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The Family Ties Project

Implementing and Evaluating the No Kids in the Middle Intervention

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Introduction

Conflict between parents that have separated can have devastating and long-term consequences for the children if they are caught in the middle. However, there is limited evidence around effective interventions to help this group of families, and little recourse available in the UK.

These families often don't benefit from traditional therapeutic approaches, and can spend many years in chronic dispute over their children, impacting negatively on their children's wellbeing and life chances and often placing a strain on the family courts and children's services.

"No Kids in the Middle" (NKM) is a semi-structured multi-family intervention originating in the Netherlands, that aims to help parents experiencing high conflict move away from intractable, polarised disputes to find new ways of communicating that place their child at the centre.

The Family Ties project, delivering and evaluating the NKM intervention in a UK setting, delivers a programme in which parents find solidarity in each other through seeing their problems mirrored in other families. Through engaging in activities that help them experience their child's perpsective, they are then able to support one another to do things differently. Children benefit from witnessing their parents come together, without fighting, in their interest. They are given a safe space and can use creative activities to share their experience with other children. At the end of the intervention, if the children feel safe to do so, they may also want to share their experience with their parents.

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Project Aims

The aim of the Family Ties project was to implement and evaluate the "No Kids in the Middle (NKM)" in two pilot sites: Hackney Child and Adolescent Mental Health Service/Children's social care and Ealing Local Authority. The evaluation focused on the following:

– The process of implementation, with an iterative feedback of learning from a first round of implementation to a second implementation

– The outcomes of the intervention for participating families

– The parents and children's experiences of the intervention.

Method

Teams of local practitioners from the two pilot sites were trained by the Anna Freud Centre (AFC) team in the principles of multi-family therapy and in the NKM model. Each pilot site then delivered the programme twice over the duration of the project.

The first round of groups were co-delivered by local practitioners and clinicians from the AFC. The second round of groups were facilitated by local practitioners, who received weekly supervision from the AFC. [NB: The second round of groups were interrupted by the Covid-19 lockdown and could not be evaluated as planned.]

The implementation process was evaluated through regular feedback and interviews with participating practitioners at key stages of the project. Learning was shared and directly applied to adapt the program as it progressed.

The outcomes for families participating in the programme were evaluated through standardised questionnaires administered at baseline and at the end of the intervention. Semi-structured interviews were conducted with parents and children who completed the programme to learn more about their experience of it.

A total of 19 families participated in the programme at the two pilot sites. Eleven families completed the intervention before the Covid-19 lockdown. Data from an additional group at the Anna Freud Centre was included in the baseline evaluation to provide a more robust description of the types of families being referred to the programme.

Summary of Key Findings

The findings from the outcome evaluation showed that, at the outset, almost all parents reported relatively high levels of conflict, especially around co-parenting. The few parents who reported low levels of conflict were less likely to engage in the groups.

A significant number of children were reported to have relatively poor wellbeing at the point of referral, mostly in terms of their family lives. Some showed high levels of trauma symptoms related to the conflict between their parents, and some parents reported their children to have significant emotional difficulties.

For those families completing the programme, on average over time:

- Parents reported significantly lower levels of inter-parental conflict
- Children reported significantly better wellbeing in their family lives
- Children reported significantly less avoidance of trauma around family conflict
- Parents reported fewer Internalising symptoms in their children
- The effect sizes of these changes were large.

19

Number of families participating in the Family Ties Project across two pilot sites.

33

Number of children who participated in the No Kids in the Middle groups

Interview Findings

The interviews revealed that most parents had a positive experience of the programme. Almost all felt it had improved their co-parenting relationship to an extent, though some conflict invariably remained. Key benefits included: better understanding of 'destructive patterns' of communication and motivation to change these; more frequent and better quality contact between children and non-resident parents; learning to 'pick your battles' in relation to co-parenting disagreements. However, many parents were worried that these positive changes would not be maintained.

Parents reported having positive relationships with clinicians, and most valued the clinicians' non-judgmental and supportive approach. Relationships with clinicians were strengthened through phone calls between group sessions, which built trust and enabled parents to continue with the group when otherwise they might have decided to stop attending. Parents also reported building strong relationships with other families, which resulted in a sense of solidarity and mutual support; many parents told us that they plan to maintain relationships with other families once the group had finished, and that they had valued receiving advice from others, particularly in the session 'new solutions for old problems'. However, for parents who were unable to relate to other group members – perhaps due to lower level of conflict, or factors such as age – the MFT format was less effective as feelings of solidarity were less likely to develop.

Children had a mixed experience of the group. Generally, the younger children (aged 4-7) enjoyed the group; whilst some found it difficult to talk about their feelings or family life, most enjoyed the games and playful atmosphere, made friends, and appreciated the opportunity to see both their parents coming together in their interest.

Older children were more ambivalent about the group.They generally found it harder to talk about family conflict, and worried about the impact of the group (including what they said to clinicians) on their parents' wellbeing; they were anxious not to 'tell tales' on their parents, or make parents feel worried or guilty. Older children sometimes found the games to be childish, or the younger children to be annoying. Parents' views of the children's experiences mostly align with what the children told us in interviews.

Key Implications

Service Implications

Initial results indicate that, with specialist training and support, Multi-Family Therapy for high conflict separated parents and their children can be successfully implemented in CAMHS and social-care settings. There were some specific service implications:

- The groups may be easier to establish in a Tier-Two parenting service alongside other parenting groups, where threshold for referral is lower and frequent responsive contact with parents is resourced and part of normal practice
- The groups may run more efficiently where there are established working relationships between the facilitators and frequent opportunities for de-briefing
- Inter-session support for many families should be factored in when planning delivery and allocation practitioner time
- Groups including children with additional needs are likely to require extra support.

Treatment Implications

Initial results indicate that Multi-Family Therapy may be an effective intervention for reducing parental conflict and improving co-parenting and child-wellbeing. There were specific practice implications:

Engagement

- Careful screening and close co-working are essential for effective recruitment of appropriate families and to prevent drop out
- The DWP parental conflict measure is a useful tool to help identify high levels of conflict
- Clinicians have a key role in explaining the importance of involving the families' networks and thinking creatively about ways to do this from the outset
- Parents tell us that a high level of keyworker support in between sessions is essential for engagement. This should be considered a key component of the intervention
- Having a group with at least five families is important for engagement and to protect the group against dropouts. In smaller groups, individual differences can be more apparent, and this can prevent a sense of solidarity from developing.

Treatment

- Parents particularly value the sessions that allow them to experiment with new ways of communicating with the support of the group. Practitioners should be open to introducing an extra session on this topic should the group request it
- Parents benefit from feeling connected with other families, and so a focus on inter-family connections should be a therapeutic priority for practitioners
- A non-judgemental attitude in practitioners is considered helpful by parents
- Practitioners need to take particular care to ensure that all children, but particularly older children (age 8 and upwards) do not feel pressured to talk about their family
- Where there is a broad range of ages, children's groups may need to be divided in order to ensure that they feel age appropriate for all children
- Children's groups should include a range of activities so that all children have opportunities to express themselves: these might include outdoor games as well as arts and crafts. Children value the opportunity to choose games for themselves
- Parents are anxious that progress will be lost, and so practitioners should spend time thinking about relapse prevention and any additional or further support needs with families.

Conclusion

Despite the interruption of Covid-19, this pilot project has produced some very positive indicators that Multi-Family Therapy for high conflict separated parents can be delivered in universally accessible services in the UK and is associated with improved outcomes for children. The study produced clear findings around implementation that have helped to refine delivery going forward.

Project Background

The Anna Freud National Centre for Children and Families (AFC) is a children's mental health charity that has been researching and delivering mental health care for over sixty years. The Contact and Residence Disputes (CRD) Team is a multidisciplinary team within the AFC, with professional expertise including family therapy, social work, child and adult psychiatry and clinical psychology. The team has developed a therapeutic assessment model that aims to support families where there are disagreements or concerns about contact, or where there are significant concerns about the impact of ongoing parental acrimony or legal proceedings on children. The CRD team works with the Family Courts and with parents or children's services to make recommendations about contact and residence, and to provide therapeutic care to reduce the negative impact of separation and ongoing parental disputes on children.

There is increasing recognition that traditional therapeutic models that are often effective in family therapy are less effective in this context. High levels of mistrust, entrenched patterns of communication, a conflict mind-set, and the need to accrue evidence to 'win' the court case often disrupt the therapeutic relationship and make it difficult for the family to move forward. Ongoing conflict means that parents are unable to recognise or be mindful of the impact on children, and in turn children do not feel sufficiently safe to open up in therapy. Other clinicians and professionals document these same challenges (Van Lawick & Visser 2015). The CRD team has developed a specialised model of assessment and intervention for work with individual families that focuses on relationship dynamics specific to high conflict separated parents (Asen & Morris 2020). However, there remains a sub-group of families who are unable to remove themselves from the 'fight' and polarised positions enough to engage in individual family work. Furthermore, such specialist intervention is very scarce within the UK, often costly and not provided by statutory services, making access to support a major obstacle. Given this context, there is an urgent need to develop methods of working with high conflict separated couples and their children and rolling these out on a wide scale in frontline services.

A large body of evidence demonstrates the impact of on-going and poorly resolved parental conflict on children and young people. Importantly, parental separation itself does not necessarily harm children, though divorce may create additional risks for children who are already vulnerable due to other factors. However, the way that conflict is managed, the extent to which children are drawn into conflict, and the enduring nature of unresolved conflict can have significant negative impacts on children's wellbeing (Grych & Fincham, 2001). Conflict that occurs during a child's early years can disrupt the formation of secure attachment (Boris & Zeanah, 1999) and consequently disrupt emotional development, including sense of security and capacity to regulate emotions (Cummings, Davies & Simpson, 1994; McIntosh, 2003). Intense and unresolved parental conflict is associated with externalising symptoms including aggression and conduct disorders (Emery, 1982, 1988; Johnston & O'Leary, 1987; Johnston et al., 1987) as well as internalising symptoms

such as depression and anxiety (Brock & Kochanska 2016; Davies & Cummings, 1988).

No Kids in The Middle

Given the evidence that interparental conflict can seriously harm children's wellbeing, there is a clear need to find more effective ways of working with these families to protect the children. A group of clinicians working in the Kinder-en Jeugdtraumacentrum (Child and Youth Trauma Centre - KJTC) in the Netherlands developed an innovative multi-family group model called 'No Kids in the Middle' (NKM) to respond to this need.

> *In the No Kids in the Middle project we try to find new roads that create a context for movement out of deadlock for these families. We try to create a dialogical space where rigid, destructive processes can be made more flexible and dialogical for parents, children and the professionals who work with them. We work with six families at a time. Twelve parents work with two therapists and, at the same time, all their children work with two therapists in a different room in the same building. Participants in both groups attend eight two-hour sessions, with a scheduled mid-session break.* (Van Lawick and Visser, 2015, p. 38)

Key principles for the intervention include: keeping the child in mind; working in groups; stopping legal proceedings; making free space for interactions; creative presentation ceremonies; reaching out to the network; recognising and changing destructive patterns; and changing through experience. Further information about the model can be found in: (Van Lawick & Visser, 2015) and in the forthcoming book: (Visser & Van Lawick, in press).

No Kids in the Middle uses a Multi Family Therapy (MFT) approach. MFT involves working with groups of families systemically. Intra- and inter-family interactions are 'intensified' (Minuchin, 1974) in a group setting where parents and children are participating in different tasks, and where they are required to examine not only their own, but also the interactions and communications of other families and their individual members – which often mirror their own difficulties. The creation of multiple perspectives, which is much harder to initiate in individual therapy sessions, is associated with change.

In the midst of personal conflict and distress, most people find it difficult to be open-minded, let alone 'objective', about their own situation, even though they are able to be very sensitive and thoughtful about the problems of other people. This phenomenon can be utilised in MFT: a setting can be created which permits mutual sharing and understanding. They are encouraged to help other families by observing and understanding seemingly identical problems and by making suggestions. An MFT approach can also be more cost effective and provided as an adjunct to other support being offered to a family. Further, being part of a group of families helps

individuals to feel less isolated and reduces the stigma that parents feel about their child's difficulties or the reasons they have come to therapy.

The therapist's tasks include managing the exchange and flow of information around the group, as well as setting up group tasks and activities that address familiar problems playfully. This can lead to 'perturbations' of unhelpful communication and interaction patterns (Boscolo, Cecchin & Hoffman, 1987). Being part of a multi-family setting demands that families and their individual members are invited to be part of continuously changing contexts, requiring each family member to adapt to different demands. This can lead to the development of new and more functional interactions and communications within families and engender hope for change.

Multi-family therapy is a treatment modality that has been extensively researched internationally, with several RCTs providing evidence for its efficacy (Gelin et al. 2018; Cook-Darzens et al. 2018). The MFT approach has been successfully applied in different settings and for a considerable range of presentations and disorders (Asen & Scholz, 2010), including, for example, eating disorders (Scholz & Asen 2001; Eisler, 2010), youth offending (Caldwell, Horne, Davidson & Quinn, 2007), conduct disorder (McKay et al., 2011), school problems (Morris et al. 2014; Kratochwill et al., 2004) and family violence (Asen, 2002). Whilst there is not yet an established evidence base for the No Kids In The Middle program, early findings show positive results for families who receive this intervention in the Netherlands, with some families beginning to break the deadlock, find new ways of communicating, and move forward, suggesting that the MFT approach may be successful for separated couples in conflict.

Drawing on the promising results from the Dutch team, and upon the evidence base for MFT more generally, the CRD team at the Anna Freud Centre have worked to deliver the No Kids in the Middle program with UK families in both specialist and Statutory (thus free at the point of access) settings. This work is delivered under the Family Ties Project, funded through the Department for Work and Pensions 'Parental Conflict Challenge Fund'. As part of the Family Ties Project, clinicians from the CRD team received training from the Netherlands group, and worked with researchers and project managers at the AFC to collaborate with two UK pilot sites, to deliver and evaluate the No Kids in the Middle program.

Format of the intervention

No Kids in the Middle (NKM) follows a semi-structured format. Families are seen for two 'intake' sessions prior to the group, where they are given an introduction to the group and assessed for eligibility. Six to eight families work together in an MFT format over 8 mostly-weekly sessions. Parents and children work in parallel in two separate groups in the same building. Two clinicians facilitate each of the two groups.

Parents take part in a number of discussions and activities, including role-play

exercises, psycho-education about 'destructive patterns', and problem-solving sessions supported by the other families. Parents are given homework tasks at the end of each group session. In the final session, parents give a presentation to their child, reflecting on what they have learnt in the program, and presenting a positive message (for example, that 'mum and dad both love you and want to work together to make you happy').

In the children's group, children are supported to talk, play and create around various relevant themes if they want to, but are under no pressure to do so. Sometimes they benefit from hearing other children talk. Just as important as the content of the children's group is that they witness their parents coming together to work in their interest. At the beginning of the group the children are introduced to the idea of working on a project, taking any form they like, on their own, or together, that shows something about their experience of being 'in the middle' (for example, a poem, artwork, or play). They are told that if they want to share their project, or parts of their project, with the parents at session 6 they can, but again they are under no obligation to do so.

At the start of the group, before the first session, there is a Social Network Meeting where each parent can invite 2-5 members of their social network, such as friends or family, to attend. The group facilitators explain the NKM approach to the social network and ask for their help in supporting the parents as they move through this process. Half way through the intervention, after group 4, the social network are invited to attend a second meeting, this time without the parents, to review how things have been and to think more about how best to support the parents and children. Engaging the social network to create and sustain change is an important part of the NKM intervention.

Figure 1: Overview of No Kids in the Middle intervention

Aims and Objectives

The overall aim of the project is to adapt, deliver and evaluate a multi-family group intervention, No Kids in the Middle (NKM), aimed at reducing the impact of parental conflict on children. This includes an evaluation of both the implementation process and the outcomes for participating children and families.

Project Timelines

The below timeline provides an overview of the project:

- **May-Sept 2019** – project set-up, R&D approvals, and data sharing agreements
- **June 2019** – the Anna Freud centre delivered a three-day training in the NKM model, to clinicians from the two pilot sites
- **July-Sept 2019** – the two pilot sites began receiving referrals, recruiting families, and conducting intake sessions
- **Oct-Dec 2019** – the two pilot sites delivered the eight-week program, co-facilitated by clinicians from the AFC (one pilot site clinician and one AFC in the children's group, and the same for the parent group). Baseline and end-point data were collected by the AFC researcher
- **Dec 2019** – post-group interviews conducted by the AFC researcher with families in both sites
- **Dec 2019-Jan 2020** –recruitment for second groups in both sites
- **Jan–April 2020** – the pilot sites delivered the groups for a second time. This time groups were facilitated by four local practitioners, with weekly supervision provided by the AFC clinicians
- **March 2020 –** groups paused as a result of Covid-19; whilst baseline data was collected, we were unable to collect end-point data as families did not complete the intervention

Covid-19

As outlined above, the second groups were suspended in March 2020 due to the Covid-19 lockdown measures. Throughout lockdown, practitioners have made concerted efforts to continue to engage with families through telephone and video calls, and to continue to work with parental couples to reduce the impact of conflict on children. It is not possible to deliver the group-based No Kids in the Middle program virtually due to safeguarding and confidentiality issues, but one-to-one work can continue with families. Webinars to the parent's groups, and remote 'check-ins' to the children's groups, have enabled ongoing support. We are in the midst of developing a program for high-conflict parents, building on the principles of No Kids in the Middle, that can be delivered virtually, in order to grow our understanding of how to help parents and protect children from their conflict.

Pilot Site Context

The program was delivered in two pilot sites: Hackney and Ealing.

Hackney

Hackney is a borough of East London. In Hackney, the project was situated in the Child and Adolescent Mental Health Service (CAMHS) but was facilitated across two services: CAMHS and Social Care. Referrals were received from multiple routes, including a child's GP, social services, and schools. The NKM group took place on Tuesday evenings from 17.00-19.00 and was held in the CAMHS building.

Ealing

Ealing is a borough of West London. In Ealing, the project was situated in Ealing Local Authority's Tier Two service: 'Supportive Action for Families in Ealing' (SAFE). SAFE is an area-based, multi-disciplinary service bringing together professionals from social work, domestic violence, education, parenting and mental health backgrounds. The service offers a range of preventative interventions to ensure better long-term outcomes for families. Families can self-refer to Family Ties through SAFE, or referrals can come through social services, GPs, and schools. The NKM group took place on Thursday evenings from 17.00-19.00 in a local children's centre.

Inclusion and Exclusion Criteria

Families were eligible to participate in the project if:

- They were identified by a professional as needing support to reduce parental conflict (child adversely affected by conflict)
- There was at least one child aged 5-11 years old*
- Parents were separated or divorced
- Both parents committed to attending the group

Families were ineligible for the project if:

- They were currently in legal proceedings
- The parents had only recently separated (less than 6 months ago)
- The child was not allowed unsupervised contact with either parent
- There was an on-going investigation about abuse perpetrated by either parent towards a child in the family
- Either parent had a restraining order
- There was current domestic abuse, including coercive control** (though historic domestic abuse did not make a family ineligible)
- There were concerns around current parental substance misuse

* In practice, it was decided that older and younger siblings could attend the group at clinicians' discretion, so long as at least one child in the family was aged between 5-11 and that child attended the group.

**Coercive control was added to the exclusion criteria between the first and second round of groups, as a result of discussions between clinicians after reflecting on the first groups.

Methodology

The implementation and outcome evaluation were co-ordinated by the project team at the Anna Freud Centre, which comprises: the lead clinician, lead researcher, research officer, and project manager.

This study used a mixed-method design, combining quantitative and qualitative data collection in order to evaluate both the process of implementing this new service in each of the two local settings, as well as the outcomes for children and families who receive the intervention.

Implementation Evaluation

The goal of the implementation evaluation was to capture learning about the process of implementing the NKM program across the two pilot sites.

The questions addressed by the implementation project were:

1) What are the barriers and facilitators to implementing NKM groups across Primary Care, CAMHS, and Local Authority settings, and what are the implications for sustainable practice?
2) What adaptations need to be made to the model for the UK context?

We used qualitative research methods to answer the above questions, employing an ongoing iterative process so that learning from the first round of No Kids in the Middle groups could be gathered and changes implemented for group 2.

Data collection occurred in a number of ways:

- Feedback forms after training, to gather information from clinicians about their experience of the training and suggestions for improvement
- Meetings with pilot site teams at strategic points, to facilitate sharing knowledge across the two sites
- Established a learning log to collect week-by-week feedback from group facilitators
- Semi-structured interviews with all group facilitators at the end of group 1 and at the end of group 2, which were then transcribed and analysed. We conducted interviews with 4 clinicians from the Anna Freud Centre, 2 from Hackney, and 2 from Ealing.

As a result of this ongoing data collection, we were able to implement changes over the course of the project, to improve the process and experience for clinicians and service users. These adaption and learnings are described in the findings section, below.

Outcomes Evaluation

The questions addressed by the evaluation of outcomes for families and children were:

1) What were parents' and children's experiences of the intervention?
2) Were there changes in the following domains from pre- to post-intervention?
    a) The children's behavioural and emotional well-being
    b) The children's experience of trauma in relation to parental conflict
    c) The level of parental conflict between participating parents

Quantitative and qualitative data were collected to address these questions.

Quantitative Data:

Standardized questionnaires were completed by service users at different time points, in order to measure change across the course of the intervention. Baseline data was collected during intake and session one, and follow-up data in session eight.

Measures

Parental conflict: DWP Parental Conflict Questionnaire for Separated Parents.

This is a 27-item questionnaire designed to measure parental conflict among separated parents. It compromises three separate measures:

1. 'Discuss & Share Decision Making' (Ahrons, 1981), a measure of co-parent interactions and communication. Four items assess inter-parental conflict, with lower scores (range: 4-20) indicating more conflictual relations. Six items assess co-parent support, with higher scores (6-30) indicating higher perceptions of support from ex-partner.
2. 'Co-parenting communication' (Kramer & Washow, 1993), to assess communication quality and satisfaction with custody arrangements – higher scores indicate better levels of communication (3-15) and satisfaction (5-25).
3. 'Frequency and Breadth of Conflict Scale' (Morrison & Coiro, 1999) – higher scores (0-27) indicate more conflict.

Child wellbeing (child-report): Child Outcome Rating Scale (CORS).

The CORS is a simple, four-item measure designed to assess areas of life functioning known to be influenced by therapeutic intervention: 'me', 'family', 'school' and 'everything' (Duncan et al., 2003). It has been developed for children aged 6-12. The child rates how happy they are with each area of life on a 10cm line, with a frowning face at one end and a smiley face at the other. Higher scores (0-40) indicate higher wellbeing.

Child wellbeing (parent-report): Strength and Difficulties Questionnaire (SDQ – Parent version).

The SDQ is a widely used emotional and behavioural screening questionnaire for children and young people (Goodman, 2001). It is a 25-item scale, compromising five sub-scales: emotional symptoms, conduct problems, hyperactivity, peer relationships and prosocial behaviour. A total difficulties score (0-40) is calculated by adding the sub-scale (0-10) scores together, except for prosocial behaviour. Higher scores indicate higher levels of difficulty. For families with multiple children, parents were asked to complete the SDQ for the child they were most concerned about or who they believe is most impacted by the conflict.

Child trauma: Child Revised Impact of Events Scale (CRIES-8).

CRIES-8 is a brief 8-item, child-friendly measure designed to screen children at risk of Post-Traumatic Stress Disorder (PTSD). It is designed for use with children aged 8 and above, consisting of four items measuring intrusion and four measuring avoidance. Higher scores indicate higher levels of intrusion and avoidance. It was used here to assess if children (aged 8+) had experienced trauma as a result of parental conflict.

Demographic information.

Relevant demographic information was collected from parents at the beginning of the program, including child age, length of time separated, parent work status and occupation, resident parent and years spent in litigation.

Qualitative Data

In addition to the questionnaire data, we used semi-structured interviews to collect qualitative data. Upon completing the program, parents from all groups across the two pilot sites were invited to take part in an informal semi-structured telephone or face-to-face interview, to share their experience of the program and provide feedback. Where appropriate, given age and maturity, children were also invited to take part in a telephone or face-to-face interview, to provide their perspective on the group. Where possible, children's interviews incorporated toys and games to create a relaxed atmosphere and to ensure that no pressure was placed upon the child.

The inclusion of interviews enabled us to gain a richer understanding of parents' and children's experiences of attending the NKM group. Interview data provides context

to the questionnaire responses and enables us to explore families' perspectives in depth, focussing on what they did and didn't like about the group, what they felt had and had not changed, particular sessions or moments identified as important mechanisms/moments of change, and suggestions for how the group could be improved going forward. This is an important way of engaging with service-users and taking seriously their experiences and perspectives, as well as triangulating the data to better inform our findings.

Two members of the research team conducted interviews with a total of 14 parents (6 fathers and 8 mothers) and 5 children. Interviews took place by telephone or in person and lasted between 10 minutes and 60 minutes.

Participants

In total, the four NKM groups across Ealing and Hackney reached 19 families: 38 parents and 33 children.

- Ealing Group 1: Six families, comprising 12 parents and 12 children
- Hackney Group 1: Five families, comprising 10 parents and 6 children
- Ealing Group 2: Five families, comprising 10 parents and 9 children
- Hackney Group 2: Three families, comprising 6 parents and 6 children

In addition, we include baseline findings from the NKM group that ran concurrently at the Anna Freud Centre for an additional 6 families. This group was not funded by the DWP and was not part of the Family Ties project. However, the same measures were used for this group and the inclusion of this data allowed more a reliable description of who the families coming into the service are, and their wellbeing and conflict levels at the point of referral.

There were no significant differences in the baseline characteristics of families from the 3 sites and so data are presented for the whole sample of 25 families (25 mother-father dyads and 42 children; see Table 1).

Overall, the sample was comprised of families that were roughly representative of the London population. Most fathers were working full-time, while two-thirds of the mothers were working full-time or part-time. Only one family had both parents unemployed. Just under half the families were from Black, Asian or other Minority Ethnic groups. There were equal numbers of male and female children.

Table 1. Participant demographics

	Mothers	Fathers	Children
Age: mean (sd)	43 (6.8)	46 (7.6)	9.4 (2.9)
range	28-53	34-62	3-15
Ethnicity: n (%)			
White	13 (54%)	14 (58%)	22 (52%)
Black	1 (4%)	1 (4%)	1 (2%)
Asian	5 (21%)	4 (17%)	6 (14%)
Mixed/other	5 (21%)	5 (21%)	13 (31%)
Parent Work status: n (%)			
Full-time	4 (29%)	13 (77%)	
Part-time	5 (36%)	3 (18%)	
Not in work	5 (36%)	1 (5%)	
Child Gender: n (%)			
Male			21 (50%)
Female			21 (50%)

The parents had been separated for an average of 4 years (range 6 months to 14 years). Most children (76%) were living primarily with their mothers; 3 families had equal custody sharing arrangements, and three parent couples still lived together with their children. No children were living primarily with their fathers, and children from two families had no contact with their fathers at the time of referral.

Group Attendance

There were 22 parents initially enrolled in the first groups that ran to completion. Of these, 6 parents (3 couples; 27%) never attended or dropped out of the intervention early. The 16 parents who engaged attended an average of 7 sessions (range 3 – 8 sessions); almost all of them (88%) of them attended 6 or more sessions.

There were some differences between the 16 completers and 6 non-completers on baseline data. More specifically, the parents who withdrew from the program were reporting lower levels of conflict on three subscales of the Parent Conflict measures: Inter-parental conflict, $t\ (17) = 2.1$, $p = .050$; Co-parent support, $t\ (17) = 4.1$, $p = .001$ and Communication, $t\ (17) = 5.0$, $p < .001$. Thus, engagement in the program

was related to the extent to which the couples were experiencing conflict and needed support.

In future, the Parental Conflict measures might be used for screening families for suitability to the program. This is discussed further in the findings, below.

Findings

Implementation Evaluation Results

The implementation evaluation encapsulates the process of implementing the program in the two pilot site contexts across the whole of the project, including set up and training, pilot site partnership, intervention delivery, and on-going supervision and learning. The evaluation drew learnings from semi-structured interviews with group facilitators, weekly feedback logs completed by frontline practitioner and AFC clinicians during the delivery of the intervention, as well as information gathered from workshops, meetings and trainings with pilot site partners, and reflections from the AFC project team itself.

1. Positive feedback on training

Clinicians from Hackney and Ealing were very positive about the experience of training in the NKM model at the Anna Freud Centre. They found the role-play and experiential exercises particularly helpful, and felt they developed good relationships with the Anna Freud clinicians. Some felt more information on the background of the model would be helpful (e.g. on multi-family therapy more generally) and would have appreciated a reading list of relevant literature. However, others felt that the training as it stood was sufficient.

2. Service context

A description of each pilot site has been detailed elsewhere in this report. The difference in service context across the two sites, and the impact of this on the program, was a point of interest and reflection throughout the project, with important implications for future delivery in these and other services.

In Hackney, the program was situated across CAMHS and social care. In practice, this meant that the child was the ‘service user’. In contrast, Ealing’s delivery of the project within their SAFE team, a family service, means that the parental couple was the service user. We found that as a consequence of this, the relationship between parental couple and practitioner was typically stronger in Ealing, meaning that practitioners felt better equipped at the start of the program to engage with parents and persuade them to enroll in the groups. Hackney practitioners were able to develop good therapeutic relationships with parental couples in their service, but this kind of work was different from normal practice in Hackney and required additional time. For example, calling parents between sessions was fairly normal for the Ealing practitioners since they routinely run parenting groups and engage with families in this way, whereas for Hackney clinicians this created an unexpected and unusual additional workload.

We found that the Ealing service context could also positively support recruitment for future groups, as Ealing practitioners, through their day-to-day work, were frequently in contact with families who meet eligibility criteria for the group. As such, referrals for the groups naturally arise through the SAFE team's work. Given the recruitment challenges encountered throughout this project – particularly as a result of tight timelines and the nature of the families involves – Ealing's capacity to more easily identify eligible families was an advantage, and may enhance the long-term sustainability of the program.

Hackney's cross-departmental approach to delivery of the program was positive in that it necessitated partnership working, helping to build relationships across CAMHS and social care, and benefit from the expertise of practitioners in both services. However, the two parts of the service had different capacity to dedicate time to recruitment and program delivery, which meant that in practice, the majority of referrals came from CAMHS. In addition, communication and partnership working across the two services could be challenging, since practitioners often worked in different places and on different days to one another. This was especially challenging in the context of organising intake sessions for families, which required that staff across both teams were able to coordinate their availability with one another and with both parents in a referred family.

3. Establishing appropriate referrals

The project encountered recruitment challenges that are typical of any new intervention. Pilot site partners advertised the program across different teams, in some cases going to each team within their service to speak about the program and discuss eligibility criteria, in order to raise the profile of this new program amongst colleagues, and answer questions. This was an essential factor in acquiring referrals for the program. Pilot site practitioners focused on raising the profile of NKM amongst 'front door' teams, to ensure that all families coming into the service were assessed for eligibility for the program.

Clinicians stressed the importance of receiving appropriate referrals and conducting a thorough assessment during intake. Important factors noted include:

- Families should be willing to engage and motivated to change
- Conflict should be on-going at the time of referral (i.e. not in the past)
- Conflict must be bi-directional. Cases of coercive control are not appropriate – clinicians noted that this can be difficult to identify during referrals, but generally felt able to manage this during intakes.
- Both parties must accept that the relationship is over.

Clinicians noted that the intake sessions were an important opportunity to give families a 'taste' of the intervention and to model the key principles, and to build parents' motivation to attend the program.

In practice, it became apparent that two families recruited into the program were 'inappropriate' referrals, and consequently these families voluntarily left the group. In one case the couple were not experiencing sufficiently high levels of parent conflict, so the nature of the intervention wasn't appropriate for them; in particular, role play exercises were ineffective, since the couple was not experiencing the kind of scenarios enacted in the role plays. In the other case, the conflict was unidirectional, and again the intervention wasn't appropriate.

To understand more about these families, we held an interview with one of the parents, and also returned to the intake questionnaires for each family. The practitioner who did the intake felt that the couple experiencing uni-directional conflict had met all criteria for the program at the time of intake. Relatedly, the couple who appeared to display insufficiently high levels of conflict had been asked to leave a different intervention because their conflict meant they were unable to cooperate with the program, though their scores on the DWP Parental Conflict questionnaire did indicate lower levels of parental conflict than is typical of other families in this intervention.

This highlights the need to establish relationships with families to ensure practitioners are able to have a good understanding of the parental dynamic. To avoid drop-outs in the future, we agreed that the same practitioner would conduct the intake for both parents, and where this is not possible, there should be close discussion between the two practitioners conducting parent intake. This will allow for a better understanding of the dynamic between the two parents, and the identification of uni-directional conflict. However, it is inevitable that at times, it will become apparent during the program that it is not appropriate for one or more of the families; since the group is more resilient with more families, there should be a minimum of five families in each group in the future, so that the group can continue to be successful even if one family leaves.

4. Tight timescales impact implementation and recruitment

A key challenge for the delivery of this program was the tight timescales between training, recruitment, and delivery. This is particularly the case at the early stages of implementing a new intervention within a service, where frontline staff are unfamiliar with the intervention, and there is little momentum to move forward. The set-up phase of the project, including training, setting referral pathways, contracting, and referrals, all took longer than estimated, causing additional pressure for front-line staff before delivery of the intervention even started.

Additionally, clinicians emphasised that the tight timeline for recruiting families for each group led to a lot of stress and required a huge amount of work. They noted that this pressure could have a detrimental impact on the group itself, since if they were forced to run a group with low numbers, or to accept families who weren't quite the right fit, this could have repercussions for the success of the group for all attending families. This finding is likely due to the fact that this was a time-limited funded project with tight deadlines. The naturalistic delivery of the intervention outside of the project may not result in the same time pressures.

These difficulties were particularly relevant for the first group, as in addition to the challenges of implementing a new service, it is also more difficult to receive referrals and conduct intake meetings during the summer holidays, when clinicians and families may be on holiday and unable to attend meetings. In order to manage this, we postponed the start of the group until 6 weeks into the school term, which created more time for referrals and intakes to take place. We anticipate that over time, the program will become more established within the two pilot sites, and referral processes will become more streamlined as awareness and understanding of the program increases amongst referrers. Consequently, we hope that recruitment will happen more quickly and easily, reducing stress on clinicians. However, given that these families are often unsure about participating in the NKM group, and that their circumstances can change rapidly meaning that they may no longer meet eligibility criteria (for example, if a couple decides to reopen court proceedings), it is

likely that recruitment will always present a challenge, and timescales must be realistic in order to take this into account.

Timescales also required recruitment for the second groups to begin whilst the first groups were still running. This proved untenable for practitioners in terms of workload, and also meant that the referral period fell over the winter holidays. Practitioners felt that this was not useful, as several families they identified before the holidays had escalated conflict over the break, making them ineligible for the group in January. As a result, we pushed back the start date of the second group until mid-February, to allow for intake to take place just before the group. In future, running two groups per calendar year would be more feasible, particularly as we would expect recruitment and set-up pressures to ease as the intervention becomes more locally embedded.

5. No Kids in the Middle is a resource-intensive program for practitioners

All pilot site practitioners stressed the resource-intensive nature of the NKM group, which often placed them under considerable pressure. This was a major theme of interviews with clinicians.

Clinicians noted that the project requires a lot of clinician time that went beyond 8-session delivery of the groups: for receiving referrals, conducting intake meetings with prospective families, planning group sessions, setting up, de-briefing, and maintaining contact with families in between sessions. In Hackney, the group was run across two services: Social Care and CAMHS. This created additional pressure for clinicians, since group facilitators did not necessarily work closely together in their normal work, and therefore had to put time aside to meet and plan the groups. Clinicians across both services also reported that raising awareness of the group with colleagues in order to promote referrals was time consuming.

Because of the time-intensive nature of the group and the considerable emotional impact, clinicians noted the importance of good co-working relationships between facilitators, fairness in distributing workload, and on-going supervision.

6. Extensive key-working of families is essential to success of the program

Some level of key-working of families is written into the NKM, however, the level of key-working that clinicians told us was required was significantly more than the program outlined.

The additional support with families started early in the process, to ensure that practitioners were able to build relationships with the family. The Ealing team established an additional meeting with parents before intake 1; this was an informal one-to-one conversation with each parent, the aim of which was to gauge their eligibility and start to build a relationship. Although this additional meeting was perceived as a positive adaptation that increased family engagement and reduced the risk of 'inappropriate' referrals, it requires additional clinician time, and this may not be feasible in other services.

Practitioners told us of the importance of navigating 'cold feet' ahead of the group starting, by maintaining constant contact with families through the referral and intake process. Making the families feel supported, getting names of attendees for the social network meeting, all of which created buy-in from the families and helped avoid last-minute dropouts.

Additional support to families continued throughout the group delivery, with weekly check-in calls, text messages, and general key working of families. This was important to keep families engaged and motivated throughout the program. This required additional time and resources (approximately an additional hour/week per person) from the group facilitators, but as outlined in sections above, was a key factor for the success of the group. Regular contact with the families also helped practitioners to stay abreast of any situations occurring with each family – a central challenge to working with high conflict families.

7. Facilitating the Parents' Groups

Clinicians told us that overall, the multi-family format worked very well; parents were able to help and constructively challenge one another, and to develop a support network that they would continue to use beyond the ending of the group. A role play about destructive patterns was particularly powerful and provoked an emotional response in a number of parents. A session about 'old problems, new solutions' was also very positive, and more time was needed to get the most out of it since parents engaged well.

Certain challenges did arise in facilitating the parent's group, mainly, the need to establish boundaries around the group. As a result, practitioners developed 'ground rules' with the parents in the first session of the group, as a way of managing challenges such as: one dominant voice in the group, families arriving late and disrupting the group, parents rushing out of the room and refusing to return when distressed. Ground rules were set collaboratively and collectively by the group, so as to ensure this was in-line with the 'non-expert' stance of clinicians.

Practitioners also told us that they recognised the need to be reflective when considering family dynamics, particularly when working with and engaging fathers. In one example, a father who was referred to participate in the group felt that he was not taken as seriously as his former partner in group discussions. In response, practitioners reassessed how they worked with fathers, to ensure they were actively engaging fathers such that fathers felt heard and supported.

8. Facilitating the Children's groups

Clinicians found facilitating the children's group to be largely positive experience as well and found that as they gained confidence in managing the group dynamic, the children responded well. As well as setting group rules, as in the parents' group, practitioners found that asking children at the beginning and the end of the first group why they were at the group helps remind the children of why they are attending, and embed key ideas: that the conflict is not the child's fault and that the parents are working together to make the child happier.

Clinicians also noted the importance of having a range of activities in the children's group, so that children have varied ways to express themselves. In the groups, clinicians focussed mostly on craft activities, but on reflection felt that they would introduce more games and other activities in the future. Inviting children to choose their own games and teach the rules to the other children worked well and helped to vary the activities on offer as well as giving children a sense of ownership over the group.

One of the challenges faced was the wide age range in the children's group. Clinicians noted that meeting the needs of all the children and introducing games that were age appropriate for everyone was difficult. This could lead to a lack of engagement from older children, unless the group was split so that older children went into a separate room. Additionally, some children (e.g. children with additional needs) needed one-to-one attention – this could be disruptive to flow of the group and required a lot of staff time. Often, additional staff members had to be brought in to help manage this, further increasing the resource-intensity of the group.

Practitioners addressed this challenge by providing more structure for the older children and allowing for more play time for the younger. The practitioners were able to bring the group together by having a variety of children's games on offer and encouraging a different child each week to choose the game. This helped the children to have ownership of the group and ensure everyone had a voice. The practitioners created a broad range of interactive games, and these have been captured in the group materials. Additionally, where possible, a third practitioner was brought in to support the children's group, particularly in groups where there were very young children or children with additional needs. While this worked well, it was additional resource required from the pilot sites. Going forward, most clinicians thought that in subsequent groups, the children's group should be split into two or three groups by age, though a minority of clinicians also felt that having older children in the group was important for the overall dynamic, and could be encouraging for the younger children.

9. Parent and Child Presentations

Towards the end of the group, children and parents prepare and deliver presentations for one another. Clinicians noted that some children responded well to presentations and were engaged and happy to present. Others did not want to present and felt worried about the impact of their presentation on parents. Clinicians reflected that it is important not to place pressure on the children, and to be flexible about if and how they deliver their presentations. When children did not want to present, clinicians took this as an opportunity to invite parents (away from the children) to be curious about why this might be the case, and encourage parents to consider that children may not feel safe sharing some of what they had talked about in the children's group due to ongoing parental conflict.

"In our group we had a lot of curiosity after that, when the children wouldn't show the parents the wall chart that they had made, the parents asked to see just a bit and said "maybe it would help us if you could show us", there was curiosity about it. And we were able to stay with 'well why do you think it is that they can't share it?' […] I guess in my head really it would have been a really nice way to finish the group for the kids to go and share this presentations and feel safe enough to do their presentations, but that wasn't possible, the kids didn't feel safe enough and we have to respect that."
(Clinician, Hackney)

Parent presentations were generally good and revealed how much progress parents had made in being able to present something as a pair, despite ongoing acrimony. Clinicians felt that most parent presentations had a significant positive impact on the children.

10. Role of social network

The role of the social network is an important component to the program. However, clinicians noted that it could be difficult to encourage some parents to invite their social network to the network meeting; this was perhaps made more difficult by the fact that many families had moved to London from elsewhere in the UK or abroad, and therefore it was difficult for their network to travel to the group meeting. Clinicians reflected that they might need to think more creatively about engaging networks that are not physically present at meetings.

To address these challenges, members of the network who attended the first meeting were asked to provide a contact email address, so that practitioners have the ability to contact them and invite them to attend the interim network meeting (although families should continue to be encouraged to engage their networks.) Practitioners then followed up via phone or email with network members who couldn't attend the interim network meeting.

We also highlighted the importance of being honest and clear with families about why the network is being involved – particularly that 'the network are not going to be asked their opinion on anything', but that they need to be part of the solution. This might help to overcome some parents' hesitation about inviting their network; interviews with parents sometimes suggested that the parents had not fully understood why the network were involved and this confusion had fueled their concerns. Given this, it is especially important that local facilitators fully understand and embrace the value of involving the network, in order to encourage parents to involve their network. More emphasis on the network during training might be beneficial in this respect in the future.

11. Supervision

AFC clinicians provided supervision to pilot site practitioners throughout the program. In group 1, where the group was co-facilitated by AFC and pilot site practitioners, AFC clinicians provided 'live supervision' where they were able to reflect and discuss in real-time, during and immediately after group sessions. Supervision for the second groups took the form of weekly phone calls or video calls with the pilot site team.

Overall, supervision discussions helped pilot site practitioners think through challenges that arose in the course of running the group. For example, several instances arose in relation to managing the dynamic of the group, including problematic alliances between mothers, such that fathers became alienated or bullied, and how clinicians find the balance between maintaining safety of the group whilst not assuming the 'police person' role. Other challenges that were discussed during supervision included how to build solidarity within a very small group, where fewer different views and perspectives are available and therefore differences between parents (such as cultural differences) are more apparent, and how to provide space and time to validate trauma that parents have experienced, while still covering all of the material needed in each group session. Finally, supervision was used to ensure that time and space for the practitioner team is protected to process difficult interactions.

Supervision has continued throughout the Covid-19 lockdown, as pilot sites continue to engage with families in a different way, using video calls with individual parents. This has included thinking together about the best way to engage with parents and children during lockdown, and consideration of safeguarding and confidentiality issues. These discussions have also supported the development of the next phase of the project, which allows for an adapted program of remote support to families.

12. Sustainability

This program was designed with sustainability in mind. Training nearly 20 front line practitioners in the approach means that pilot sites are well resourced to run the group in the future. We also learned about the value of staying engaged with families who have completed the intervention and found it useful; participants from group one were keen to support future families in the program, offering to act as mentors and supporters. Some parents from Ealing recorded messages about their experience, which we were able to play to new families in the network meeting of the second group. We hope this will increase engagement amongst new families at the beginning of the program and ensure the sustainability and continuation of the group.

Outcomes evaluation results: Quantitative Data

The questionnaire data was collected from parents and children at **baseline** (assessment and/or prior to session 1 of the intervention) and, for those families completing the NKM groups, at **follow-up** at the end of the last session.

The baseline data includes all those parents and children who joined the program in Hackney, Ealing and the Anna Freud Centre. This data is presented so that we can learn more about the families being referred to and entering No Kids in the Middle. There were no substantial differences between the 3 sites in the baseline data for participating families.

Only two groups (one in Hackney and one in Ealing) were completed before the Covid-19 lockdown, so follow-up data is presented for this subgroup of participants. For the parents and children who completed both baseline and follow-up questionnaires, we present data and statistical analyses of change over time. The very small sample size means that these results should be interpreted with caution. Effect sizes are reported in addition to measures of statistical significance. Not all participants completed all questionnaires at the various time points, so sample sizes differ across measures.

Parental Conflict Measures

The measures for separated parents selected to be used as part of the Reducing Parental Conflict program were used for this evaluation. This is a composite of 3 scales, each with two subscales.

Table 2. Results of Parental Conflict Measures

	Baseline *N = 44* *Mean (SD)*	**Follow up** *N = 14* *Mean (SD)*	**Pre-post** *N = 11* *Mean T1-Mean T2*	t-test *p*
Discuss & Share Decision Making Scale: **Inter-parental conflict** (high scores = less conflict; range 4-20)	8.6 (3.7)	9.3 (3.0)	6.9 – 8.9	.089*
Co-parent support (high scores = more supportive; range 6-30)	18.1 (4.4)	19.7 (4.1)	17.7 – 18.9	.347
Co-parenting communication Scale: **Communication** (high scores = better communication; range 3-15)	6.6 (3.6)	7.1 (3.3)	4.9 – 6.5	.127
Satisfaction with custody arrangements (high scores = more satisfaction; range 5-25)	13.7 (4.5)	15.6 (5.2)	14.6 – 14.9	.883
Frequency & Breadth of Conflict Scale: **Frequency of conflict** (high scores, more frequent conflict; range 0-27)	9.9 (4.6)	11.1 (3.4)	12.6 – 10.8	.171
Breadth of conflict (high scores = more breadth of conflict; range 0-9)	4.5 (2.1)	5.2 (1.6)	5.1 – 5.0	.852

* Statistically significant change from baseline to follow-up at $p < .100$ level

Baseline: The mean scores for all subscales tended to be around the midpoint of the potential ranges. Individual item analyses of the Frequency and Breadth of Conflict Scale showed that the most frequently reported cause for arguments between parenting couples was about their children. At baseline, 98% of the parents

reported some arguments about their children; almost half of these were classified as “often”. This suggests that the families entering the program were appropriate referrals as difficulties around co-parenting the children was a central issue for them. The next most frequently cited causes for arguments were about money (70%), chores and responsibilities (70%), and relatives (60%). Arguments for other reasons, such as drinking, new partners and leisure time, were much less frequently reported. This pattern remained relatively stable over time.

Change over time: There were 11 parents who completed the questionnaire before and after the intervention. Related samples t-tests were carried out to compare changes over time. One of the six subscales, Inter-Parental Conflict, showed a reduction in conflict over time that was statistically significant at the $p>.10$ level: $t(10) = -1.88$, $p = .089$, $d = 1.19$. This subscale measures “the degree of hostility, conflict, tension and disagreement present when couples discuss a parenting issue”. The other subscales did not show any statistically significant changes over time.

Child Outcome Rating Scale (CORS)

The CORS is a self-rating scale for children aged 6-12. It asks children to rate “How are you doing? How are things going in your life?” on a visual analogue scale. There are four domains: Me, Family, School and Everything. Total scores can range from 0-40 and the clinical cut-off is 32 or below.

Table 3. Results of CORS ratings

	Baseline N=28 Mean (SD)		**Follow up** N=12 Mean (SD)	**Pre-post** N=10 Mean T1- Mean T2	t-test p
CORS me	7.3 (2.5)		6.5 (3.4)	7.2 – 6.3	.426
CORS family	5.4 (3.2)		8.6 (2.0)	5.9 – 8.3	.061*
CORS school	8.2 (2.7)		8.0 (3.1)	8.2 – 8.1	.984
CORS everything	7.5 (2.3)		8.0 (2.5)	7.0 – 7.8	.367
CORS Total (high scores = better functioning)	28.1 (8.0)		31.0 (7.3)	28.3 – 30.6	.482
	N(%) below cut-off of 32		*N(%) below cut-off of 32*		
CORS clinical cut-off scores	17 (63%)		5 (45%)		

* Statistically significant change from baseline to follow-up at $p < .100$ level

Baseline: Of the 28 children who completed the CORS at baseline, two-thirds of them were reporting overall dissatisfaction across four categories of myself, my family, my school and/or everything, meaning they scored within the clinical range. When looking at the individual items, the most problematic domain for the young people was clearly family related. This suggests that the program successfully targeted families where the children may have needed a family intervention.

Change over time: There were 10 children who completed the CORS at two timepoints. Of these:

- 3 did not score in the clinical range at either time point
- 4 scored in the clinical range at both time points
- 1 moved from the nonclinical to clinical range, and
- 2 moved from the clinical to non-clinical range

The total summed scores on the CORS did not change significantly over time.

However, when looking at the individual domains of functioning (me, family, school, everything), children reported more positive views of their family functioning at follow-up than baseline, moving from an average of 6 to 8 on the 10-point scale. The change on this subscale is statistically significant at the $p<.10$ level; $t(9) = -2.14$, $p = .061$. The effect size ($d = 1.43$) was large. Although the sample size is very small, and the change may have been relevant to only some children, this is a promising finding suggesting that the intervention may be effective in improving children's subjective sense of wellbeing in their families. See Figures 2 and 3.

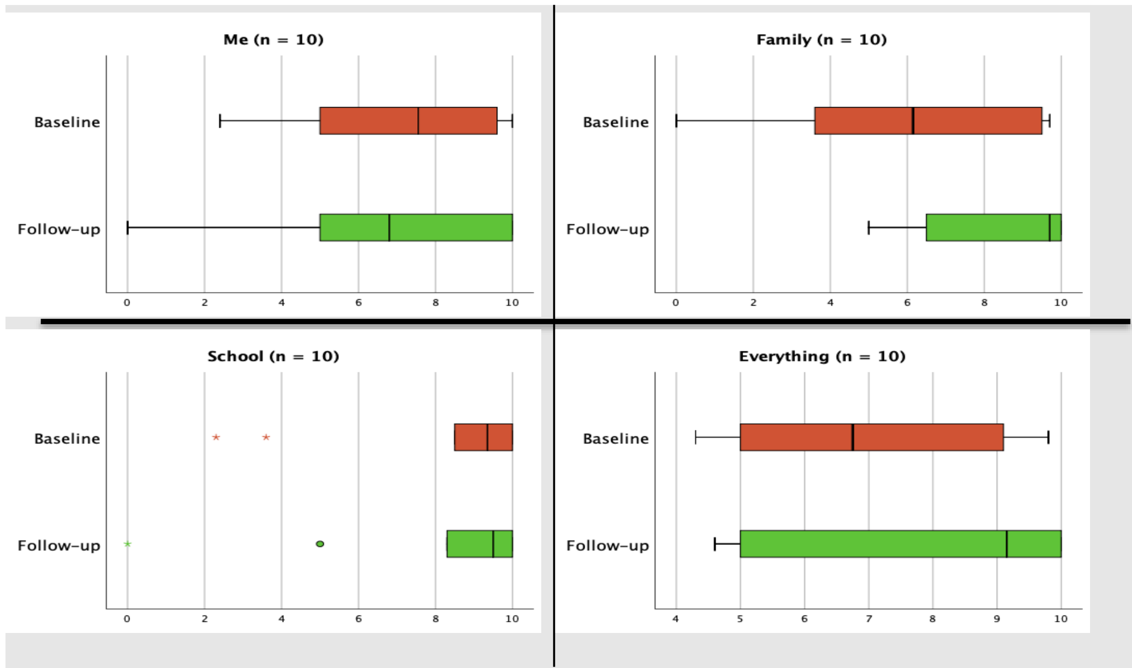

Figure 2: CORS Subscales Baseline and Follow-up (n = 10)

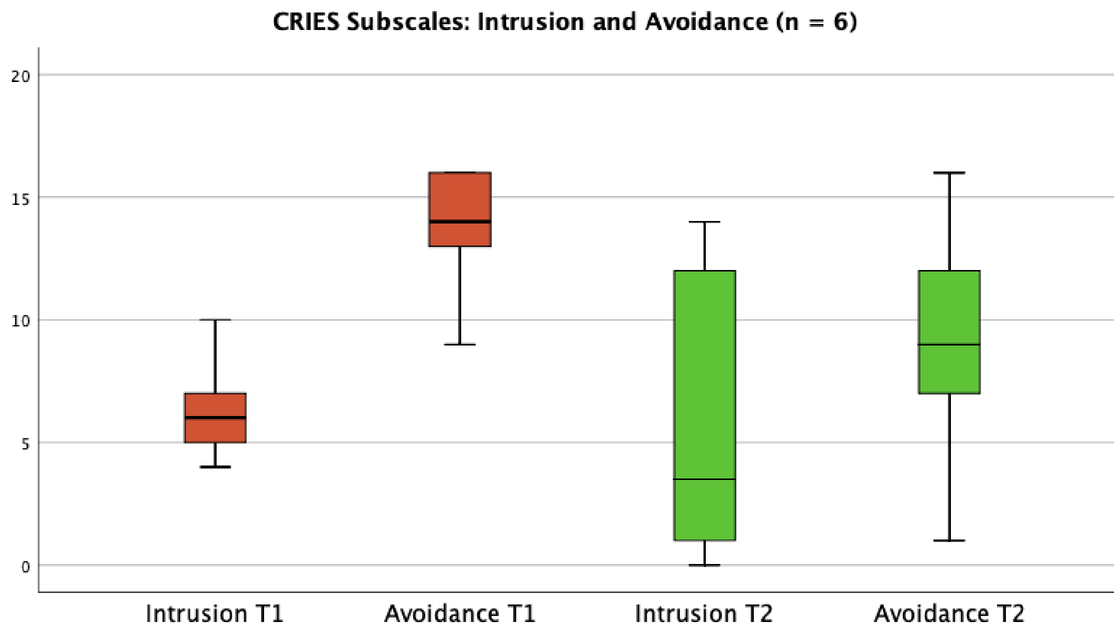

Figure 3: CRIES Subscales – Intrusion and Avoidance, Baseline (T1) and Follow-up (T2) (n = 6)

Revised Impact of Events Scale (CRIES)

The CRIES is a brief child self-report measure designed to screen children at risk for Post-Traumatic Stress Disorder. In this evaluation, we asked children to complete the questions in relation to the conflict between their parents; children were asked to 'think about how it is when your parents are fighting or not getting on with each other – maybe you have a memory of a time when the arguing was really bad. If you can, try to keep that in mind when you're answering the questions. There are 2 subscales: Intrusion and Avoidance. A total score of 17 or more suggests possible PTSD. It is developed for children aged 8 and older, so was only given to the older children in this sample. The results are presented in Table 4.

Table 4. Results of CRIES ratings

	Baseline N = 29 Mean (SD)	Follow up N = 7 Mean (SD)	Pre-post N = 6 Mean T1- Mean T2	t-test p
Intrusion	5.7 (5.2)	5.6 (5.4)	6.3 – 5.7	.706
Avoidance	9.2 (5.9)	8.4 (4.9)	13.7 – 9.0	.073*
Cries Total	15.0 (9.2)	14.0 (7.4)	20.0 – 14.7	.148
	N(%) above cut-off of 17	*N(%) above cut-off of 17*		
CRIES clinical cut-off scores	13 (45%)	3 (44%)		

* Statistically significant change from baseline to follow-up at $p < .100$ level

Baseline: The CRIES demonstrated relatively high levels of trauma symptoms for some children entering the program. At baseline, almost half of the children rated themselves as experiencing PTSD-type symptoms from the conflict between their parents that reached clinical significance.

Change over time: For the six children who completed the CRIES at baseline and follow-up:

- 0 did not score in the clinical range at either time point
- 2 scored in the clinical range at both time points
- 1 moved from the nonclinical to clinical range, and
- 3 moved from the clinical to non-clinical range

There were no statistically significant changes in the total CRIES scores over time. However, overall, these six children reported less Avoidance of traumatic thoughts at follow-up than baseline, moving from an average score of 14 to 9 on this subscale. The change on this subscale is statistically significant at the $p<.10$ level; $t(5) = 2.27$, $p = .073$. This change had a very large effect size ($d = 2.03$).

This finding may point to a promising outcome of the intervention in helping children to process and cope better with the traumatic experiences of conflict between their parents.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is an emotional and behavioural screening questionnaire for children. The parent-report version was used. Both mothers and fathers were asked to complete the questionnaire about a single target child in the family (the child they were most concerned about). However, some parents wanted to complete questionnaires for all of their children, and for these families we collected more than one SDQ questionnaire per parent.

The measure provides subscales for Internalising and Externalising difficulties (range 0-20 each) and a Total Difficulties score (range 0-40). Recommended clinical cut-off total scores are: Normal (0-13), Borderline (14-16) and Abnormal (17-40).

Table 5. Results of SDQ ratings

	Baseline *Mean (SD)*	**Follow up** *Mean (SD)*	
SDQ Mother-report	*N = 29*	*N = 6*	
Internalising	6.0 (3.8)	7.8 (6.4)	
Externalising	6.7 (4.1)	9.0 (7.6)	
Total Difficulties	11.9 (7.0)	16.8 (13.0)	
SDQ Father-report	*N = 22*	*N = 7*	
Internalising	5.5 (4.0)	9.0 (5.9)	
Externalising	9.2 (5.9)	11.0 (5.3)	
Total Difficulties	15.0 (9.2)	20.0 (10.8)	
SDQ Completed Pre- Post Intervention[a]	*N = 7*	*N = 7*	**t-test** *p*
Internalising	7.7 (2.8)	5.4 (2.9)	.075*
Externalising	6.3 (4.9)	6.4 (5.2)	.897
Total Difficulties	14.0 (6.1)	11.9 (6.7)	.150

a. Pooled from 5 mother-report and 2 father-report SDQ's with pre- and post-intervention data.

* Statistically significant change from baseline to follow-up at $p < .100$ level

Baseline: At baseline, several children were experiencing significant difficulties according to both mother- and father-report. According to the mothers, almost half of the children were scoring in the borderline (14%) or abnormal (41%) range. Similarly, the fathers reported that several children were experiencing considerable emotional and behavioural problems (19% borderline, 19% abnormal).

For the 5 children for whom both mother and father-report SDQs were completed at baseline, the correlation was extremely poor and not statistically significant (Spearman's rho = .154, p = .805). This means that mothers and fathers were seeing their children's well-being in very different ways. The mother-reported scores were significantly related to child self-rated well-being on the CORS (r = -.530, p = .024), but father-reported total difficulties were not associated with CORS scores (r = -.170, p = .580). Future research with a larger data set will investigate if this discrepancy between how the two parents see their children's wellbeing lessens over time.

Change over time: To measure change over time with maximum sample size, we added data from two fathers to the 5 mother-report questionnaires for which pre- and post-data existed, giving a total of 7 children for whom change over time could be assessed. Of these 7 children, 4 had total scores in the normal range at both time points and 3 had scores in the abnormal range at both time points. This suggests that the parents did not report clinically significant changes in their children's overall wellbeing. However, it is important to note that the clinical cut-offs are based on total scores rather than the Internalising and Externalising subscales, which are relatively independent of each other. Statistical analyses examined these separately. The total score and Externalising subscales did not show any statistically significant changes. However, t-tests showed improvements on the Internalising subscale that were statistically significant at the $p<.10$ level; $t(6) = 2.15$, $p = .075$. The effect size ($d = 1.78$) was large.

Qualitative evaluation results: Key Themes from Parent and Child Interviews

1. Parents Making Changes: Progress not Perfection

Most parents thought that attending the group had made, or at least had the potential to make, changes in their relationship and reduce conflict.

Parents reported that the idea of destructive patterns was very helpful and had resonated with them; many enjoyed learning about the patterns and were actively trying to change their patterns, though most found this difficult. Many reported improvements in communication, such as less aggressive emails, or learning to 'pick your battles' and not get drawn into arguments.

Another powerful session for parents was 'new solutions to old problems', where parents were invited to discuss a familiar problematic child-care issue in front of the group and provided with support and ideas from other parents for new ways of engaging with old issues. Parents suggested that future groups should dedicate more time to this activity. In response to this, Ealing introduced a second session in

group 1, to allow for more time for every couple to discuss a problem with the support of the group. Parents enjoyed these sessions because they were able to draw practical guidance from them, which they were able to then enact in real life. It helped them to feel less stuck.

Another key improvement, voiced by many of the dads, was a better relationship with non-resident children, and more frequent access to children. For many of the dad, more time with the children was a goal at the beginning of the group, and they were very pleased to have achieved this by the end of the program.

However, parents were honest about the fact that in all couples, some conflict remained, and some issues were not yet resolved. Indeed, levels of conflict fluctuated throughout the course of the group, so at times specific couples felt very hopeful, and then something would happen, and conflict would rise again.

However, this variability and inconsistency is to be expected, since different couples come to the group at different stages of conflict, more or less ready to change, meaning that progress will look different for different couples. Further, many of these couples have been in very high conflict for a long time, and it is unlikely that conflict will be fully resolved after an eight-week course. Therefore, whilst change takes time, and conflict remains, most couples felt they had made progress from where they began. Notably, the couples who felt that they'd made the least progress / no progress were generally (though not exclusively) the couples who felt they weren't appropriate for the group, suggesting that they had not engaged or the group had not been right for them.

'For me it definitely enlightened me to some of the ways that the divorce can affect your children and what your children feel, and it makes you re-evaluate how you behave and communicate. I didn't have an epiphany but it has made me recognise that I over-manage things and if I did that less maybe he would feel less controlled, and I think our sisters are now in contact with each other and that's a great thing.' (Mum, Hackney)

~

We've been fighting legally for a year and a half, and we weren't on speaking terms at all, we tried everything, court cases, and we didn't even get to speak. But this surprisingly this actual parenting ties classes that we have been attending have actually been magnificent. Through the program, after the first couple of sessions, me and my ex started speaking, which is obviously, it doesn't matter what you've done and who is right and who is wrong, it's hard to do but you've got to remember you've got kids, [...] we are talking again or at least communicating, and I get to see the kids almost every day, and a lot of it is thanks to this organisation and these classes.' (Dad, Ealing)

2. Importance of contact between sessions for maintaining motivation

A number of parents reported that regular phone calls from clinicians between groups, especially at the start of the intervention, were very important for maintaining motivation and preventing dropouts. These phone calls helped build a

therapeutic relationship and made families feel safe, cared for, and encouraged; this enabled them to continue attending the group despite challenges. Notably, these phone calls were not part of the NKM model, but rather, pilot site group facilitators recognised the need to check-in with parents and implemented this practice after discussion amongst themselves.

'Twice I was just about to quit, and I just wanted to call you and inform you about not coming and I'm quitting. But [facilitator] called me. He didn't know that I want to quit. He didn't know anything, but he just called to ask me how I'm doing and what's going on and how the children are. You know this. And he spent with me one hour 20 minutes over the phone […] he was really, really helpful and he made me- without knowing- he made me change my opinion and I just continued, and after that to be honest I was okay to come, after that I was strong enough to do it and to improve myself, you know improve the situation between my ex-partner and me.' (Mum, Ealing).

~

'The calls in between really helped because at one point I was going through some difficulties with my daughter and her dad, I was hell bent on not coming back at one point, and but once I'd explained the situation, they just seemed really caring and understanding about the situation, and they convinced me to give it another shot, so without that phone call I wouldn't have bothered coming back.' (Mum, Hackney).

3. A good relationship with clinicians

The majority of parents reported feeling that the clinicians were professional, caring, motivated, fair, and non-judgemental, and this was important for maintaining engagement with the group. They reported that clinicians were adept in not taking sides; something that parents recognised took considerable skill.

'The facilitators are hell bent on making it work.' (Dad, Hackney)

~

'The clinicians are really good, really good, I think you have to be really, really good like the way they diffused situations when they could see they were getting out of hand and they just kept control of the group. I think they are very skilled professionals, and made you feel like they understood you and heard what you're saying and felt what you're saying, but not choosing sides.' (Mum, Hackney)

Importantly, parents sometimes found the non-judgmental attitude of clinicians difficult. One parent suggested that he wanted the clinicians to be clearer about who is in the wrong, and to call out past wrongdoings before being able to move forward. In his mind, he could not reconcile with his ex-partner until her previous actions had been acknowledged, and therefore found the clinicians' non-judgmental stance to be challenging.

However, one parent voiced the opposite opinion, stating that she found one clinician to be judgmental and bullying. This experience was an important minority,

and perhaps points to a 'personality clash' between this parent and practitioner. Concerns such as these can be reflected upon in supervision and managed appropriately.

4. Ambivalence about Involving the Network

Involving the family's network (friends, neighbours, other family members) is a key part of the NKM model. However, parents reported that they did not always understand the importance of or rationale behind involving their network, and consequently some decided not to involve their network in the group.

It is a central principle of the program that the network is often involved in perpetuating the conflict, but with support, the network can take a step back and take the side of the child, playing their part in changing destructive patterns and supporting parents to maintain their commitment to the program as the course progresses. Given this, families' unwillingness to involve their network may have impacted their outcomes and experience during the NKM program.

Families were worried about involving network because:

- members of their network 'hate' their ex-partner and won't be in the same room as him/her
- embarrassment / concern about involving friends/family in their personal lives
- members of their network live far away

This first two reasons perhaps suggest that families had not understood the reason for involving the network, since network members' feelings towards ex-partners, and involvement in the personal lives of the family, are key reasons for including the network. However, the final reason is a logistical concern, which perhaps can be overcome through use alternative ways to engage with the network if they cannot attend meetings in person (e.g. through telephone or email).

Despite these challenges, those parents who did involve the network mainly described the experience as positive and saw the potential for the network to provide support both to the parents and the children.

'Also you know you almost every time you advise to talk to our network, and okay I was doing this and I tell you something: all my network, absolutely every single person said 'skip it, don't do it, this is nonsense' and if you listen to my network as you advise, I wouldn't go to this course, you know, so I would be careful about this, about advising network that much' (Mum, Ealing)

~

I involved my network for some but not all of the homework, my sister has been helpful, but of course your network are already on your side, they understand your concerns as a parent already, so in a way I didn't get anything new out of talking with her about the children. So, whether my network can help unpick bad habits might be limited because they already share your point of view and are part of that perspective. I never spoke to my ex-partner's network and he never spoke to mine – maybe if they had we could have moved forward, because you recognise that those other people love

your children and want the best for them. It would have been good to take advantage of that lack of hostility between the two networks and let them communicate and keep in mind the goals and values of the parent that they know, when trying to help negotiate things with the child's best interests front and centre.' (Mum, Hackney).

~

'Speaking to my network was a positive, they were happy to be drawn in, to be honest my network has been saying for a long time that we need to break this cycle, stop fighting it and find a new way. And also, I do trust my ex-wife's network to put the kids first, honestly the whole network are as despairing as I am.' (Dad, Hackney)

5. Solidarity between families in the group

Many parents enjoyed the multi-family format of the group and were able to draw support and encouragement from others in the group. Whilst sometimes it was difficult to hear advice from other parents, mostly parents appreciated this aspect of the group and stated that they intend to stay in touch with the other parents in order to help maintain changes and the sense of solidarity.

Some parents talked about feeling less isolated and getting a better understanding of their own situation through hearing others' stories. Many parents reported feeling safe to share details of their own life because other parents in the group were equally open, creating a non-judgmental atmosphere.

This was one of the anticipated benefits of the group and one of the reasons for developing a multi-family group model with this cohort; solidarity within the group, combined with support from the network outside of the group, are thought to be a key mechanism for maintaining change.

'It's about having people to lean on and take advice from because they are in a similar situation to your own. I really bonded with the other mums and we have each other's numbers so we can carry on supporting each other, because although we have our networks, to actually be the one directly involved and going through the same thing, it's nice to talk to people who know exactly what you're feeling.' (Mum, Hackney)

However, although the majority of people found the group helpful in this respect, a small number of parents felt unable to share within the group or trust advice from other parents, because they felt that they were different from the other families in an important way. For example, one couple reported feeling different from the other families because they were quite a bit younger, and another parent said that he and his wife were not divorced, so he didn't feel able to identify with the other families. Additionally, parents who subsequently left the group due to being 'inappropriate referrals' (see above) also found it difficult to develop the sense of solidarity with others, because their situation was different (i.e. lower levels of conflict). This emphasises the importance of carefully screening referrals to ensure that all families are an appropriate 'fit' for the group, to maximise the chance that solidarity and supportive relationships will develop between families. Further, it is important to

discuss the intervention with families at intake and check that they like the idea of a multi-group format, since some parents will naturally be more shy and therefore might benefit from a different form of support.

6. Younger Children's Experiences of the Group

Those children who enjoyed the group were generally younger children (primary school aged). They enjoyed the playful atmosphere of the group, enjoyed games and snacks, and enjoyed seeing their parents in the same room working together. For some children in particular, having their parents together and being able to be with both parents simultaneously made them very happy.

In the Hackney children's group, the balance of genders was quite uneven, and male children said that they would have been happier had there been more boys in the group.

'I liked that we had food and it was fun […] I liked the games at the end, and cos we got to choose the game rather than not having a choice.' (Child, Hackney)

Parents' views generally aligned with those of their children; most parents also reported that the younger children enjoyed the groups, though some were anxious at first. Parents reported that the children made friends and mostly looked forward to attending the groups and playing with the other children. Some parents reflected that the children could be quite 'hyper' and that it would have been good for the younger children to have some outdoor space to play, or a greater range of activities including more active games, particularly for those children who did not particularly enjoy arts and crafts.

'My four-year-old, every time we have to go to the meeting, he's looking forward to it. So most probably it helps.' (Mum, Ealing)

7. Older Children's Experiences of the Group

Older children were more ambivalent about the group. These children were old enough to understand why they were attending the group, and some found it difficult to acknowledge or discuss family issues, either because they had already established coping mechanisms that involved not talking about parental conflict, or because they worried about the impact of the group on their parents. In particular, older children who felt a sense of responsibility for their parents' wellbeing and emotions worried that their parents found the group hard, or they worried about the impact of their behaviour in the group on their parents – for example, they were concerned that by talking about conflict, they might get their parents in trouble or make their parents feel guilty. Some older children also found the group activities to be too childish, and were annoyed by the behaviour of the very young children.

'But what I thought was not fun, kind of not fun in a way, was and when they were like telling me questions about my family, that was a bit personal and stuff. A bit uncomfortable.' (Child, Ealing)

~

''It's just so frustrating because I didn't want to talk about my family's stuff, it's kind of private. They kept on asking me a lot of

questions, it was so frustrating, they kept on asking questions and questions and questions' (Child, Hackney)

Interviewer: What did you think of the idea of doing a presentation to the mums and dads, telling them how we are feeling as children about our family, particularly how we might feel if our mums and dads aren't getting on?

Child, Hackney: *It's a bad idea […] I thought my family would have been kind of angry at me because I'm literally like sharing stuff.*

Again, parents' views generally aligned with those of the children; parents also noted that the older children struggled to talk about their feelings, and some parents worried that the children has been put under pressure to discuss family issues when they might not want to.

'My daughter didn't like the group at the start which I think is because you guys got her to talk about her emotions and she's a very closed book.' (Mum, Ealing)

Despite the challenges older children experienced when talking about parental conflict, some parents mentioned that their children had come to more of an understanding and acceptance of their family situation as a result of attending the group, and consequently were less likely to hope that their parents would reconcile and enter into a relationship once more. Some parents felt that their children became less stressed during handover periods, and that the child's relationship with the non-resident parent had improved.

'My thirteen-year old, I think it helps him. I think, because every Christmas since we were separated, every Christmas he has his wish list to Santa, he always asks, he wants us to be a family again with his dad, but now he never wrote it on his wish list. So, there's a change there, I know that helps him a lot. (Mum, Ealing)

Generally, these findings suggest that it is important to maintain the age boundaries of the group, since older children were less able to benefit from the playfulness of the group, and perhaps required different activities to engage them. However, despite this, some older children did benefit from attending the group.

These findings also suggest that it is important to stay true to the NKM model and ensure that pressure is not placed on the children – children should never be pushed to talk about feelings or give a presentation to the parents if they do not want to. If a child doesn't feel safe enough to talk openly then facilitators must respect that.

8. Parents worry about maintaining changes

Many parents reported worrying that positive change might slip back, without the ongoing support of facilitators and regular meetings of the group. They were not confident that they would be able to maintain changes alone. Often, this worry was explained in terms of a fear that even if they continued to try, their ex-partner might not, and this would jeopardize progress and harm the children. A number of parents worried that their ex-partner had only attended the group for 'show' and therefore would revert back to previous behaviours, and this led to a feeling of powerlessness and anxiety.

One way to help maintain changes is to build a robust support system around families and to emphasize the importance of involving the network and continuing to lean on one another for support. Some families may also need ongoing clinical support, such as attendance at other parenting programs.

'Since after the meetings, so far, he's been complying […] but I know that he'll comply because there's people that can see, it's like keeping an eye on him, keeping an eye on us. He'll comply because I will comply. But if it stops and no one will keep an eye on him, it's just going to be… that's what's happened now.' (Mum, Ealing)

'I said to her [ex-wife] we're here today, we've done 75% of sessions, so with your past history with me in the court hearing was always to restrict, to stop the children from spending time with me… only two hours a week… and all these unnecessary allegations, and then we end up here and all of a sudden you're playing the supportive partner. It's good, it might be genuine, it might be playing, my question is: what has made you change? So, I can have assurance that actually you realise.' (Dad, Ealing)

Conclusions and Future Directions

Summary of Findings

Conflict between parents that have separated can have devastating and long-term consequences for the children if they are caught in the middle. This project implemented and evaluated the "No Kids in the Middle" program, a multi-family group intervention, in frontline services for children and parents. The implementation was largely successful. The evaluation of the implementation process highlighted positive elements of training and delivering these groups in the pilot site, and also pointed to adaptations and factors to be taken into account in future. Key practical learning points included:

- The group can be successfully run in a CAMHS or social-care setting. The groups may be easier to establish in a Tier-Two parenting service alongside other parenting groups, where threshold for referral is lower and frequent responsive contact with parents is resourced and part of normal practice. Further, the groups may run more efficiently where there are established working relationships between the facilitators and frequent opportunities for de-briefing

- The importance of careful screening of families at intake, to ensure that they are appropriate for the group – this prevents dropouts that can disrupt the sense of solidarity that is central to an MFT format. Where possible, one clinician should conduct intake sessions for both parents, to gain a good understanding of the couple's relationship dynamic, and thus ensure there is sufficient level of conflict and that the conflict is two-sided (not a case of

coercive control)

- The importance of having a sufficiently large group with at least five families, to protect the group against dropouts. In smaller groups, individual differences can be more apparent, and this can prevent a sense of solidarity from forming

- The value of phone-call check-ins between sessions; these should ideally be provided by the same clinician to the same couple each week. This could perhaps be extended to include brief check-ins with children, to prevent dropouts and build a therapeutic relationship

- Recognition that the group is resource intensive for clinicians. This highlights the importance of giving clinicians sufficient time and resources to run the intervention

- Ensuring clinicians understand the importance of involving the families' networks, and thinking creatively about ways to do this, particularly when network members live far away

- The value of particular sessions, such as 'new solutions to old problems'– where parents want to, it may be beneficial to introduce an extra session in order to give more time to this activity

- Generally, it seems important to maintain the age-boundaries of the children's group, and not include children aged 12 or above. However, where practical restraints mean that older children must attend, the children's group should be split into two such that older children have a separate space, and clinicians adapt games and activities to suit the older children. Where possible, children's activities should include more active games in addition to arts and crafts. Additional staff members may need to be brought in to manage the children's group where individual children have additional learning needs.

- Clinicians in the children's group should be careful not to pressure children to talk about their family life if they do not want to. Similarly, children should not be pressured to give a presentation to parents unless they feel safe to do

The evaluation of outcomes for parents and children participating in the program enabled us to learn more about: 1) the types of families coming into the services and the problems they were experiencing and 2) the potential outcomes over time for families going through the intervention.

The findings showed that, at the outset:

- Parents reported relatively high levels of conflict, and the main topic of conflict was issues to do with the children and co-parenting.
- The parents who reported low levels of conflict at referral were more likely to withdraw from the program.

- A significant number of children were reported to have relatively poor well-being, at the point of referral, mostly in terms of their family lives, some showed high levels of trauma symptoms related to the conflict between their parents, and some parents reported their children to have significant emotional difficulties.
- The level of agreement of parental couple reports of their children's emotional and behavioural functioning was low, meaning that the parents "saw" their children in very different ways.

For those families completing the program, on average over time:

- Parents reported lower levels of conflict, and especially statistically significant reductions in the degree of hostility, conflict, tension and disagreement when discussing parenting issues.
- Children reported significantly better well-being in their family lives.
- Children reported significantly less avoidance of trauma around family conflict, indicating more willingness to acknowledge and find ways of handling these difficult feelings.
- Parents reported fewer Internalising symptoms in their children.

The interviews with parents and children at the end of the program enabled us to understand more about their experiences of it. Overall, most parents had a positive experience of the program, and almost all felt it had improved their co-parenting relationship to an extent, though some conflict invariably remained. Key benefits included: better understanding of 'destructive patterns' of communication and motivation to change these; more frequent and better-quality contact between children and non-resident parents; learning to 'pick your battles' in relation to co-parenting disagreements. However, many parents were worried that these positive changes would not be maintained, particularly if their ex-partner ceased cooperating once the course was over.

Parents reported having positive relationships with clinicians, and most valued the clinicians' non-judgmental and supportive approach. Relationships with clinicians were strengthened through phone calls between group sessions, which built trust and enabled parents to continue with the group when otherwise they might have decided to stop attending. Parents also reported building strong relationships with other families, which resulted in a sense of solidarity and mutual support; many parents told us that they plan to maintain relationships with other families once the group had finished, and that they had valued receiving advice from others, particularly in the session 'new solutions for old problems'. However, for parents who felt different from others in the group – perhaps because of a lower level of conflict, or factors such as age – this could prevent feelings of solidarity from developing and thus prevent the MFT format from being as effective for these parents.

Children had a mixed experience of the group. Generally, the younger children (aged 4-8) enjoyed the group; whilst some found it difficult to talk about their feelings or family life, most enjoyed the games and playful atmosphere, made friends, and appreciated the opportunity to see both their parents. However, older children were more ambivalent about the group. They generally found it harder to

talk about family conflict, and worried about the impact of the group (including what they said to clinicians) on their parents' wellbeing; they were anxious not to 'tell tales' on their parents, or make parents feel worried or guilty. Older children sometimes found the games to be childish, or the younger children to be annoying. Parents' views of the children's experiences mostly align with what the children told us in interviews.

Future Directions

There were several limitations to this evaluation that may be addressed in future work. The number of participants was small; this is particularly the case since we were not able to complete the second round of groups due to the Covid-19 lockdown, which limits our follow up data. Further, since families sometimes missed sessions, joined late, or did not return questionnaires, some questionnaire data is missing from the overall set. Taken together, this means that the findings detailed here cannot be generalised, since the sample is too small. However, this was a pilot project, and it was not our intention to produce generalizable findings at this stage. Rather, we have collected a rich set of quantitative and qualitative data in order to understand the experience of children, parents and clinicians, and this data has demonstrated hopeful findings which suggest the NKM program may be effective for high-conflict separated couples and their children. Further, the implementation evaluation has resulted in a number of recommendations for improving the implementation and delivery of the program in the UK in future. This data is valuable, and can be used to inform future iterations of the NKM program in local frontline services. As more groups are run across different sites, more data will be collected, and we can develop a better understanding of whether and how this intervention is effective. If delivery of the program in the pilot sites and elsewhere continues to show promising initial findings, the next phase of evaluation will be to conduct a large scale controlled trial evaluating the efficacy of the intervention relative to treatment as usual over the longer term.

We hope to continue to support Ealing and Hackney in the support they offer to families who are in conflict as well as building the evidence base for multi-family therapy interventions for this target group so that learning can be shared and training further developed. We look forward to continuing to diversify the support that is on offer for high conflict families through working with the Department for Work and Pensions and other relevant parties.

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