Foundations
What Works Centre for Children & Families

EVIDENCE ANNEX

Parenting thorough Adversity (11-18) Practice Guide

Introduction

This evidence annex sets out the evidence underpinning each of the six reccomendations specified in the Parenting thoughAdversity (11–18) Practice Guide. Influenced by our evidence toolkit standards, the table pulls out the key methodological information which defines the strength of evidential certainty behind our recommendations. It also identifies the qualitative evidence which underpins our principles. A reference list of evidenced studies is also provided.

Department for Education

More information on the evidence underpinning this guide:

- Technical annex on methodology: https://foundations.org.uk/wp-content/uploads/2025/12/technical-annex-parenting-through-adversity-11-18-practice-guide.pdf
- Systematic review: https://foundations.org.uk/wp-content/uploads/2025/12/systematic-review-parenting-through-adversity-11-18-practice-guide.pdf

Go to the Parenting Disabled Children & Young People Practice Guide: foundations.org.uk/toolkit/practice-guides/parenting-through-adversity-11-18

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

Evidence underpinning recommendations (meta-analysis)

Table 1. Make evidence-based interventions available to families where behaviours that challenge are present to improve and empower effective parenting practices.

Recommendation	No. of trials	No. of effect sizes included	Effect size & 95% confidence intervals	Heterogeneity	% of studies assessed to have a low risk of bias	Strength of evidence rating
Recommendation 1: Make evidence-based interventions available to families where behaviours that challenge are present to improve and empower effective parenting practices.	5	5	*d* = -0.19; 95% CI -0.29,-0.09	0%	**Fonagy et al. 2018/2020a: Some concerns** **Asscher et al. 2013: Some concerns** Humayun et al., 2017: Some concerns Irvive et al. 2015: Some concerns Duppong Hurley et al. 2020: Some concerns 0% of included studies have a low risk of bias	Good

Summary of findings

Fonagy et al. 2018/2020a

Fonagy et al. (2020) conducted a pragmatic RCT in 10 English local authorities with 450 adolescents presenting with severe antisocial behaviour, comparing Multisystemic Therapy (MST) with management-as-usual (MAU). Family functioning was assessed through the Family Adaptability and Cohesion Evaluation Scale (FACES) and parenting practices using the Alabama Parenting Questionnaire (APQ). At 12 months, no significant differences were observed between MST and MAU for family adaptability (F=0.72, p=.40) or cohesion (F=0.88, p=.35). Both groups showed small improvements over time, but the rate of change was comparable, indicating that MST did not produce additional benefits beyond routine services. However, **MST parents reported significantly lower inconsistent discipline compared with MAU (MST mean=7.74 vs. MAU mean=8.22; 95% CI −1.05, −0.24) at 24 months**, suggesting a modest but reliable improvement in parenting

practices. Subgroup analyses failed to detect differential effects among families with higher baseline risk or dysfunction. Overall, findings indicate that, in UK practice settings, MST had limited impact on family adaptability and cohesion but may support reductions in inconsistent discipline.

Asscher et al. 2013

Asscher et al. (2013) conducted an RCT in the Netherlands with 256 adolescents (12–18 years) with severe antisocial behaviour, randomised to Multisystemic Therapy (MST) or treatment-as-usual (TAU). Child behavioural outcomes were measured using parent report measures, the Child Behaviour Checklist (CBCL) and the DSM Disruptive Behaviour Disorders scale (DBD), and young person report measures, the Youth Self Report externalising subscale (YSR) and the Self-Report Delinquency scale (SRD). Parenting outcomes were assessed via parent, adolescent, and observer ratings of discipline, relationship quality, and parental competence. Compared with TAU, MST parents reported significant increases in parental sense of competence ($F=8.17$, $p<.01$, $d=.36$). MST also improved positive discipline according to parents ($F=13.13$, $p<.001$, $d=.47$), adolescents ($F=5.07$, $p<.05$, $d=.28$), and observational ratings ($F=6.90$, $p<.01$, $d=.33$). Quality of the parent–adolescent relationship improved in MST relative to TAU according to parents ($F=6.03$, $p<.05$, $d=.31$) and observers ($F=8.72$, $p<.01$, $d=.37$), though not adolescents. **MST also significantly reduced inept discipline in observational ratings (d=0.27; 95% CI: 0.02, 0.52) over a six-month period**. These findings suggest MST strengthened parenting competence, discipline, and relationship quality in the Dutch context, though effects varied by informant.

Humayun et al. 2017

Humayun et al. (2017) conducted the first UK RCT of Functional Family Therapy (FFT) for 111 adolescents (10–17 years) with offending or antisocial behaviour, randomised to FFT + management-as-usual (MAU) (n=65) or MAU alone (n=46). Parenting outcomes were assessed via the Alabama Parenting Questionnaire (APQ) and directly observed parent–youth interactions (“Hot Topics” task). Results showed no significant differences between FFT and MAU on parental monitoring at 6 months ($d=0.05$, $p=.79$) or 18 months ($d=0.18$, $p=.37$). Similarly, no group differences emerged in observed positive parenting (6m: $d=0.36$, $p=.11$; 18m: $d=0.17$, $p=.44$) or negative parenting (6m: $d=0.18$, $p=.43$; 18m: $d=0.18$, $p=.46$). Over time, both groups showed small within-group reductions in poor monitoring, but improvements were not attributable to FFT. The authors concluded that FFT did not significantly improve parenting practices or parent–child relationship quality compared with MAU, suggesting that in this UK context, family processes did not mediate behavioural change.

Irvine et al. (2014)

The Irvine et al. (2014) study evaluated the Parenting Toolkit, an online behavioural parent training program, through a randomized controlled trial with 307 parents of at-risk adolescents aged 11-14 (determined by at least four behaviours such as such as poor grades, trouble at school, drug use, or associating with troublesome peers). Participants were predominantly female, low-income, and racially diverse, recruited from six urban Community Technology Centers. Parents completed baseline and 30-day follow-up assessments. Parent-focused outcomes were measured using the Parenting Scale–Adolescent version (discipline style: over reactivity, laxness), a self-efficacy scale, and a behavioural

intentions scale. In intent-to-treat analyses, parents in the treatment group showed significant improvements in self-efficacy (p=.02) and intentions to use positive parenting practices (p=.02), with trends toward reduced over reactivity (p=0.7) and laxness (p=0.7). Among those who actively engaged with the program, significant improvements were observed across all parenting outcomes, with effect sizes ranging from small to moderate. These findings suggest that brief, scenario-based online training can strengthen parents' confidence, consistency, and intentions in managing adolescent behaviour.

Duppong Hurley et al. (2020)

Duppong Hurley et al. (2019) conducted a randomised trial to examine the efficacy of the Boys Town In-Home Family Services (IHFS) programme. 300 children aged 5-14 were recruited for the trail, of which 152 were randomly assigned to the IHFS programme and 148 assigned to the services as usual comparison group. Parenting practices were measured using the Alabama Parenting Questionnaire (APQ) subscales and the Parenting Scale. In intention-to-treat analyses, IHFS did not significantly improve positive parenting (APQ-PP: g=-0.06, p=.569) or parental involvement (g=0.01, p=.952). Similarly, there were no significant differences for poor monitoring/supervision (APQ-PMS: g=-0.12, p=.231) or inconsistent discipline (APQ-ID: g=-0.07, p=.504) compared to services-as-usual. However, there was a small improvement in dysfunctional discipline style on the Parenting Scale, (p=.016), although this did not meet the stricter corrected significance level. Dose–response analysis indicated service engagement (25–75 hours) was linked to greater improvements in parenting skills, particularly reductions in poor discipline practices. Overall, IHFS showed limited direct effects on positive parenting, supervision, or consistency, though service dosage appeared important.

Table 2. Recommendation 2: Make evidence-based parenting interventions available to families experiencing poor family functioning and child behavioural issues to reduce parenting stress.

Recommendation	No. of trials	No. of effect sizes included	Effect size & 95% confidence intervals	Heterogeneity	% of studies assessed to have a low risk of bias	Strength of evidence rating
Recommendation 2: Make evidence-based parenting interventions available to families experiencing poor family functioning and child behavioural issues to reduce parenting stress.	4	4	*d* = -0.35; 95% CI -0.51, -0.19	0%	**Asscher et al. 2013: some concerns** Fongaro et al. 2023: Some concerns Salari et al. 2014: Serious **Duppong Hurley et al. 2014: Some concerns** 0% of included studies have a low risk of bias	Good

Asscher et al. (2013)

Asscher et al. (2013) evaluated Multisystemic Therapy (MST) in the Netherlands with 256 families of adolescents referred for severe antisocial behaviour. Parent outcomes included sense of competence, assessed with the Parenting Stress Index competence subscale. **Parents in the MST group reported a significant improvement in their sense of competence from pre- to post-treatment (6 months)** compared with parents receiving treatment-as-usual ($F=8.17$, $p<.01$, $d=.36$). While MST parents' ratings increased, suggesting greater confidence in their parenting abilities, parents in the comparison group showed a slight decline. This finding aligns with MST's theoretical emphasis on empowering caregivers as the primary agents of change. By providing intensive support in the home and community, MST appears to strengthen parents' belief in their ability to manage their adolescent's behaviour, which is considered a key mechanism for sustaining positive change.

Fongaro et al. (2023)

Fongaro et al. (2023) conducted a single-blinded RCT in France evaluating the Non-Violent Resistance (NVR) parent training programme for families of children aged 6–20 exhibiting severe tyrannical behaviour (STB), characterised by child-to-parent violence and domination of family dynamics. Eighty-two parents were randomised to NVR or treatment-as-usual (TAU; supportive counselling and psychoeducation), with assessments at baseline and 4 months, and an additional 8-month follow-up for NVR. The primary outcome was parental stress (Parenting

Stress Index–Short Form). At 4 months, stress reduction did not differ significantly between groups (NVR: −4.3 vs TAU: −7.6; p=0.42). Within-group analyses showed reductions in stress for TAU at completion (p=0.03) and for NVR only at follow-up (p=0.002 from baseline to 8 months). Parental anxiety (HADS-A) decreased significantly over time in NVR (p<0.001), while depressive symptoms showed small improvements, mainly in TAU. Findings suggest NVR may help reduce parental stress and anxiety, but effects emerge more clearly in the longer term rather than immediately post-treatment.

Salari et al. (2014)

Salari, Ralph, and Sanders (2014) evaluated Standard Teen Triple P (Positive Parenting Program) with 62 families of adolescents aged 11–16 years showing elevated behavioural or emotional problems. Parents' mental health was assessed using the Depression, Anxiety and Stress Scales (DASS-21). Compared to the waitlist control group, parents in the intervention group showed no significant improvements in depression (F=0.06, p=.814), anxiety (F=0.07, p=.794), or stress (F=1.10, p=.300) following the programme. Effect sizes were small (d=−.07 to .31), indicating negligible to minor changes. At three-month follow-up, no sustained improvements were evident in stress (F=3.72, p=.072, d=.62), depression (F=2.65, p=.123, d=.57), or anxiety (F=5.36, p=.034, d=.63), though the authors noted trends toward moderate effects for stress and anxiety reduction. Overall, the intervention demonstrated clear benefits for parenting practices and family conflict, but it did not produce reliable improvements in parents' mental health, highlighting limits of the programme in addressing parental wellbeing directly.

Duppong Hurley et al. (2019)

Duppong Hurley et al. (2019) evaluated Boys Town In-Home Family Services (IHFS) in a randomised trial with 300 families of children aged 5–14 with significant emotional and behavioural problems. Caregiver mental health was assessed using the Caregiver Strain Questionnaire (CGSQ), capturing both objective and subjective strain. Compared with services-as-usual, caregivers in the IHFS group reported significantly greater reductions in overall strain at post-test (g=−0.40, p=.004), representing a moderate effect (immediately post-intervention, 3-4 months after baseline). Subscale analyses showed improvements in objective strain (e.g., disruptions to family life) and subjective externalised strain (anger, resentment), but no significant change in subjective internalised strain (worry, guilt). Dose–response findings indicated that the largest improvements in strain were observed among families receiving 25–75 hours of service, suggesting a moderate level of intervention intensity may be most effective. Overall, IHFS demonstrated a clear and clinically meaningful impact on reducing caregiver stress, highlighting its value in addressing the mental health burden experienced by parents.

Table 3. Recommendation 3: Make evidence-based parenting interventions available to reduce negative emotional behaviours.

Recommendation	No. of trials	No. of effect sizes included	Effect size & 95% confidence intervals	Heterogeneity	% of studies assessed to have a low risk of bias	Strength of evidence rating
Recommendation 3: Make evidence-based parenting interventions available to reduce negative emotional behaviours.	8	8	*d* = -0.11; 95% CI -0.22,-0.01	2.3%	**Fonagy et al. 2018: Some concerns** Fongaro et al. 2023: Some concerns Hogue et al. 2015: High Olseth et al. 2024: High Slesnick et al. 2013: High **Barone et al. 2021: Some concerns** Salari et al. 2014: Serious Ghaderi et al. 2018: Some concerns 0% of studies were of low risk of bias	Good

Summary of findings

Fonagy et al. (2018)

Fonagy et al. (2018) conducted the Systemic Therapy for At Risk Teens (START) trial, a large RCT in England comparing Multisystemic Therapy (MST) with management-as-usual (MAU) for 684 adolescents (11–17 years) with moderate-to-severe antisocial behaviour. Internalising symptoms—covering anxiety, depression, and emotional difficulties—were measured using the Strengths and Difficulties Questionnaire (SDQ) and the Mood and Feelings Questionnaire (MFQ). At 6 months**, young people self-reported significantly lower emotional problems in MST than MAU (SDQ mean difference = −0.62, 95% CI −0.99 to −0.25, p=.0013; MFQ difference = −4.61, 95% CI −6.37 to −2.85, p<.0001). Parents also reported lower adolescent emotional symptoms on the SDQ in MST compared with MAU (mean difference = −2.00, 95% CI −3.02 to −0.98, p=.00011)**. However, by 12 months these between-group differences had diminished, and by 18 months no significant effects remained. Findings indicate MST produced short-term improvements in adolescent emotional wellbeing but these gains were not sustained over the longer term.

Fongaro et al. (2023)

Fongaro et al. (2023) conducted a single-blind RCT in France evaluating Non-Violent Resistance (NVR) parent training versus treatment-as-usual (TAU) for parents of children aged 6–20 with severe tyrannical behaviour (STB), a form of child-to-parent violence. Internalising symptoms were measured using the Child Behaviour Checklist (CBCL) and Strengths and Difficulties Questionnaire (SDQ). At baseline, both groups reported high levels of anxiety/depression, withdrawn behaviour, and somatic complaints in the clinical range. At 4 months, both NVR and TAU showed within-group reductions in CBCL internalising problems (NVR −3.21; TAU −2.46), but there were no significant between-group differences (p=.67). Similarly, SDQ emotional symptoms decreased slightly in both groups, but not significantly more in NVR (−0.18) than TAU (−0.72; p=.23). At 8-month follow-up (NVR only), internalising scores showed continued modest improvement. Overall, findings suggest that while NVR parents reported gradual reductions in adolescent internalising difficulties, outcomes were comparable to TAU, with no evidence of superior short-term effects.

Hogue et al. (2015)

Hogue et al. (2015) conducted an RCT in a U.S. community setting comparing usual care family therapy (UC-FT) with non-family usual care (UC-Other) for 205 adolescents (mean age 15.7) referred for conduct and substance use disorders. Internalising symptoms—covering anxiety, depression, and somatic complaints—were measured using the Youth Self-Report (YSR) and Child Behavior Checklist (CBCL). Across the full sample, both adolescent- and caregiver-reported internalising symptoms declined significantly over 12 months (YSR pseudo $z=-5.6$, $p<.001$; CBCL pseudo $z=-4.5$, $p<.001$). However, declines were significantly greater for adolescents in UC-FT compared with UC-Other on youth self-reports (pseudo $z=-3.3$, $p<.01$, $d=0.78$). Trajectory analyses showed that UC-FT youth reported continuous reductions in anxiety, depression, and somatic complaints over one year, whereas UC-Other youth improved initially but plateaued or slightly worsened. Caregiver reports also indicated improvements, but differences between groups were not significant. Findings suggest that family therapy in routine care may reduce adolescent internalising difficulties more effectively than non-family treatments, at least from the adolescent's perspective.

Olseth et al. (2024)

Olseth et al. (2024) conducted an RCT in Norway testing Functional Family Therapy (FFT) against treatment-as-usual (TAU) for 161 adolescents (ages 11–17) referred to Child Welfare Services for disruptive behaviour. Internalising outcomes were measured using the Child Behavior Checklist (CBCL) and Teacher Report Form (TRF). Across the full sample, parent-reported internalising problems decreased significantly from pre- to post-test ($d=0.43$, $p<.001$), but this effect was observed in both FFT and TAU groups, with no significant group × time differences at post-test ($d= 0.06$). Between post-test and 18-month follow-up, however, TAU showed greater reductions in parent-reported internalising compared to FFT ($B=2.95$, $p=.045$, $d=0.27$), indicating a small but significant effect in favour of TAU. Teacher-reported internalising showed no significant changes across time or condition. Overall, findings suggest that while internalising symptoms improved across all families during treatment, FFT did not outperform TAU, and long-term outcomes favoured services-as-usual.

Slesnick et al. (2013)

Slesnick et al. (2013) conducted an RCT with 179 runaway adolescents (aged 12–17) recruited from a crisis shelter, all meeting criteria for substance abuse or dependence. Families were randomised to Ecologically-Based Family Therapy (EBFT), the Community Reinforcement Approach (CRA), or Motivational Interviewing (MI), with follow-ups to 24 months. Internalising symptoms were assessed using the Youth Self-Report (YSR) and Child Behavior Checklist (CBCL). Across all three interventions, both adolescent- and caregiver-reported internalising behaviours declined significantly over time (YSR linear slope β=−2.55, p<.001; CBCL β=−1.21, p<.05). Youth self-reports showed that MI produced a significantly steeper short-term decline than EBFT (β=−1.74, p<.05), although symptoms later rebounded (quadratic slope β = 0.33, p < .01, while CRA showed similar short-term improvements (linear slope β = −2.76, p < .001) followed by relapse in the second year (quadratic slope β = 0.14, p < .05). EBFT participants maintained steady reductions (linear slope β = −1.78, p < .01) without later increases (quadratic slope β = 0.12, p > .05). By 24 months, caregiver reports indicated significantly lower internalising scores for EBFT compared with CRA (mean difference=−4.94, p<.05). Findings suggest that all three interventions reduced internalising problems initially, but EBFT sustained improvements most consistently over time.

Barone et al. (2021)

Barone et al. (2021) conducted a multicentre RCT in Italy testing Connect, a 10-week attachment-based parenting programme, with mothers of adolescents aged 12–18 reporting behavioural problems. Two studies were run: Study 1 (N=100 mothers) and Study 2 (N=40 mother–adolescent dyads). Internalising outcomes were measured using the Strengths and Difficulties Questionnaire (SDQ). **In Study 1, mothers in the Connect group reported significantly lower adolescent internalising symptoms compared with controls at both post-intervention (estimate=−1.84, SE=0.81, p=.024) and 4-month follow-up (estimate=−2.14, SE=0.81, p=.009)**. In Study 2, combining mother and adolescent reports, internalising problems also decreased significantly in the Connect group relative to controls at post-intervention (estimate=−3.12, SE=0.85, p<.001) and follow-up (estimate=−3.95, SE=0.85, p<.001). Mediation analyses showed reductions in adolescent attachment anxiety following Connect at post-test predicted fewer internalising symptoms at follow-up in both study 1 p = .025) and study 2 (p=.025). Overall, Connect demonstrated robust effects on reducing internalising difficulties, supporting the role of improved attachment security as a pathway to adolescent emotional wellbeing.

Salari et al. (2014)

Salari, Ralph, and Sanders (2014) evaluated Standard Teen Triple P (STTP), a behavioural family intervention, in a quasi-randomised trial with 62 Australian families of adolescents aged 11–16 experiencing behavioural and emotional problems. Internalising outcomes were assessed using the parent version of the Strengths and Difficulties Questionnaire (SDQ) and the Depression Anxiety Stress Scales (DASS-21). Compared to waitlist controls, the intervention group showed no significant improvements in SDQ emotional symptoms (F=0.03, p=.860, d=−.05). Similarly, no significant condition × time effects were found for parent-reported depression (F=0.06, p=.814, d=−.07), anxiety (F=0.07, p=.794, d=.08), or stress (F=1.10, p=.300, d=.31). At three-month follow-up, small-to-moderate within-group reductions were observed for depression (d=.57), anxiety (d=.63), and stress (d=.62), but these did not differ significantly from baseline or controls. Overall, while STTP

effectively reduced externalising behaviours and coercive parenting, it did not produce reliable improvements in adolescents' internalising symptoms or parental mental health, limiting its impact on internalising domains.

Ghaderi et al. (2018)

Ghaderi et al. (2018) conducted a randomized effectiveness trial in Sweden comparing the Family Check-Up (FCU) with iComet, an Internet-delivered parent training programme, for 231 families of children aged 10–13 with conduct problems. Internalising outcomes were measured primarily with the parent version Strengths and Difficulties Questionnaire (SDQ). Parent-reported emotional symptoms significantly decreased from pre- to post-treatment across both conditions ($F(1,483)=53.44$, $p=.001$, $d=0.96$), but no significant group × time interaction was found. At 1- and 2-year follow-up, emotional symptoms remained stable in the FCU group but slightly worsened in the iComet group, producing a significant interaction ($F(2,483)=3.07$, $p=.04$, $d=0.23$), although pairwise differences were only marginal at 2 years ($p=.08$). Child- and teacher-reported internalising symptoms showed no significant changes across time or condition. These findings suggest both interventions modestly reduced parent-reported internalising problems in the short term, with some indication that FCU may better maintain gains than iComet over the longer term.

Table 4. Recommendation 4: Make evidence-based family therapy interventions available to reduce challenging behaviours in adolescents.

Recommendation	No. of trials	No. of effect sizes included	Effect size & 95% confidence intervals	Heterogeneity	% of studies assessed to have a low risk of bias	Strength of evidence rating
Recommendation 4: Make evidence-based family therapy interventions available to reduce challenging behaviours in adolescents.	5	5	-0.51; 95% CI -0.87, -0.14	81.4%	**Hartnett et al. 2016: Some concerns** **Fonagy et al., 2018; 2022b: Some concerns** Cassells et al., 2015: Critical Fongaro et al., 2023: Some concerns **Gan et al., 2021: Some concerns** 0% of included studies have a low risk of bias	Good

Summary of findings

Hartnett et al. (2016)

Hartnett, Carr, and Sexton (2016) evaluated Functional Family Therapy (FFT) in Ireland in a randomised controlled trial with 97 families of adolescents at high risk of mental health disorders. Youth behavioural difficulties were measured with the parent and adolescent versions of the Strengths and Difficulties Questionnaire (SDQ). Parent-reported outcomes showed significant improvements for FFT compared to controls: SDQ total difficulties scores declined from a clinical mean of 23.07 at baseline to 16.47 post-treatment, versus 23.05 to 20.35 in the control group (Group × Time interaction: $F=11.30$, $p=.001$, $d=.68$). At 3-month follow-up, gains were sustained ($M=17.60$, $d=1.07$ from baseline, $p<.01$). Clinical recovery rates indicated that 50% of FFT youth moved below the SDQ clinical cut-off versus only 18.2% of controls ($\chi^2=11.09$, $p<.01$). Using reliable change indices, recovery was observed in 38.1% of FFT cases compared with 12.7% of controls ($\chi^2=8.47$, $p<.01$). Findings suggest FFT significantly reduces parent-reported youth behavioural problems, with medium to large effects sustained over time.

Fonagy et al. (2018;2020a)

Fonagy et al. (2018, 2020a) conducted two large independent RCTs in England evaluating Multisystemic Therapy (MST) for adolescents aged 11 - 17 with severe antisocial behaviour referred to social care or youth offending services. In the START trial (2018, N=684), the primary outcome was out-of-home placements at 18 months, measured using administrative records. Secondary outcomes included time to first criminal offence and total number of offences, also measured from administrative records. Mental wellbeing was assessed using the Strengths and Difficulties Questionnaire (SDQ), completed in both adolescent and parent-report versions. Antisocial and behavioural outcomes were measured using the parent and young person versions of the Inventory of Callous and Unemotional Traits, as well as several young person self-report measures: the Self-Report Delinquency Measure (including a substance misuse scale), the Antisocial Beliefs and Attitudes Scale, and the Youth Materialism Scale. Parents and teachers completed the attention deficit hyperactivity disorder subscales of the Conners Comprehensive Behaviour Rating Scales (CBRS). Intermediate outcomes relating to parenting and family functioning were assessed via parent-report using the Alabama Parenting Questionnaire (APQ), Loeber Caregiver Questionnaire, Family Adaptability and Cohesion Evaluation Scale, Level of Expressed Emotion Questionnaire, and the Conflict Tactics Scale. MST showed some short-term benefits: at 6 months, parents reported reduced antisocial behaviour and improved monitoring/supervision (APQ, $p<.001$), and adolescents reported less substance use ($p=.001$). However, these effects faded by 12 months and were absent at 18 months, with no difference in out-of-home placements (13% MST vs 11% MAU, $p=.37$) and significantly more police-recorded offences among MST youth ($p<.001$).

The second trial (2020, N = 684) conducted in different local authorities, measured criminal convictions as its primary outcome, using administrative data from a centralised police database. It also measured a large variety of secondary outcomes related to substance misuse, individual and family well-being, behavioural and cognitive outcomes, which were evaluated using self-report questionnaires completed by both young people and parents or carers. This study also found no significant advantage of MST over management-as-usual in reducing adolescent antisocial behaviour, safeguarding concerns, or offending. Together, findings from two independent UK RCTs indicate that MST did not achieve sustained improvements in adolescent behaviour outcomes in practice-based settings.

Cassells et al. (2015)

Cassells et al. (2015) evaluated Positive Systemic Practice (PSP), a family therapy model for adolescents with emotional and behavioural problems, in a non-randomised controlled trial in Ireland. 126 adolescents aged 12–18 with clinically significant difficulties were allocated to PSP (n=77) or a waiting-list control (n=49) based on service availability. Behaviour outcomes were assessed using the Strengths and Difficulties Questionnaire (SDQ) and family functioning using the Systemic Clinical Outcomes and Routine Evaluation (SCORE). At 16 weeks, the intent-to-treat analyses 31% of intervention participants showed clinical improvement on the SDQ compared with 14% of controls($\chi^2=4.60$, $p<.05$), though this was not sustained at the six-month follow-up. Parent-report SDQ scores showed large reductions in difficulties in the PSP group ($F=38.84$, $p<.01$, $d\approx1.0$), though not more than controls. PSP appears promising, though evidence is limited by the non-randomised design.

Fongaro et al. (2023)

Fongaro et al. (2023) conducted a single-blind RCT in France evaluating the Non-Violent Resistance (NVR) parent training programme for parents of children and adolescents aged 6–20 years with severe tyrannical behaviour (STB), compared with treatment-as-usual (TAU). 73 parents (36 NVR, 37 TAU) completed baseline and 4-month assessments. Children's behavioural outcomes were assessed with parent report versions of the Child Behavior Checklist (CBCL) and Strengths and Difficulties Questionnaire (SDQ). Parent outcomes included parenting stress, measured using the Parenting Stress Index/Short-Form (PSI-SF), and anxiety and depression symptoms were measured using the Hospital Anxiety and Depression Scale (HADS). At 4 months follow-up, there were no significant between-group differences in CBCL total problems (p=0.69), internalising (p=0.67), or externalising (p=0.61). Parent-reported SDQ subscales also showed no significant differences between NVR and TAU (total difficulties, p=0.18; conduct problems, p=0.05; emotional symptoms, p=0.23). There were also no significant differences in parenting stress measured by the PSI-SF total score change (p=0.42). Improvements in the NVR group continued at 8-month follow-up, though without a control comparison. Overall, NVR did not demonstrate superior effects to TAU in reducing adolescent behavioural problems in the short term.

Gan et al. (2021)

Gan et al. (2021) conducted the first RCT of Functional Family Therapy (FFT) in a non-Western context, evaluating 120 youth offenders (Mean age=16.2) on probation in Singapore, randomly assigned to FFT plus treatment-as-usual (TAU) (n=63) or TAU alone (n=57). Outcomes included mental well-being, measured by the Youth Outcome Questionnaire – self-Report 2.10 (YOQ-SR2.0), family functioning, measured by the Family Assessment Device – General Functioning Scale (FAD-GF), and probation completion, measured by administrative data Statistically significant results were found for mental well-being (F=4.67, p=.013): **FFT youth showed significant reductions from baseline to post-treatment (p=.011) and to end of probation (p=.001), with gains maintained.** For family functioning, group differences over time were non-significant (p=.15), but reliable change (21.7% vs 6.7%; p=.034) and clinical recovery (41.7% vs 13.0%; p=.028) favoured FFT. Probation completion was significantly higher in FFT (88.9%) than TAU (70.2%) (OR=3.99, p=.007). Findings support FFT's effectiveness in improving youth well-being and probation outcomes in a non-Western context.

Evidence underpinning the recommendations (narrative synthesis)

Table 5. Recommendation 5: Make evidence-based systemic family therapy models available to support improved family functioning where behaviours that challenge exist.

Recommendation	Citation	Study design	Sample size	Population	Study Risk of Bias (RoB 1/2)	Primary findings
Recommendation 5: Make evidence-based systemic family therapy models available to support improved family functioning where behaviours that challenge exist	**Hartnett et al.,2016**	RCT	**Intervention:** 42 **Control:** 55	(a) Adolescents aged ~14 years with significant behavioural problems (SDQ total difficulties score ≥17); (b) Parents and adolescents consented to participate in the trial; (c) there were no practical obstacles to participating in the study.	Some concerns	Hartnett et al. (2016) conducted an RCT in Ireland with 97 adolescents (M≈14 years) with clinically significant behavioural problems, randomised to Functional Family Therapy (FFT) (n=42) or a waiting-list control (n=55). Adolescent behaviour problems and risk of mental health disorder was assessed with the parent and adolescent versions of the Strengths and Difficulties Questionnaire (SDQ). Family functioning was measured using the Systemic Clinical Outcomes and Routine Evaluation (SCORE), completed by both parents and adolescents. Results showed significant Group × Time interactions: **parents in the FFT group reported greater improvements in family adjustment compared with controls (F=13.91, p<.01, d=0.64), with sustained effects at 3-month follow-up (p<.01, d=1.07).** Parents also reported large improvements in problem severity (F=23.84, p<.01, d=1.19) and problem impact (F=11.96, p<.01, d=0.82). Adolescents similarly reported significant gains in family adjustment (F=11.51, p<.01, d=0.27), reduced problem severity (F=14.83, p<.01, d=0.64) and impact (F=18.59, p<.01, d=0.73). Effect sizes ranged from small-to-medium for adolescent reports to medium-to-large for parent reports. Improvements were maintained at 3-month follow-up, suggesting FFT significantly enhanced family adjustment and reduced perceived severity and impact of problems in the Irish context.

Recommendation	Citation	Study design	Sample size	Population	Study Risk of Bias (RoB 1/2)	Primary findings
Recommendation 5: Make evidence-based systemic family therapy models available to support improved family functioning where behaviours that challenge exist	**Robbins et al., 2011; Horigan et al., 2015a; Horigan et al., 2015b**	RCT	**Intervention:** 246 **Control:** 235	(a) adolescent ages 13 to 17 with a self-report illicit drug use in the 30-day period preceding the baseline assessment; (b) or referred from an institution (e.g., detention, residential treatment) for the treatment of drug abuse; (c) living with a family (defined to include any parental/adult guardian, except foster) (d) No current/pending sever criminal offenses that could resultin incarceration; (e) adolescent assent and a parent or legal guardian consent to participate in the study.	Some concerns	Robbins et al. (2012) conducted a multisite RCT in the United States across eight community treatment agencies, evaluating Brief Strategic Family Therapy (BSFT) against treatment-as-usual (TAU) with 480 adolescents (aged 13–17) referred for behavioural problems. Adolescent drug use was measured using the Timeline Follow-Back (TLFB). Parenting and family functioning was assessed through a parent-reported composite scale created from the Parenting Practices Questionnaire and the Family Environmental Scale. **Parent reports indicated significant improvements in family functioning for BSFT relative to TAU (p=.011), including more positive changes in parenting practices (p=.023) and the family environment (p=.033).** Overall, the findings suggest that BSFT was not effective on improving rates of adolescent drug use but was effective in strengthening family functioning from the perspective of parents, particularly in relation to parenting practices and the family environment, although these improvements were not mirrored in adolescent self-reports.
Recommendation 5: Make evidence-based systemic family therapy models available to support improved family functioning where behaviours that challenge exist	**Cassells et al.,2015**	QED	**Intervention:** 37 **Control:** 35	(a) Adolescents aged 12–18 years referred to Crosscare Teen Counselling with clinically significant emotional and/or behavioural problems (SDQ ≥16) and their parents, (b) At least one parent was required to participate, (c) Excluded if presenting with acute suicidal risk, ongoing	Critical	Cassells et al. (2015) conducted a non-randomised controlled trial in Ireland evaluating Positive Systemic Practice (PSP), a family therapy model for adolescents (12–18 years) with significant emotional and behavioural problems. Families were allocated to PSP (n=77) or a waiting-list control (n=49). Results for the treatment completer analysis included 37 PSP participants and 35 waitlist participants. Child emotional and behavioural problems were assessed using the parent and child versions of the Strengths and Difficulties Questionnaire (SDQ). Family adjustment was assessed using the Systemic

Recommendation	Citation	Study design	Sample size	Population	Study Risk of Bias (RoB 1/2)	Primary findings
				intra-familial child abuse, moderate/severe intellectual disability, psychosis, severe drug/alcohol problems, or severe anorexia.		Clinical Outcomes and Routine Evaluation (SCORE). **Parent-reported SDQ scores demonstrated significant improvements in total difficulties (F=18.97, p<.01, d≈1.03). Gains were maintained at 6-months follow-up with an increased effect size (d≈1.48). Parent-reported SCORE results showed greater improvements in overall family adjustment compared with controls for treatment completers only (F=4.13, p<.05, d≈0.46). Gains were maintained at 6-month follow-up, with effect sizes increasing to medium (d≈0.61).** Improvements in family functioning were significantly correlated with reductions in adolescent behavioural problems (r≈.38–.42, p<.05). Findings suggest PSP strengthened family functioning and improved child and adolescent emotional and behavioural problems, particularly as perceived by parents, though the non-randomised design and high dropout rate limit generalisability.
Recommendation 5: Make evidence-based systemic family therapy models available to support improved family functioning where behaviours that challenge exist	**Asscher et al. 2013**	RCT	**Intervention:** 147 **Control:** 109	(a) Youth aged 12–18 years with severe antisocial behavior (externalizing or violent) requiring treatment.	Some concerns	Asscher et al. (2013) conducted an RCT in the Netherlands with 256 adolescents (12–18 years) with severe antisocial behaviour, randomised to Multisystemic Therapy (MST) or treatment-as-usual (TAU). Child behavioural outcomes were measured immediately at the end of the intervention (6 months) using parent report measures, the Child Behaviour Checklist (CBCL) and the DSM Disruptive Behaviour Disorders scale (DBD), and young person report measures, the Youth Self Report externalising subscale (YSR) and the Self-Report Delinquency scale (SRD). Parenting outcomes were assessed via parent, adolescent, and observer ratings of discipline, relationship quality, and parental competence. **Compared with TAU at 6 months, MST parents reported significant increases in parental sense of competence (F=8.17,**

Recommendation	Citation	Study design	Sample size	Population	Study Risk of Bias (RoB 1/2)	Primary findings
						p<.01, d=.36). MST also improved positive discipline according to parents (F=13.13, p<.001, d=.47), adolescents (F=5.07, p<.05, d=.28), and observational ratings (F=6.90, p<.01, d=.33). Quality of the parent–adolescent relationship improved in MST relative to TAU according to parents (F=6.03, p<.05, d=.31) and observers (F=8.72, p<.01, d=.37), though not adolescents. MST also significantly reduced inept discipline in observational ratings (d=0.27; 95% CI: 0.02, 0.52), but not by parent or adolescent report. These findings suggest MST strengthened parenting competence, discipline, and relationship quality in the Dutch context, though effects varied by informant.

Table 6. Recommendation 6: Make evidence-based parenting interventions available to families whose children are already known to children's social care, to support parental mental health

Recommendation	Citation	Study design	Sample size	Population	Study Risk of Bias (RoB 1/2)	Primary Findings
Recommendation 6: Make evidence-based parenting interventions available to families whose children are already known to children's social care, to support parental mental health	**Swenson et al. 2010**	RCT	**Intervention:** 43 **Control:** 35	(a) Youth aged 10–17 years and their custodial parent, referred by the county CPS for physical abuse occurrence; (b) family resided within Charleston County; (c) case was opened within the past 90 days; Excluded from the study were: (a) children and their parents not currently or previously enrolled in an MST project, (b) families where the child had been removed from the home and reunification was deemed inappropriate or unsafe by CPS or (c) cases in which children or parents have active psychosis.	Some concerns	Swenson et al. (2010) conducted a randomized effectiveness trial in the United States with 86 families referred by Child Protective Services for incidents of child physical abuse. Families were randomly assigned to Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) or Enhanced Outpatient Treatment (EOT), both delivered in a community mental health centre. Youth behavioural and emotional functioned was assessed using: the Child Behaviour Checklist (CBCL), the Child Behaviour Checklist PTSD Scale (CBCL-PTSD), the Trauma Symptom Checklist for Children (TSCC) and parent rated version of the Social Skills Rating System. Maltreatments outcomes such as reabuse and youth out-of-home placement was also assessed using CPS records. Parent mental health was assessed using the Brief Symptom Inventory (BSI). Parenting behaviour was measured using parent and youth reports of the Conflict Tactics Scale. Social support for parents was measured using the Interpersonal Support Evaluation List. Youth in the MST-CAN group showed greater reductions in PTSD symptoms than those in the EOT group ($p<.05$, $d\approx.73$). MST-CAN youth also had significant decreases in parent-reported internalising ($p<.05$, $d\approx71$), PTSD ($p<.05$, $d\approx.55$), and total

						symptoms (p<.01, d≈.85), as well as youth-reported dissociation (p<.05, d≈.73).MST-CAN was associated with larger decreases in global psychiatric distress (p<.05, d≈.63) relative to EOT. **Clinically, the percentage of MST-CAN parents exceeding clinical thresholds for psychiatric distress declined by 75% (from 20.5% to 5.3%), whereas the EOT group showed no change over 16 months post-baseline.** Parents in the MST-CAN group reported significant increases in total (p<.01, d≈.46), appraisal (p<.01, d≈.67), and belonging social support (p<.05, d≈.57). MST-CAN was significantly more effective than EOT at reducing neglect (youth report: p<.01, d=.89, parent report: p<.01, d=.28), psychological aggression (youth report: p<.01, d=.21), minor assault (youth report: p<.01, d=.14), severe assault (youth report: p<.01, d=.54, parent report: p<.01, d=.57) and non-violent discipline (youth report: p<.01, d=.20, parent report: p <.01, d=.57). Youth in the MST-CAN group were significantly less likely to experience an out-of-home placement ($\chi^2(1, N = 86) = 3.74$, p<.05) and had significantly fewer placement changes (t(1) = 3.88, p<.05) compared with youth in the EOT group. Findings suggest MST-CAN was effective in reducing youth mental health symptoms, parental emotional distress, parenting behaviours associated with maltreatment, youth out-of-home placements and changes in out-of-home placements in high-risk, physically abusive families.
Recommendation 6: Make evidence-based parenting interventions available to	**Akin et al. 2018**	RCT	**Intervention:** 461 **Control:** 457	(a) parents of children, ages 3–16, newly entering or reentering foster care with serious emotional or behavioral problems,	Some concerns	Akin et al. (2018a) conducted a large RCT in the United States with 918 families of children aged 3–16 in foster care, testing Parent Management Training – Oregon Model (PMTO) (n=461) against services-as-usual (SAU) (n=457). Effective parenting was

families whose children are already known to children's social care, to support parental mental health				(b) With reunification as case plan goal, (c) Parent resided in the service area and was not incarcerated longer than 3 months or under court order of "no contact. (d) Caregiver was identified as the primary caregiver.		measured using the Family Interaction Task (FIT) at baseline and 6 months. Caregiver functioning was measured with the North Carolina Family Assessment Scale (NCFAS) at baseline and 6 months. **Results showed that PMTO caregivers were significantly more likely at 6 months to improve on the caregiver mental health domain compared with controls (OR=2.01, p<.001).** Parents also showed significant improvements in substance abuse (OR = 1.67, p<.001)social support (OR = 2.37, p<.001) and readiness for reunification (OR = 1.64, p<.001). These findings indicate that PMTO has clinically meaningful benefits for reducing psychological strain, substance abuse and increasing social support and readiness for reunification among biological parents of children in foster care.

Evidence underpinning the key principles

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key principle 1: Increase engagement in parenting support by creating trusting, respectful, and non-judgmental environments with parents and families with multiple complex needs	1.1 Facilitators who had a non-judgemental attitude towards families and created a safe environment for emotional expression reduced parental shame and stigma (with parents often fearing interventions were going to tell them they were a "bad parent"), and increased engagement	The finding was informed by 14 qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate concerns regarding methodological limitations.
	1.2 Proactively listening to families to provide flexible support tailored to their needs, and consistently following-through on promised actions was identified as a facilitator of trust	The finding was informed by 14 qualitative studies.	
	1.3 Early intervention sessions were viewed by staff in five studies as a key opportunity to understand family dynamics, routines and interests and build rapport and trust	The finding was informed by five qualitative studies.	
	1.4 A strengths-based approach empowered parents and increased their confidence, with parents feeling motivated to continue engagement when they saw positive changes in their family relationships	The finding was informed by six qualitative studies.	
	1.5 Barriers to developing a therapeutic alliance: Negative previous experiences, distrust or fatigue of services	The finding was informed by six qualitative studies.	
	1.6 Barriers to developing a therapeutic alliance: Families dealing with multiple complex stressors	The finding was informed by five qualitative studies.	

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key principle 2: Approach family dynamics with curiosity, seeking to understand the reasons behind patterns of interactions and work with families to understand and build on individual and family strengths	Peer support and the structured support and neutral ground provided by facilitators helped families understand each other's perspectives and reflect on their family dynamics. This can transform not only parent-child relationships, but also parents' self-perception and confidence in their parenting role. As a result, young people disclosed their emotions and needs to their parent/s more openly and parents felt more comfortable and less anxious in their role as a parent	The finding was informed by eight qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate concerns regarding methodological limitations.
Key principle 3: Build parental confidence through parenting support to respond effectively to behaviours that challenge	This increased confidence was often linked to a clearer understanding of how to set and maintain appropriate boundaries, which in turn contributed to a shift in the power dynamics within their household. This was particularly important in families dealing with adolescent conduct issues, where parents had previously felt disempowered or unsure of how to respond. The interventions supported parents in feeling more in control, helping them to overcome the fear of enforcing boundaries due to their child's externalising behaviours. Parents described feeling empowered to consistently apply and persevere with the techniques they had learned, even when their children showed initial resistance. The interventions reinforced the idea that changes in the family unit take time and that their efforts were worthwhile particularly among those in group interventions who received the encouragement of their peers.	The finding was informed by seven qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate concerns regarding methodological limitations.

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key Principle 4: Develop a flexible local offer that responds to families' needs and preferences through a mix of support types, including options for intensive support when needed	Some participants felt that the home environment was a distraction and reported that being on neutral ground may be more suitable for better concentration For some parents, the structure of the interventions posed practical challenges, particularly when meetings were scheduled on weekdays as this created additional pressure due to work, and childcare responsibilities, sometimes leading to missed sessions or reduced engagement over time. This suggests that flexibility and choice was more important to families than a one mode of delivery being better for all participants. Additionally, the pace and content of some programmes felt rushed or incomplete, leaving parents wanting more depth and continuity	The finding was informed by four qualitative studies.	Good: This finding was graded as moderate confidence because of the data relevance and coherence. However, there were concerns about methodological limitations and richness of detail in the studies included.

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key principle 5: Group-based support encourages peer connection providing parents with the opportunity to build reciprocal relationships	Parents across these studies highlighted that being part of a group dynamic offered a sense of solidarity and mutual understanding, creating a supportive environment where the parents, often navigating complex family dynamics, felt less isolated in their experiences. The group environment was described as a relaxed and consistent space by parents, rather than feeling like a formal or clinical setting. While programme facilitators were instrumental in teaching parenting skills and offering support, parents found that their peers were equally influential often providing insights and empathy that facilitators, despite their expertise, could not replicate. The group therefore acted as a reciprocal environment for some parents, who reported feeling they could add value to the group through their personal experiences. **Challenges** • Feeling of inadequacy/ self doubt: parents comparing their progress to that of others in the group, can hinder the motivation to stay engaged with the programme • Personal circumstances too complex or specific to be fully addressed in a group setting (e.g. parents of SEND children). Some parents found sharing certain personal experiences within the group emotionally difficult or triggering for others, particularly those in vulnerable positions.	The finding was informed by three qualitative studies.	Good: This finding was graded as moderate confidence because of the data relevance and coherence. However, there were concerns about methodological limitations and richness of detail in the studies included.
Key principle 6: Ensure the local parenting offer is culturally	6.1 Importance of using culturally relevant metaphors and imagery	The finding was informed by two qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate
	6.2 Reflecting parenting norms such as authoritarian versus authoritative parenting styles	The finding was informed by two qualitative studies.	

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
responsive and addresses the cultural values, beliefs, and experiences of the local population through authentic partnership and co-production	6.3 Adapting programmes developed in individualist cultures that promote emotional expression to more collectivist cultures	The finding was informed by one qualitative study.	concerns regarding methodological limitations.
	6.4 Recruiting staff from the same linguistic and cultural backgrounds as participants	The finding was informed by six qualitative studies.	
	6.5 Having a well-respected community member from the same cultural background facilitating the programme increased their recall and understanding and prompted participants to take a more active roles within their community	The finding was informed by two qualitative studies.	
	6.6 Considered the intersectionality between identities (for example ethnicity and sexuality) by involving a diverse group of young people in the adaption process and implementing cultural humility training for staff	The finding was informed by one qualitative study.	
	6.7 Tailoring of intervention to reflect parental experiences of trauma by incorporating mindfulness and emotional coaching into the intervention sessions	The finding was informed by one qualitative study.	
Key principle 7: Promote evidence-informed, integrated and innovative organisational culture to facilitate successful implementation and maintain fidelity of effective parenting support	Provider readiness was a facilitator of implementation and fidelity. Provider readiness included: positive attitudes towards evidence-based practice, clinical flexibility, a willingness to engage with new practices, a strong history of interagency working, a problem-solving culture and good alignment between the parenting programme model and the organisations mission, vision, strategy and processes.	The finding was informed by 14 qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate concerns regarding methodological limitations.

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key principle 8: Ensure effective multi-agency collaboration, defined organisational responsibilities, and strong place-based systems to enable seamless, family-centred coordination between agencies to improve referral pathways so families get the right help at the right time	The requirement for strong multi-agency relationships to ensure referral of eligible families into parenting programmes, which could be facilitated by collaboratively developing referral pathways, clear communication and reflection on eligible referrals in regular multiagency meetings and regular collaboration between lead practitioners and wider professionals such as social workers and youth justice workers	The finding was informed by 12 qualitative studies.	

Key principle	Systematic review finding	Supporting studies	Confidence in finding (CERQual)
Key principle 9: A consistent, supported and skilled workforce that can work relationally and intensively is essential to the delivery of effective parenting support	Combining training and reflective supervision to increase staff confidence to implement the parenting programmes. Practitioner training is also an important facilitator of competence and adherence to parenting programmes. Training which moved beyond model concepts and taught staff how to implement training programmes in practice was important for increasing staff confidence Incorporating interactive elements into training sessions such as roleplay, video case studies, and adapting session content to focus on real life scenarios from the setting and participants Providing ongoing support as staff gained firsthand experience of implementing the parenting programmes was important in increasing staff autonomy, improving accountability and fidelity, and giving staff confidence the model worked to improve outcomes for families. This included regular opportunities for reflective case practice via supervision, coaching, consultation, peer support or communities of practice, and reflexive monitoring of case files or videotaped sessions to monitor fidelity and identify necessary adaptions. Staff not having time to attend training was a barrier, particularly in services that were focused on reacting and responding to families in crisis or where staff were required to be trained in multiple evidence-based interventions. Protecting staff time to attend training away from immediate workplace demands and accrediting training as a mandatory part of role requirements were strategies proposed to address this.	The finding was informed by 22 qualitative studies.	Strong: This finding was graded as high confidence because of the richness of the data, and there were only moderate concerns regarding methodological limitations.

Other evidence sources underpinning the key principles

The key principles were also informed by Foundations' advisory group and in-house knowledge and experience of parenting interventions.

Advisory group

Before commencing work on the Practice Guide, we established an advisory group made up of academics, stakeholders and professionals within the field. We met with the advisory group multiple times across the course of conducting the evidence review and during the Guidance writing. We also had correspondence with the group over email.

The purpose of the advisory group has been to:

- Help with designing the aims and objectives of the evidence review
- Unpick the findings of the evidence review
- Provide guidance on language and terminology
- Review and provide feedback on the Practice Guide.

By having a broad range of perspectives, the key principles reflect key voices in the sector and will hopefully ensure that the Guide can have meaningful impact to its readers.

In-house expertise

The team working on the Guide bring with them their own methodological, practical, and personal experience and expertise. Those who have written and contributed to the key principles section have experience working in local authorities and Government, and those who have written the recommendations have extensive experience in intervention evaluation, evidence synthesis, evidence-informed practice, and knowledge mobilisation.

Recommendations for further evaluation and testing of interventions in England

- Future research should prioritise UK-based randomised controlled trials (RCTs) and evaluations to strengthen the evidence on intervention effectiveness within local service delivery contexts and ensure findings are relevant to UK policy and practice
- Consistent use of validated and standardised outcome measures across studies will enhance comparability and allow for more robust meta-analytic synthesis of intervention effects
- Long-term follow-up assessments (beyond six–12 months) are essential to determine the sustainability of intervention impacts on parenting stress, adolescent behaviour, and family functioning
- Future studies should embed equity-focused data collection using frameworks such as PROGRESS-Plus to ensure that findings are disaggregated by key demographics (e.g., ethnicity, gender, disability, socio-economic status) and to identify any differential effects across groups
- Research should explore the mechanisms of change and contextual moderators that influence effectiveness, including parental mental health, child welfare involvement, and the interaction of multiple family adversities
- Further research should examine implementation processes in depth, focusing on organisational readiness, workforce capacity, training, supervision, and interagency collaboration as enablers of ensuring interventions are delivered to high fidelity
- Studies should incorporate co-production with parents, carers, and young people, ensuring that interventions are culturally responsive and tailored to diverse family needs.

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Recommendation 1

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