMISING EVIDENCE

There is promising evidence that parenting interventions can reduce the risk of harm to children for the group of parents in scope for this Practice Guide.

Families who experience multiple adversities face challenges which can impact their parenting capacity. Nevertheless, consistently harsh and violent parenting[14] has significant and long-term impacts on the development and health of children.

There is promising evidence that single interventions can have short-term, small-scale effects on reducing the risk of more serious harm to children.

It is important to recognise that there is insufficient evidence currently to suggest that a single intervention by itself can provide a sustained and long-term solution for serious problems, especially where families experience complex adversities. However, parenting support should be part of a 'jigsaw' of helpful services to prevent more serious risk of significant harm to children.

As part of their responsibility to prevent and address serious harm to children, local leaders and commissioners should ensure a coordinated and jointly owned network of support for parents.

Local leaders and commissioners should focus on the specific intervention models and practices that evidence shows are the **most effective in** reducing the risk of more serious harm to children.

14 Harsh and violent parenting refers to both sustained and consistent physical punishment (e.g., hitting, shoving) and emotional abuse (e.g., shouting, threatening, insulting)–c

Evidence-identified fixed and structured delivery models are more effective at reducing risks of more serious harm to children than more flexible models. Local leaders should reflect the need for more structured parenting support and wider multi-disciplinary services in the targeting of resources and prioritisation of support for families on the edge of care and in Family Help.

CHILD FIRST

Child First is a home-based, therapeutic intervention targeting babies and children aged 0-3 at risk of emotional problems, developmental delay and abuse and neglect. The model aims to bridge universal, targeted and specialist/intensive services to provide a tailored package of support to meet the unique needs of each family. The programme is delivered by two practitioners: a practitioner who connects families to community-based services as part of their family-driven plan and a degree or Master's qualified psychologist who provides home visiting support. Once the family and practitioners have agreed a plan, weekly home visits begin for a period of 6 to 12 months. Each visit lasts between 45 and 90 minutes, depending on the family's needs and the number of family members present. During these sessions, family members receive Child–Parent Psychotherapy.

Recommendation 2: Make evidence-based parenting interventions available to families with a child aged 0 to 3 years to strengthen parent-child relationships.

STRONG EVIDENCE

There is strong evidence for the benefits of providing parenting interventions to strengthen parent–child relationships.

Typically, interventions that improve parent-child relationships are underpinned by Social Learning Theory and/or Attachment Theory and the science of early child development. Practice supervisors and practitioners working directly with families should be well-trained (typically at degree-level) in these theories and their limitations and in specific evidence-based interventions that are prioritised locally. They should also undertake regular refresher training to understand the latest theories and appropriate application of these.

Child attachment refers to the patterns of relationship expectations that arise in the context of early relationships between child and primary caregivers, which lay the foundations for children's emotional and psychological development into adulthood.

Practice supervisors and practitioners focused on improving child attachment should deliver programmes that highlight the importance of strengthening sensitive and responsive caregiving. In some, the focus is on improving parents' actions. In others, practitioners also address intergenerational attachment experiences and parents' own internal working models of attachment that influence their parenting.

Practitioners should deliver sessions that employ child-led play to promote curiosity and use careful observation to reflect on the meaning that parents give to their child's cues and explore how a parent's own childhood experiences may have shaped their responses to their child.

Interventions focused on parent-child relationships are usually not in a fixed schedule. Instead, they work around the individual needs of the primary caregiver (e.g. work commitments or medical appointments). Interventions such as Infant–Parent Psychotherapy and Promoting First Relationships are typically delivered in the home environment and provide practical, in-depth strategies that promote secure and nurturing relationships between the child and primary caregiver.

INFANT-PARENT PSYCHOTHERAPY

Infant-Parent Psychotherapy (IPP) is a therapeutic intervention targeting mother-infant pairs who may be at risk of an insecure attachment.

Parents identified as being depressed, anxious, traumatised or at risk of maltreating their child, attend weekly sessions with their baby (more than six months) for 12 months or longer.

Therapists help the parent to reflect on past and present psychological, emotional and relationship issues that could impact their caregiving and their child's relationship with them.

The psychotherapist models sensitive responding and helps the parent to interpret their baby's behaviour appropriately. As the therapeutic relationship develops, the parent learns to differentiate negative feelings informed by their own childhood from their interactions with their child and appropriately interpret their child's behaviours.

Please note that this describes the evidence for a specific manualised programme that makes use of psychotherapy. It does not describe the evidence for parent-infant psychotherapy with babies and young children as a broader practice. The more general practice of infant-parent psychotherapy in the UK most often takes place within Child and Adolescent Mental Health Teams (CAMHS) in early attachments services, in NHS perinatal mental health services, or within specialist Parent-Infant Relationship teams, and is delivered by clinical psychologists or psychoanalytic parent-infant psychotherapists with a postgraduate or doctoral level training.

Interventions often aim to strengthen the maternal relationship with the child during the perinatal period (years 0-3) and can be delivered both inside and outside the home. During an intervention, practitioners should observe interactions between parents and children and provide feedback on aspects such as communication behaviour and responsiveness to child eye contact, sound and movement. Practitioners should model new techniques, encourage parental self-esteem, and provide practical parenting knowledge (e.g. soothing techniques).

Recommendation 3: Make evidence-based parenting interventions available to families to improve child behaviour and effective parenting practices.

STRONG EVIDENCE

There is strong evidence of the impact of parenting interventions on child behaviours overall,[15] and behaviours that challenge,[16] seen in both the short-term and sustained over time.

Parenting interventions can work to empower parents to adopt more positive parenting practices and, in turn, model these behaviours for their children to learn from. Improvements in child behaviour can lead to a range of positive outcomes in later life for the child.

Evidence shows that parenting interventions benefit child behaviour in both the short-term (0-6 months post-intervention) and long-term (+6 months post-intervention).

Practice supervisors and practitioners should use practices and interventions that are well-evidenced to improve child behaviour, where this is a priority need for the parent and child being supported. Key features shared by effective parenting interventions that should be adopted by practice supervisors and practitioners in intervention content and/or interactions with parents:

- Content which supports parents in setting clear expectations and boundaries for their child
- Content that supports child-led interactions.

15 Overall behaviour is a composite measure of both externalising behaviours (e.g. aggression, defiance, and hyperactivity) and internalising behaviours (anxiety, fearfulness, and social withdrawal).
16 Behaviours that challenge (externalising behaviours) refer to behaviours which manifest in a child's outward behaviour, such as aggression, defiance, and hyperactivity.

Interventions can also include practitioner-led content such as participation in group discussions, role-play activities and short videos to highlight key concepts and ways of achieving changes for parents and children.

From when a child is age 2, effective parenting strategies should be taught, role modelled and encouraged by practitioners to support parents to improve children's behaviour and support children's self-regulation, such as:

- Parents holding boundaries during episodes of behaviours that challenge (e.g. consistent non-compliance or more serious aggression)
- Parents using a point system and other incentives for rewarding behaviours that are optimal for children's healthy interactions with family and peers
- Parents using verbal praise (e.g., encouragement and recognition in a warm and loving tone of voice, saying thank you, and using responsive body language) when children are behaving in a way that is healthy in terms of interactions with family and peers
- Not arguing with children or engaging in long periods of verbal negotiation.

While many parents are aware of these strategies and know how to use them, others do not know them, may apply them incorrectly, or may not have the resources to deploy them when they are overwhelmed by experiences of adversity. Practice supervisors should support awareness and use of these strategies among practitioners, where improvements in child behaviour are a priority.

Some parents have difficulty implementing effective strategies because they either misinterpret the reasons for their child's behaviour, or they lack the confidence to follow through with effective discipline.

Studies suggest that a child's behaviours may impact parent stress and depression. For example, parents who have not been supported with parenting skills may become increasingly lenient when trying to cope with their child. The child's behaviour, in turn, can become more difficult to parent, which can further increase

FAMILY CHECK-UP

Family Check-Up 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. The first is a brief, three-session programme that involves three one-hour sessions: interview, assessment and feedback. The intervention is delivered over nine sessions of 50-60 minutes' duration, each by one therapist or social worker who is qualified at postgraduate/doctoral level. In the sessions, parents learn positive behaviour support strategies to help them proactively structure family situations to promote children's self-regulatory development and minimise problem behaviour. In the short term, parents learn positive strategies for engaging with their child. In the longer term, children are less likely to engage in antisocial and risky behaviour.

parenting stress. Therefore, intervening to support parents to respond to children's behaviour effectively has benefits for both child and parent.

There is strong evidence that parenting interventions reduce negative parenting practices and improve positive parenting practices.

Positive parenting practices include sensitive, warm and nurturing parenting and parent-child interactions led by the child, sometimes expressed as 'serve and return' interactions. Negative practices include overly punitive, harsh or inconsistent behaviours toward the child or distant and emotionally unresponsive behaviours towards the child.

These parenting interventions are mainly guided by Social Learning Theory, where children learn behaviours from their environment and experiences. Overly strict, harsh or unresponsive parenting can create and reinforce negative behaviours in children.

Practitioners should address these negative cycles by supporting parents to model a more effective interaction style, help change patterns of interactions and behaviour, and reinforce positive interactions.

Practitioners can conduct parent coaching to empower parents with the confidence and ability to better manage child behaviour. Practitioners should be skilled in coaching techniques, have experience of previously delivering parent coaching, and have the interpersonal skills needed to develop long-lasting, trusting relationships (e.g. empathy and compassion). Coaching can also provide opportunities and support for parents to practice and strengthen core parenting skills and receive individualised feedback from practitioners (such as through role play, homework, and group exercises).

INCREDIBLE YEARS SCHOOL AGE BASIC

The Incredible Years (IY) School Age Basic Programme is for parents with concerns about the behaviour of a child between the ages of 6 and 12. It is delivered in 12 to 16 (2-hour) sessions in groups of 8 to 12 parents, although can also be delivered individually to families in 12 to 16, 90-minute sessions. Sessions are led by a practitioner qualified to postgraduate/doctoral level.

During the sessions, parents share their own experiences of parenting, and undertake role-play, where they learn new parenting strategies from the perspective of the child. These newly learnt strategies are then practised in the home environment with their children. Parents are also assigned a reading task each weak, providing theory behind the strategies learnt and watch video clips of other parents, aiding the development of effective parenting principles.

The intervention has also been evidenced to work with preschool children and has also been adapted with an add-on (Incredible Years Basic + Advance Parent Training). The Advance programme involves adding 9 to 12 sessions of 2 to 2.25 hours alongside the Basic Programme.

Practitioners should, through interventions, support parents to better understand how they think about themselves and their child. Practitioners should support parents to observe, recognise and scaffold the communications or initiatives from the child, helping them to 'tune in' to the child's experiences and needs.

Effective interventions, such as Incredible Years and Parent Child Interaction Therapy, combine Social Learning Theory with approaches that recognise the importance of parents' thoughts, feelings and beliefs about their children. These approaches focus on helping parents set age-appropriate expectations and boundaries for their children while encouraging positive behaviour through praise and rewards.

Recommendation 4: Make evidence-based parenting interventions available to reduce levels of parenting stress and support parental mental health.

There is strong evidence that parenting interventions have a positive impact on reducing levels of parenting stress.

STRONG EVIDENCE

Parenting stress is the experience of distress in parents arising from the demands of the parenting role. High levels of parenting stress can significantly interfere with parents' ability to form a positive working relationship with practitioners and learn new skills.

Practice supervisors should ensure that practitioners are given sufficient time to build relationships with parents and enable them to develop the confidence to learn new skills and make use of feedback. Practitioners should be skilled in understanding the impacts of stress on parents experiencing adversity and how they can promote parental engagement with the content provided.

Persistent and severe parenting stress is known to increase adverse outcomes for parents, their children, and the wider family. These outcomes include increases in poor mental health, conflict in the couple's relationship and impacts on the parent-child relationship. Higher levels of parenting stress can overwhelm parents and are associated with increases in behavioural, social and emotional difficulties in children.

An example intervention can be found in Triple P Online, which combines behaviour management and relationship enhancement elements.

TRIPLE P ONLINE

Triple P Online is a web-based parenting intervention. It is designed to reach parents who prefer to complete a programme online or are harder to reach. It is available to parents with children aged up to 12 years with significant social, emotional or behavioural problems. The programme consists of eight sessions, lasting 30-60 minutes. It is led by practitioners with an undergraduate degree. The first four modules cover core programme content relating to positive parenting principles, with the remaining four modules focusing on helping parents to integrate learnt strategies through parenting plans.

There is strong evidence that parenting interventions can support improved parental mental health.

Evidence offers important reassurance to local leaders and commissioners of the value of offering parenting support to all parents, including where parents are experiencing mental health problems.

Evidence shows parenting interventions alone are not sufficient to see a significant (clinical) change in parental mental health over time. Nevertheless, even for parents with clinical levels of mental health problems, evidence shows parenting interventions can improve parenting skills.

In the perinatal period, our evidence identified interventions such as Infant-Parent Psychotherapy and Child First (see case studies).

Practitioners should strengthen the relationship between parent and baby/young child by offering developmental guidance and strategies to nurture the child's development. Practitioners should give support to the parents' capacity to think (executive function) and to manage their emotions.

Where parents are experiencing more acute or severe mental health needs, a parenting intervention alone should not be considered sufficient to foster improvements and a more holistic service offer is recommended, including referral to specialist mental health support.

CASE STUDIES

These case studies are hypothetical examples intended to demonstrate how the evidence in this Practice Guide could be applied by the workforce and local leaders to support families. We will update the case studies in partnership with local authorities.

CASE STUDY I: CHILD FIRST

Child First is a therapeutic, home-based intervention targeted at infants/toddlers/children aged 0 to 5 years old who are at risk of developmental delay, abuse and neglect, and emotional problems. The intervention aims to provide a tailored package of support to meet the unique needs of families. This case study highlights the importance of targeted early support for families facing adversity, with a child at risk of developmental delay, abuse and neglect.

The issue

Aubrey was born prematurely after a difficult pregnancy. During pregnancy, her mother, Sandra let midwifery staff know that she was struggling, in discussions prompted by the Whooley Questions.[17] Sandra shared that she wished she had never become pregnant, she worried she wouldn't be a good mum, and that Aubrey was causing trouble even before she was born. Aubrey's father, Johnny shared his concerns about Aubrey and Sandra's wellbeing during the pregnancy, but was overall excited about becoming a Dad and reassured Sandra that things would be okay and that she would be a wonderful Mum. However, he shared that he had recently had an injury, had been laid off from his construction job and was struggling to find work. These things were causing him stress as he did not know how they were going to afford all the things a new baby needs, but he did not want to share this with Sandra.

Sandra was induced, and Aubrey was born prematurely and spent three months in the neonatal intensive care unit (NICU). This was an incredibly worrying time for Sandra and Johnny, but when Aubrey was discharged home, she fed well, put on weight as expected, and experienced no ongoing health issues. Sandra received some extra support from the midwifery team during her pregnancy and Aubrey's time in the NICU, and seemed to be coping well during follow up appointments after leaving hospital.

17 The Whooley questions are a two-question screening tool developed to diagnose common mental disorders in primary care settings. The questions have been adopted for use in maternity care to identify mental health problems during pregnancy and postpartum recommended in NICE guidelines.

However, at 9 months old, a health visitor noticed that Aubrey was not meeting some of the expected developmental milestones at her routine health review. Aubrey was sitting without support and eating well, but struggled to hold and play with toys, and wasn't making as many babbling sounds or responding to the health visitor's attempts to engage her. The health visitor also noticed that Sandra seemed withdrawn during the appointment and struggled to describe any activities or play she did with Aubrey to support her development.

The health visitor arranged follow up 'listening visits', with Sandra – Johnny was not back in time– to explore how they were finding parenting and to share their concerns about what they observed during the review. Sandra and Johnny both talked about how their experience of being first-time parents did not match what they read or saw online, and that the challenges, both during pregnancy and in Aubrey's first few months did make them both feel anxious. This anxiety, combined with sleepless nights and no time as a couple, meant they often missed how life was before Aubrey.

Johnny shared that as he now had two jobs to make ends meet, he felt tired most evenings and didn't always have the energy to spend time playing with Aubrey. Sandra said sometimes Johnny would get angry and frustrated when she asked him to help with Aubrey in the evenings and would take a couple of tins of beer and go into the bedroom on his own, leaving Sandra with Aubrey.

Sandra shared that she found it difficult to enjoy her time with Aubrey during the day as she was often exhausted after an interrupted night's sleep and doing housework during the day, while also making sure Aubrey got her meals, milk feeds, and naps. Sandra also shared that because of this, she often placed Aubrey in the cot on her own while she watched TV and took a nap. They shared that they did not really have a wider family network as they had both moved away to a new town for a fresh start.

Sandra and Johnny consented to a referral to their local Family Early Help team for support with the challenges of parenting, and learn new ways to support Aubrey's development.

The support offered

The family were allocated a family support worker who met with the family in their home. She used a strengths-based approach to work with Sandra and Johnny to build trust and rapport with the parents and over a number of assessment sessions together they created a 3-month plan which included some individual sessions with Sandra, a Dad's group for Johnny and some joint play sessions with them as a family. The support worker could see that both Sandra and Johnny were really trying but were unable to stick to routines or develop consistency in using the suggested techniques and would often argue about who was doing it right or wrong. It was getting increasingly difficult to soothe Aubrey when she got upset, and at other times she appeared tired and disengaged. Sandra disclosed

that Johnny had pushed her to the ground a few times. She said Johnny was becoming verbally abusive and was drinking more and she would often shout and swear back at him, telling him he was a rubbish father. Sandra expressed that she felt Aubrey didn't like her and she sometimes thought that Aubrey would be better off without her. The support worker discussed her concerns about escalating conflict between the couple and Sandra's increasingly withdrawn presentation. She shared her worries about Aubrey's emotional development. It was agreed that the family could benefit from a more intensive therapeutic assessment and support.

The family consented to a referral to the Child First programme, which offers targeted support from two practitioners: a qualified care coordinator who would connect the family to community-based services as part of a needs-driven plan for support and offer general mentoring support; and a qualified clinician who would provide home visiting support. The support offered to the family included the following components: family engagement, a comprehensive assessment of child and family, development of a support plan for the child and family, parent-child psychotherapy, and care co-ordination.

The results

The Child First programme helped to promote a positive and sensitive child–parent relationship during Aubrey's early years, which helped lay a positive foundation for Aubrey's social, emotional, and cognitive development. As a result, Sandra and Johnny felt more confident in their parenting, and in their understanding of their daughter and the positive role they played in supporting her development. They were able to clearly enjoy and cherish their ordinary interactions with her and the games they played together. The programme also provided the family with coordinated and integrated care, by offering community-based support, signposting families to relevant services, and facilitating referrals to appropriate service providers. This helped to reduce the psychological stress Aubrey's parents were experiencing. In the longer term, Child First can lead to reduced risk of negative outcomes, such as child abuse and neglect.

CASE STUDY 2: STRENGTHENING FAMILIES THROUGH COLLABORATIVE EARLY HELP PARENTING SUPPORT

The issue

Fairfield is a large metropolitan borough with significant income disparities across the local area and some families experience high levels of deprivation. A recent rise in referrals from health providers and primary schools for parenting support led to the Local Safeguarding Children Partnership (LSCP) conducting a review to understand the reasons for this increase.

The review, coordinated by the LSCP business unit, included:

- **Local service mapping,** including a multi-agency review of referrals, to understand what was available for parents and where this was being delivered; what support was provided prior to referrals; which families were being referred and by whom; which families were attending; and whether families were completing the intervention. They also used a waiting well strategy to understand waiting times and analyse support provided to families while awaiting services.
- **Local multi-agency workforce mapping,** including an audit of training levels and workforce skills to identify training needs in delivering parenting interventions, and to better understand how Early Carer Social Workers were being supported to engage with diverse families.
- **Local stakeholder mapping and engagement,** including roundtable sessions with multi-agency practitioners to build and strengthen collaboration across the local system, including roundtables with partnership and practice supervisors, and coffee sessions with parents in different community locations to gain feedback from families and review their experience and accessibility of interventions.

The findings

Parenting support and interventions were primarily led by the local authority. A more coordinated approach to practice and commissioning across multiple agencies would enhance their effectiveness.

Awareness of available support and how to access it was limited among some multi agency professionals and the public, leading to delays in providing the right support to parents at the right time.

A variety of parenting programmes were available but their utilisation varied. Analysis of available data indicated that reach varied across communities, with some minoritised populations being underserved. Analysis of service audit and feedback from parents showed that knowledge, stigma and programme characteristics, such as time and delivery location, were barriers for fathers. Lack of father-inclusive practice from service providers was also identified as a barrier to fathers' engagement. Language barriers were identified as a key barrier for minority parents engaging in support, with families expressing the need to integrate cultural differences into provision.

Multi-agency workforce development presented an opportunity to enhance consistency in language, practice approaches, and referrals to programmes, supporting a more cohesive system-wide approach to practice.

A gap in information sharing between General Practitioners and Children's Services meant that mental health support for parents was not always identified or understood on a multi-agency level. This gap impacted the effectiveness of multi-agency support plans for the child.

The Family Help team identified an increase in the numbers of referrals linked to parenting stress, especially where parents were experiencing challenges with their child's development, and in the context of poverty, poor mental health and social isolation.

The review identified the need for targeted parenting support to address the challenges faced by families with young children.

The action

The first step taken by Fairfield's LSCP was to collaborate to develop a coordinated response, agreeing a set of joint values and mission with clear aims and desired outcomes. This was supported by an engaged and committed elected member and driven forwards by a part-time project lead funded jointly by the partnership.

Together they designed the Thriving Families programme, a flexible, tiered model of support. The goal was to deliver holistic, multi-agency Family Help support to help empower parents, enhance children's outcomes and reduce the need for statutory interventions.

The local offer included:

- Universal access to parenting workshops delivered regularly in Family Hubs located in the most disadvantaged wards, focussed on positive parenting strategies, communication and child development.
- Targeted support offering evidence-based group-based interventions for families with identified challenges such as child behavioural issues and parenting stress

- Intensive evidence-based intervention offering one-to-one sessions with appropriately qualified staff (likely with level QCF 6/7 qualifications) to families needing bespoke support (such as navigating family conflict or addressing behavioural concerns), and supporting onward referal into more specialist interventions, such as referring families to specialist parent-infant relationship teams, where indicated.

Fairfield's LSCP engaged all partners from the outset, with schools, health visitors and voluntary, community and faith organisations co-designing services alongside local families and providing venues for delivery of interventions, consultations and workshops. Local families contributed to designing information to share with parents and practitioners to raise awareness of the support available. Early and sustained publicity was key to the model's outcomes. Thriving Families was delivered by a multi-agency team including Early Help practitioners, CAMHS workers for mental health support, volunteer parent peer supporters and interpreters to ensure inclusivity for families with English as an additional language. Partners worked together to review, update and embed referral pathways across the partnership to promote access to support. The partnership sought to work with existing community networks and structures to promote positive perceptions of available services by offering outreach 'taster' sessions, representing the Thriving Families offer, in community settings such as religious spaces and groups.

A multi-agency panel received referrals supporting interdisciplinary discussion and facilitating families journeys into effective support. A task and finish group worked together to improve information sharing with GPs with a focus on how parental mental health is understood and supported, in collaboration with the Integrated Care Board. Stronger collaboration and shared understanding across the local partnership supported improvements in recruitment and retention onto available parenting programmes.

The model was supported by investment in workforce development across the partnership, with practitioners being trained in and supported to refer to a range of evidence-based interventions and provided with ongoing supervision and dedicated time to access technical assistance support and participate in communities of practice to embed learning.

A virtual team hub allowed stronger interagency communication and coordination of workforce training, intervention monitoring and feedback across teams and settings to promote continuous improvement. Staff were able to easily access a repository of research and practice evidence and guidance; coordinate feedback from families; access bite-size refresher training; and seek consultation from specialist practitioners.

This included the development of some recorded presentations in a variety of community languages to support local practitioners and parents to easily access information and advice to support navigation across the local offer.

The results

Fairfield started to see better attendance from education and health partners in routine multi-agency meetings as part of Early Help and Child in Need support plans. Frequent, well-informed case discussions strengthened relationships across the partnership, which ensured that support for parents and their children was coordinated, and less work was duplicated.

Fairfield's Thriving Families programme team worked collaboratively to 'do things differently', building trusting relationships that allowed for flexibility and responsiveness to families' varying, and sometimes changing, needs. Collaboration supported the design and delivery of services to improve accessibility of services to parents from across the local communities in ways that were culturally sensitive and responsive to families' needs.

Taking a 'Think Family' approach supported the partnership to innovate and to develop new ways of approaching identified challenges.[18] Placing families at the centre of service design and bringing multi-agency stakeholders together helped to achieve clear improvements in desired outcomes. Continuous use of local data allowed the partnership to refine and target interventions more effectively. Engaging parents early on in shaping the model and threading opportunities for feedback throughout, improved trust and motivation among families, and therefore meant Fairfield could engage them in the right support, at the right time.

18 Think Family is a whole-family approach that recognises the links between parental mental health problems and child wellbeing. It promotes coordination, support, and partnership between adult and child services. See: https://safeguarding-guide.nhs.uk/context-of-NHS-safeguarding/s2-05/

RESOURCES

Parenting Through Adversity Practice Guide 0–10 (online summary)

Explore the summary version of the Practice Guide on our website: https://foundations.org.uk/practice-guides/parenting-through-adversity-0-10/

VISIT

Summary for Elected Members

This document summarises the Key principles and Recommendations of the Practice Guide to support elected members to reflect on their local offer for parents experiencing adversity, and consider how it could be strengthened: https://foundations.org.uk/wp-content/uploads/2025/02/summary-elected-members-parenting-through-adversity-0-10.pdf

DOWNLOAD

Extended definitions

Find out more about the scope and definitions for this Practice Guide: https://foundations.org.uk/parenting-through-adversity-pg-0-10-extended-definitions/

VISIT

Systematic reviews

Read the two systematic reviews that underpin the Practice Guide. If you are an academic or a researcher, you might be particularly interested in this:

- **Quantitative review:** https://foundations.org.uk/wp-content/uploads/2025/02/systematic-review-interventions-practices-parents-complex-multiple-needs.pdf

DOWNLOAD

- **Qualitative review:** https://foundations.org.uk/wp-content/uploads/2025/02/rapid-qual-synthesis-implementation-interventions-parents-multiple-complex-needs.pdf

DOWNLOAD

Evidence annex

DOWNLOAD

Find out more about the underpinning evidence for each Key Principle and Recommendation and read recommendations for future research and evaluation. This might be of most interest to researchers or academics:
https://foundations.org.uk/wp-content/uploads/2025/02/evidence-annex-parenting-through-adversity-0-10.pdf

Technical annex on methodology

DOWNLOAD

Find out more about the methodology used in the creation of this Practice Guide. If you have an interest in the production of evidence-based guidance, or are a researcher or academic, you may find this helpful:
https://foundations.org.uk/wp-content/uploads/2025/02/technical-annex-parenting-through-adversity-0-10.pdf

EVIDENCE SUMMARY

Summary of evidence underlying recommendations:

RECOMMENDATION	STRONG EVIDENCE	GOOD EVIDENCE	PROMISING EVIDENCE
1. Evidence-based parenting interventions should be made available to families as part of integrated strategies to reduce the risk of more serious harm to children			✔
2. Make evidence-based parenting interventions available to families with a child aged 0 to 3 years to strengthen parent-child relationships	✔		
3. Make evidence-based parenting interventions available to families to improve child behaviour and effective parenting practices	✔		
4. Make evidence-based parenting interventions available to reduce levels of parenting stress and support parental mental health	✔		

This resource is part of a set of publications linked to the Parenting Through Adversity Practice Guide (0–10):

- Online summary guide: www.foundations.org.uk/practice-guides/parenting-through-adversity-0-10
- Summary for Elected Members: https://foundations.org.uk/practice-guides/parenting-through-adversity-0-10/

Find out more about the series of Practice Guides:
foundations.org.uk/practice-guides

We want to hear from local leaders who are engaging with the Practice Guides.
Get in touch at practice_guides@foundations.org.uk.