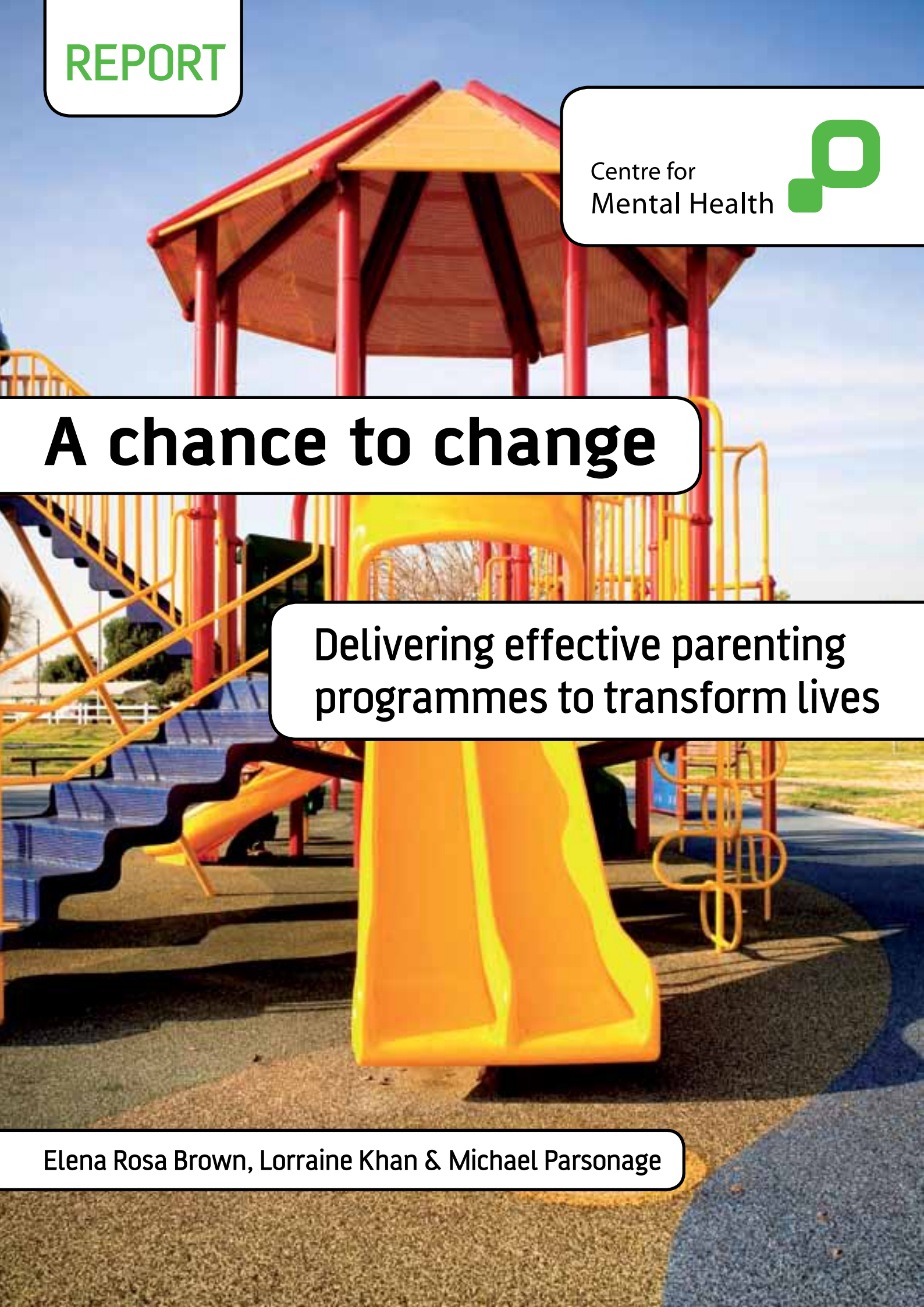
REPORT

Centre for Mental Health



A chance to change

Delivering effective parenting programmes to transform lives

Elena Rosa Brown, Lorraine Khan & Michael Parsonage

A Chance to Change

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Centre for Mental Health is an independent national mental health charity. We aim to inspire hope, opportunity and a fair chance in life for people of all ages with or at risk of mental ill health. We act as a bridge between the worlds of research, policy and service provision and believe strongly in the importance of high-quality evidence and analysis.

We encourage innovation and advocate for change in policy and practice through focused research, development and training. We work collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

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Executive summary

This report sets out the findings of a project on the implementation of evidence-based parenting programmes for children with, or at risk of developing, serious behavioural problems. It is based on a review of published research, detailed studies in four local areas in England and a national survey of parenting leads.

Evidence shows that parenting interventions can be very effective – but only if the programmes in question are tried and tested and not just well designed but also well implemented. It is crucial, for example, to ensure that programme take-up is high and drop-out is low among high-risk groups. We discuss in detail the key requirements of successful implementation and the main barriers that may get in the way.

Building on the findings of this report, a follow-up project to be undertaken over the next 12 months will seek to develop practical tools to support commissioners, managers and providers in strengthening the delivery of evidence-based programmes.

Early behavioural problems and why they matter

Mental health difficulties in childhood cast a long shadow and nowhere is this more apparent than in the case of early behavioural problems, particularly among the 5 per cent of children whose problems are sufficiently severe to merit a clinical diagnosis of conduct disorder.

These problems have a strong tendency to persist over time and are associated with a range of adverse long-term outcomes, including not only continuing mental health difficulties in adult life but also poor educational and labour market performance, criminality and other forms of antisocial behaviour, high rates of teenage pregnancy and marital breakdown, and reduced life expectancy associated with risky behaviours such as drug and alcohol misuse.

The lifetime costs of severe behavioural problems are so high that even modest improvements in outcomes are likely to produce a high return on investment in early intervention.

A strong body of research demonstrates that a range of family-based programmes can generate such improvements. These include Family Nurse Partnerships, which support teenage mothers during the first two years of a child's life, and parenting programmes such as Triple P and Incredible Years, aimed at the families of children aged 3–11 who are showing early signs of behavioural problems.

The availability of these programmes is increasing, but many are failing to deliver their full promise because of shortcomings in implementation.

The scale of need and targeting

Severe behavioural problems affect about 5 per cent of children under 11, with a further 15% suffering from less serious problems which nevertheless put them at increased risk of poor long-term outcomes. Children vulnerable to these problems may be identified either on the basis of risk factors such as maternal mental illness or at the first signs of emerging behavioural difficulties.

There is substantial variation around the country in the availability of family-based early intervention programmes. Provision in some areas is insufficient to meet the needs even of the relatively small number of children with the most severe problems.

Our local studies show that methods of targeting vary from place to place, with some areas actively seeking out high-risk groups and others using lower level eligibility criteria.

Imprecise targeting of family-based programmes has a number of disadvantages. For example, research shows that if parenting programmes are offered universally, only about two out of ten parents of children with severe behavioural problems get the help they need. On the other hand, recruitment rates increase when programmes are specifically targeted at those with the greatest difficulties.

Programmes focused on children with the most severe problems produce the highest benefits for parents and children and have the highest returns.

Identification and referral

Most parents of children with behavioural problems seek help or advice, but few go on to access effective support.

The services most commonly approached by parents are schools and GPs, but these services often have poor awareness of the significance of early behavioural problems and of where to access effective and responsive local support.

Initial discussions between services and parents about children's behavioural patterns provide critical opportunities to identify parents who may benefit from early intervention. Parents stressed the importance of referrers using carefully considered language during initial contacts; language should reinforce benefits and outcomes which are meaningful for them.

Some parents are more accepting of an offer of support than others. Those living the most challenging lives may require a greater intensity of initial support to maximise motivation to attend programmes.

There is wide variation in the speed and quality of referral pathways to parenting programmes. These pathways can be complex and unwieldy, particularly for referring agencies or for families unfamiliar with children's services. Single gateways have been successfully used in some localities.

There is currently little agreement on the most appropriate referral tools for parenting programmes.

Poor information about available services is a barrier to successful referral. Systematic networking and promotional work with potential referrers by parenting teams can support the referral process.

The range of potential referring agencies in routine contact with parents who may benefit from support is very wide and includes not just schools and GPs but also health visitors, early years workers,

housing staff, those dealing with family violence, social workers and also workers in adult services such as mental health and criminal justice.

All these referrers can help to increase the motivation of parents to engage with parenting programmes.

Engagement

Increasing the enrolment of parents in family-based programmes and reducing attrition or drop-out are key means of improving the overall effectiveness and cost-effectiveness of these interventions.

Barriers to engagement take a number of different forms. Some are of a very practical nature such as difficulties with child-minding or transport, and others are more intangible but nevertheless very important, such as lack of readiness to change among some parents.

Providers tackle these barriers by: ensuring programmes are easy to access, holding the sessions in convenient venues with crèche facilities; encouraging other agencies to promote the programmes; and meeting parents before the course, particularly as a means of developing the strong therapeutic alliance between workers and parents. Published research and our own findings highlight this as one of the key ingredients of successful engagement.

Providers also seek to maintain the engagement of parents by sustaining positive relationships throughout the course, by helping those who miss sessions to catch up and by offering additional support when this is needed.

Nurses working in Family Nurse Partnerships, which require sustained contact with teenage mothers over two years, place great emphasis on enrolment and retention. High engagement levels are achieved by a combination of persistence, 'elastic tolerance' in the face of missed appointments, collaborative working with parents and development of a strong therapeutic alliance.

Because the effectiveness and cost-effectiveness of family-based programmes can be so severely compromised by low take-up and high drop-out, the funding of programmes should always allow for some expenditure on resources aimed at minimising the adverse impact of barriers to engagement.

Practitioner skill

A skilled workforce is essential for the achievement of good outcomes. Some studies have shown that practitioners with the lowest level of skills actually make outcomes worse.

The effective provision of parenting courses relies not on 'reading from a book' but on delivering programmes as intended by the programme designers in a therapeutically confident and highly skilled manner.

The key skills identified for practitioners include: an engaging, empathetic and trustworthy approach; highly developed communication, collaborative, therapeutic and group facilitation skills; and the ability to work reflectively and responsively.

Parents also value practitioners who are themselves parents and have faced challenges and life experiences similar to their own.

Local problems in the recruitment and management of parenting practitioners have recently included reductions in the funds available for training new staff and previously trained staff not being released or prepared to deliver programmes.

Delivering the programme as intended

Evidence-based programmes have core ingredients which, when replicated faithfully and delivered by skilled staff, maximise the likelihood of good outcomes. Conversely, when programmes are not delivered as intended, poor outcomes may result.

Effective programme-specific supervision and coaching play an important role in ensuring programme fidelity, building on training and supporting continuous learning, but their use in practice is variable. For example, models of supervision and coaching range from non-trained generic managers supervising programme delivery as part of their broader management responsibilities to highly trained programme-specific coaching offered in addition to workload supervision.

Other areas of variation include the calibre and intensity of quality assurance for programmes and differences in practitioner awareness and ownership of their individual performance in relation to fidelity benchmarks, with limited scope to monitor performance against national or local standards.

Some degree of adaptation of programme models is acceptable, as long as this does not interfere with the core ingredients associated with positive outcomes. We noted a range of adaptations being made to programmes, some of which appeared to amount to a drift from the core programme and others which had been carefully planned and negotiated with the programme developers.

Programme changes made as a way of saving money are generally likely to be a false economy.

The strategic infrastructure

National policy is supportive of early intervention, but implementation at the local level has been adversely affected by budget cuts and over-reliance on short-term funding opportunities. Management of the external environment and the 'scrabble' for new pots of money dominate the time of many parenting leads.

Obtaining funds for early intervention is always likely to be a challenge, particularly when in competition with funds for statutory and acute children's services. The financial benefits of early intervention accrue over long periods of time and across a wide range of public services, including some, such as the criminal justice system, which have little strategic link with children's services and no obligation to re-distribute savings.

Evidence suggests that effective implementation is significantly helped by the presence of a high-level local champion who acts as advocate, coordinator and overarching programme supervisor.

Our work suggests a mixed picture of partnership working at the strategic level. Some areas are attempting to develop shared outcomes and associated arrangements for joint monitoring, but poor linkages between data systems and a lack of resources and technical know-how to track and analyse outcomes over time are sometimes major stumbling blocks.

There is little evidence of parental involvement in the development of early intervention strategies and plans.

Recommendations

1. National outcome and inspectorate frameworks should include targets relating to improved outcomes for children with behavioural problems and the quality of parenting programmes.
2. The Department for Education and the Department of Health should spearhead a national campaign to broaden public and professional awareness of childhood conduct problems.
3. Health and Wellbeing Boards should promote greater awareness of maternal mental health problems.
4. Health and Wellbeing Boards should promote the development of integrated pathways for children with severe behavioural problems.
5. Health and Wellbeing Boards should review local arrangements for partnership working.
6. Joint Strategic Needs Assessments should include estimates of the numbers of children with behavioural problems.
7. Health and Wellbeing Boards should ensure that parenting programmes are targeted at the families who need them most.
8. Commissioners of parenting programmes should always ensure that contracts with providers include an allowance for expenditure on measures designed to maximise take-up and minimise drop-out, especially among socially-excluded and high-risk groups.
9. Local children's services should improve staff recruitment and ongoing training.
10. Central guidance and tools should be prepared to support greater consistency across the country in programme-specific supervision, fidelity and outcome monitoring and other quality control systems for parenting programmes.
11. Local children's services should identify a high-level champion and 'orchestrator' for family-based programmes.
12. Local children's services should provide parents with simple and engaging ways of getting support.
13. Health and Wellbeing Boards, local commissioners and providers should ensure that parents have a greater role in the commissioning, planning and delivery of family-based programmes.
14. The Office for National Statistics should undertake a new national survey of childhood mental health.



1 Introduction

This report sets out the findings of the first phase of work in a 30-month Centre for Mental Health programme on early intervention for children with behavioural problems which is being funded by the Esmée Fairbairn Foundation. The key focus of this programme is on how to improve the delivery and implementation of evidence-based parenting programmes for the support of children aged up to 11.

It is well established that behavioural or conduct problems which emerge early in childhood are very likely to persist into later life; indeed, problem behaviour in the early years has the highest continuity into adulthood of all measured human traits except intelligence. Childhood behavioural problems are associated with a wide range of adverse long-term outcomes. Most obviously these include continuing mental health difficulties: severe childhood behavioural problems are a risk factor for almost every known adult mental illness.

But the damaging consequences go much wider than this and also include poor educational and labour market performance, disrupted personal relationships, teenage pregnancy, homelessness, substance misuse, criminality, poor physical health and premature mortality. For the one in twenty young children whose behavioural problems are sufficiently severe to merit a clinical diagnosis of conduct disorder, life chances are seriously compromised. The risks of poor long-term outcomes are also significantly elevated for the much larger numbers of children whose problems fall short of a diagnostic threshold.

Early onset behavioural problems have identifiable and, in many cases, preventable risk factors. Much is now known about how to mitigate these problems. An increasingly strong body of evidence demonstrates the effectiveness of a range of family-based programmes in preventing problems from occurring at all and in preventing existing problems from persisting or escalating. These programmes are not only effective; they are also extremely good value for money, partly because of their relatively low cost and also because the scale of potential benefits is so large that even a relatively small improvement in outcomes is sufficient to ensure a high return. Over a period of years, these programmes pay for themselves many times over. Early intervention works.

Despite the undoubted benefits, both for individuals and for society as a whole, the availability of evidence-based interventions falls well short of what is needed and the quality of services remains very variable. There is widespread lack of awareness among policy makers, commissioners, service managers and front-line staff, of both the enormous long-term costs of early behavioural problems and the scope for effective intervention. Even when programmes are provided, they are often not evidence-based. Many fail to target those who need them most. Take-up rates are low and drop-out rates are high. Staff providing the services are not always adequately trained or supervised. In short, there is a very sizeable gap between the promise of research and the reality of current practice in the effort to transform the life chances of the many thousands of children with early behavioural difficulties. We know what works in terms of the design and content of effective interventions, but we seem to know much less about how to ensure that these programmes are delivered successfully on the ground.

Our aim is to help bridge this gap through a two-part programme of research and development which began in April 2011. The research phase of the programme, as described in this report, has sought to identify and analyse in detail the key factors that determine the successful delivery and implementation of evidence-based interventions and equally the main barriers that currently hamper such efforts. Building on the findings of this analysis, the subsequent development phase will entail collaborative working with key stakeholders including families, practitioners, providers and commissioners, aimed at working up practical means of improvement.

In undertaking the research phase of our work, we have employed the following methods:

- First, we have carried out a detailed review of the published literature, with a specific focus on evidence relating to the implementation of parenting programmes. To keep this report to a manageable length, the literature review will be published separately in electronic form, but relevant research evidence has been extensively drawn on here and each of the main chapters in this report starts with a short summary of key findings from the literature review.
- Second, we have undertaken detailed fieldwork in four localities in England, aimed at collecting information on the delivery and implementation of parenting programmes from a wide range of stakeholders in a number of different settings. The fieldwork included semi-structured interviews with 44 parents, including some who had attended parenting courses and some who had not, and semi-structured qualitative interviews with a further 159 stakeholders, including strategic leads/commissioners, providers, referrers and multi-agency partners. All fieldwork sites have been anonymised.
- And third, a short national survey was sent out electronically to 376 parenting leads around the country, to which we received 160 replies (a response rate of 43%). The survey questionnaire is shown in the Appendix.

Chapter 2 describes the relevant background to our research, including the scale and importance of childhood behavioural problems, the evidence on interventions and also the policy and public expenditure context. This is followed by a series of chapters which set out the key findings of our study organised according to the following themes:

- scale of provision and targeting
- identifying need and seeking help
- referral
- engagement
- recruitment and practitioner skill
- delivering programmes as intended
- the strategic infrastructure.

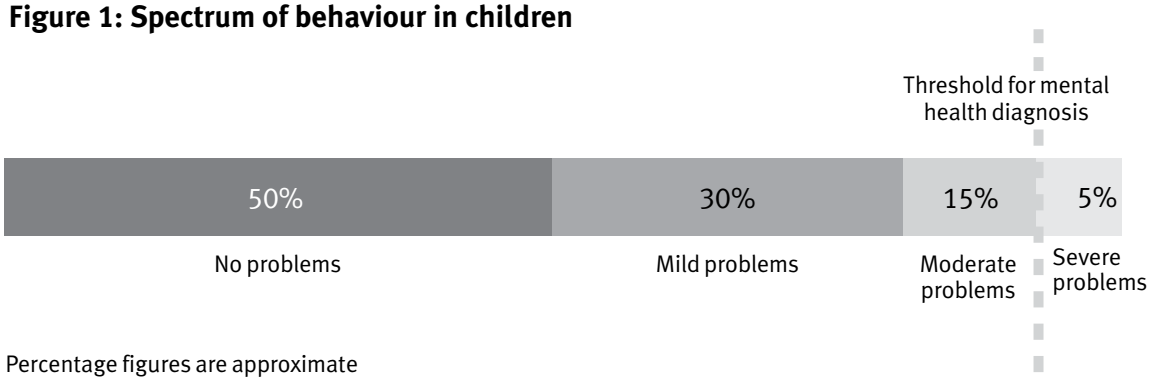


2 Early behavioural problems and why they matter

Childhood behaviour extends across a spectrum from children with no behavioural problems to those with severe and persistent behavioural problems (see Figure 1). Most parents face intermittent challenges when managing children's behaviour. Challenging behaviour can be a normal part of healthy childhood development. In most instances, children and parents negotiate these phases without difficulty and with minimal need for support.

However, for some children, behavioural problems become more severe and entrenched and can be a critical gauge of a child's developmental progress, health, wellbeing and life chances. Children at the extreme end of this spectrum meet the criteria for the mental health diagnosis of 'conduct disorder' and have been shown in research to face the very worst health and social outcomes (Fergusson, Horwood & Ridder, 2005). Conduct disorder is the most common childhood mental health problem and is defined as "a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms are violated" (Rowe *et al.*, 2010). To meet the threshold for diagnosis, behaviour should also cause significant functional impairment.

Figure 1: Spectrum of behaviour in children



Percentage figures are approximate

Caution is advised about diagnosing conduct disorder before the age of three due to the rapid developmental changes taking place at this age; however, there are equally downsides to ignoring severe problems since it can exacerbate distress and result in children not getting the vital help they need (Carter, Briggs-Gowan & Davis, 2004; Egger & Angold, 2006; Gardner & Shaw, 2008).

The most recent national survey of childhood mental health carried out by the Office for National Statistics shows that the prevalence of conduct disorder among children aged 5–10 is 4.9 per cent (Green *et al*., 2005). The condition is almost twice as common among boys (7.5 per cent) as among girls (3.9 per cent). About a third of all children with conduct disorder are diagnosed with other co-existing mental health problems, most commonly anxiety disorders or hyperactivity problems. There is also evidence that the prevalence of serious conduct problems among adolescents has increased significantly over the last 30 years (Collishaw *et al*., 2008) although reasons for this increase remain unclear (Collishaw *et al*., 2012). Nor is there clarity about whether increases during adolescence are matched by increases during earlier years.

Box 1 lists some of the behaviours that are associated with conduct problems.

Box 1: List of behaviours associated with conduct problems

Bullying/intimidation
Destruction of property (fire setting or other persistent damage)
Cruelty to animals or people
Fighting
Staying out late (under the age of 13 years)
Playing truant (under the age of 13 years)
Using weapons
Early sexual precocity/teenage pregnancy
Forcing someone into sexual activity
Criminal behaviour
Stealing
Temper outbursts
Arguing with adults
Disobedience
Deliberately annoying others
Passing on blame
Being easily annoyed
Spitefulness
Being resentful, spiteful or vindictive
Telling lies

About 30,000 children (5 per cent) in each one-year cohort in England are likely to meet the threshold for conduct disorder, while a further 90,000 (15%) have moderate conduct problems. However, research trials have highlighted considerable local variation in prevalence with between a third and 40% of children meeting the criteria for conduct problems in some communities (Scott *et al*., 2009; Scott *et al*., 2010). While more than half of young children demonstrating the highest levels of conduct problems in childhood will show some improvement by the time they reach adolescence (Zoccolillo *et al*., 2009), many remain at increased risk of very poor and costly long-term outcomes (Gardner & Shaw, 2008).

Impact of severe and persistent behavioural problems

Research indicates that children with conduct disorder face much more negative and debilitating future health and social prospects than:

- children experiencing other mental health problems such as depression or anxiety (Richards & Abbott, 2009) and
- children who begin to develop behavioural problems for the first time during adolescence, the majority of whom grow out of these problems as they adopt adult responsibilities (Moffitt, 2006).

In fact, conduct disorder during childhood is associated with a broad range of negative outcomes including a greater likelihood of:

- experiencing intellectual and developmental delay in school;
- being identified with special educational needs;
- being excluded from school: 30–40% of these children compared to 1–2 per cent in the broader population;
- school non-attendance: around 40% in comparison with 2 per cent on average (Green *et al*., 2005).

Negative outcomes stretch well beyond childhood years. Longitudinal studies, tracking children's progress into adulthood, highlight adverse outcomes across a range of domains including poor educational and labour market performance (Collishaw *et al*., 2008), financial problems, poorer physical health, reduced life expectancy, homelessness (Barker & Maughan, 2009), greater risk of suicide, disrupted personal relationships, criminality, imprisonment, teenage pregnancy and substance misuse (Bardone *et al*., 1998; Fergusson *et al*., 2005; Moffitt, 2006; Moffit & Scott, 2008).

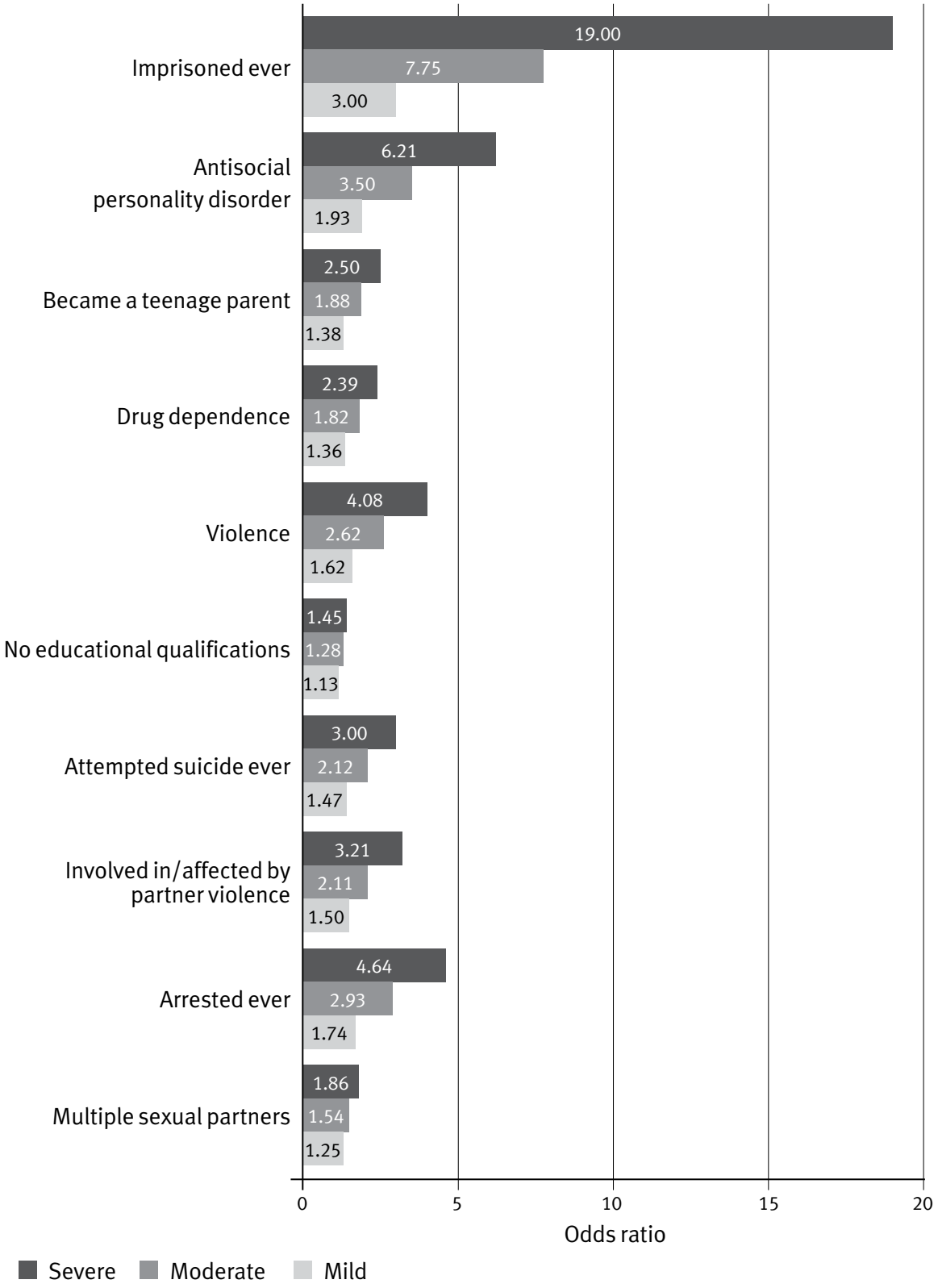
The adverse impact of childhood behavioural problems on long-term outcomes is illustrated in Figure 2. By the time they are in their mid-twenties, the 5 per cent of people who suffered from severe behavioural problems in childhood are nineteen times more likely than those with no such problems to have served a prison sentence, six times more likely to suffer from anti-social personality disorder and three times more likely to have attempted suicide. The figure further highlights how children with moderate problems falling short of clinical significance also face an elevated risk of poor outcomes, albeit to a lesser extent than the 5 per cent with the most severe problems. The estimates in Figure 1 have been adjusted to take into account the effect of other possible influences on outcomes such as family socio-economic background and cognitive ability.

Children at the extreme end of this spectrum face greater risk of almost every adult mental illness (Kim-Cohen *et al*., 2006). In this respect, severe and persistent behavioural problems may be a sign of emerging long-term mental health problems requiring early intervention to mobilise potentially protective resources.

Conduct problems and economic burden

Children presenting with early onset conduct disorder impose an increased economic burden over their lifetime, with one study estimating additional lifetime costs of around £225,000 per child (Friedli & Parsonage, 2007). Another study found that by the time they were in their late twenties children with conduct disorder cost public services about ten times more than those without behavioural problems (Scott *et al*., 2001). Most of the additional costs have been assessed to fall within the criminal justice system (Friedli & Parsonage, 2007), but increased expenditure has also been identified in adult mental and physical health treatment, social security payments linked to higher unemployment,

Figure 2: Increased likelihood of a range of outcomes compared to children with no behavioural problems

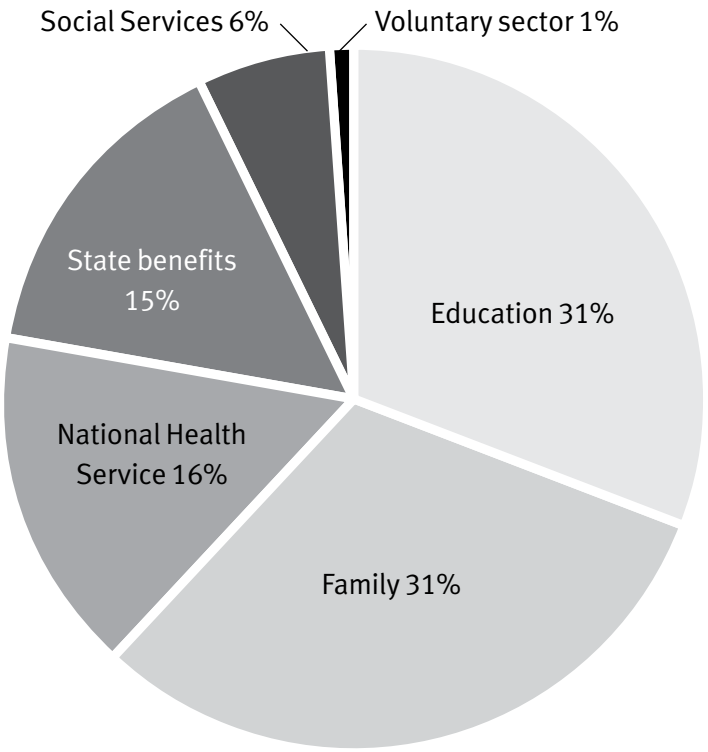


Adapted from: (Fergusson, Horwood & Ridder, 2005)

residential/foster care placements, increased contact with social services, alternative educational provision and teenage pregnancy (Scott *et al*., 2007; Dretzke *et al*., 2009).

During childhood, the pattern of economic burden follows a slightly different pattern, with the majority of costs falling on schools and families. Romeo *et al*., (2006) identified the average additional cost of each child with conduct disorder as being around £15,000 per year in 1996–1997, broken down as shown in Figure 3.

Figure 3: Breakdown of which parties bear the costs of conduct disorder during early childhood



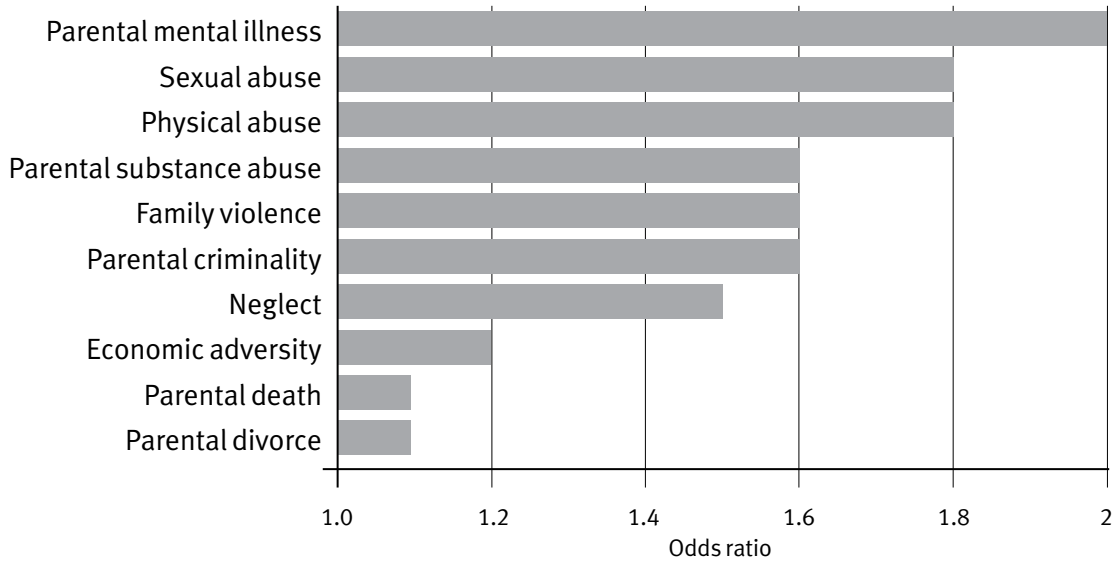
Risk factors

The causes of childhood mental health problems are complex, linked to a constellation of genetic, family and environmental risk and protective factors interacting with each other (Moffit & Scott, 2008; Vitaro & Tremblay, 2008). The relative importance of some readily identifiable risk factors is shown in Figure 4.

Parenting is a critical influence on children's behavioural development. Behavioural problems in childhood are particularly associated with hostile, critical, punitive and coercive parenting (Rutter, Giller & Hagell, 1998). Positive parenting is a key protective factor for healthy development (Gardner *et al*., 1999; Denham *et al*., 2000; Hutchings *et al*., 2007a).

Positive parenting involves promoting play, providing positive reinforcement, praise and rewards for desired behaviours, and clear instructions and limit setting (Gardner, Burton & Klimes, 2006).

Figure 4: Childhood adversities and risk for first onset of mental disorder



Source: Maughan (2011), based on Kessler and McLaughlin (2010). Reproduced with the kind permission of Professor Barbara Maughan.

Research suggests that some children are at enhanced genetic risk of experiencing behavioural problems, although a number of environmental risk and protective factors can significantly affect the way this risk develops (Kim-Cohen *et al*., 2006). Positive parenting can improve outcomes for children with severe behaviour problems (Denham *et al*., 2000), including children with enhanced genetic risk for developing behavioural problems (Caspi *et al*., 2002; Kim-Cohen *et al*., 2003) and children with temperament-based risk factors (Barker & Maughan, 2009) such as attention or impulsivity problems.

A further important risk factor for conduct problems is poor maternal mental health (Shaw *et al*., 2003; Kessler & McLaughlin, 2010), particularly post-natal depression and high levels of pre-natal anxiety (Barker & Maughan, 2009). Indeed, Figure 4 shows that poor parental mental health roughly doubles the risk that a child will develop a mental health problem. This does not mean that parents who experience mental health problems are poor parents; however, the impact of poor parental mental health can at times undermine positive parenting skills affecting attachment, responsiveness and warmth which cultivate positive mental health in children (Reyno & McGrath, 2006).

Childhood maltreatment (Aguilar *et al*., 2000; Jaffee *et al*., 2005), substance misuse among parents and family violence (Barker & Maughan, 2009; Kessler & McLaughlin, 2010) have also been associated with higher risk of child behavioural difficulties.

The relationship between socio-economic deprivation and the development of serious childhood behavioural difficulties is complex. Parenting can be undermined by poverty and poverty may indeed drive other risk factors such as poor maternal mental health (Simons *et al*., 1993; Conger *et al*., 2002). However, there is equal evidence that positive parenting has potential to act as a protective buffer against the negative effects of poverty (Kim-Cohen *et al*., 2004). It is generally held that policy and interventions should seek a multi-pronged approach addressing the worst effects of deprivation as well as bolstering parenting (Stewart Brown, 2010).

Multiple risks

Children experiencing multiple risks such as social disadvantage, family adversity and cognitive or attention problems are at greater risk of developing behavioural problems than their peers (Fergusson, Horwood & Ridder, 2005). Risk factors have a multiplicative effect, with rates of conduct disorder increasing exponentially for every added risk factor. An analysis of data for 16,000 children in the 1970 British Cohort Study suggested that boys with five or more risk factors were almost eleven times more likely to develop conduct disorder under the age of ten than boys with no risk factors, while girls with five or more risk factors were nineteen times more likely to develop the disorder than those with no risk factors (Murray *et al*., 2010). Teenage parents have also been identified as a group whose children may face a higher risk of multiple disadvantages (Olds *et al*., 1997; Olds, 2006).

Evidence-based parenting programmes

A range of family-based programmes have been identified as having a proven impact on outcomes for children with behavioural problems. Some programmes target risk factors for poor outcomes before behavioural problems develop while others respond to the first signs of problematic behaviour in children, strengthening parenting skills before problems escalate.

Recent reviews of early intervention, such as those by Graham Allen MP (2011a) and the National Academy for Parenting Research (Asmussen & Weizel, 2010), provide increasingly clear and objective advice on a range of effective family-based programmes aimed at improving parenting.

Examples of evidence-based programmes

One well-researched preventive programme is the Family Nurse Partnership (FNP), an intensive and highly targeted nurse home-visiting service supporting low-income, first-time teenage mothers during the first two years of their child's life. This voluntary programme begins early on in pregnancy and has been shown to benefit both parents and children. FNP is a relatively high-cost intervention, but long-term follow-up studies in the US, where the programme was first developed, show clear evidence of enduring improvements in outcomes with associated financial benefits (Olds, 2006). Some of the improvements observed over time have included:

- fewer childhood injuries (Olds, Henderson & Kitzman, 1994; Olds *et al*., 1997; Olds, 2006)
- improved school readiness (Olds *et al*., 2004; Kitzman *et al*., 2010)
- improved maternal employment (Olds *et al*., 1997; Olds, 2006)
- fewer arrests and convictions, fewer breaches of probation (Olds *et al*., 1998)
- reductions in the number of girls entering the criminal justice system (Eckenrode *et al*., 2010)
- better infant emotional and language development (Olds, 2006; Kitzman *et al*., 2010).

Results from ten pilot sites in the UK (Barnes *et al*., 2008; Barnes *et al*., 2009; Barnes *et al*., 2011) indicate that FNP can be effectively delivered in the UK with comparable results to initial US trials. Results from a UK-based randomised controlled trial are due in 2013.

A range of less intensive programmes has been designed to be used at the first signs of problematic child behaviour. Programmes such as Triple P parenting and Incredible Years aim to develop positive parenting skills and techniques and are targeted at parents of children aged two to eleven with early and severe behavioural difficulties. Programmes generally are delivered in group settings, involve eight to eighteen weekly sessions of around two hours duration each, and are delivered by two trained

facilitators, with some potential to deliver programmes on a one-to-one basis for harder to reach parents (Farrington, 2005). The Triple P parenting programme includes a suite of interventions spanning five levels of intensity and ranging from whole-population awareness-raising to more intensive group work. The most reliably robust and positive results have been associated with higher-intensity Triple P group work programmes.

A broad body of well-designed studies has tested the effectiveness of these programmes and demonstrated a positive impact on parenting skills and children's behaviour (National Institute for Health and Clinical Excellence, 2006). Programmes have also been noted to:

- have a positive effect on parental mental health (Lindsay *et al*., 2011)
- improve children's school attainment (Scott *et al*., 2009)
- reduce the number of children placed on Child Protection Registers and in local authority care (Prinz *et al*., 2009).

Effects show promising signs of being sustained over at least a decade if interventions are well implemented (Webster-Stratton & Herman, 2010).

There is also good evidence to show that these programmes are not only effective in improving outcomes but also very good value for money. This reflects the very large scale of potential benefits, particularly when measured over a period of years, compared with the relatively modest cost of intervention, at around £1,200 per family, assuming an 80:20 mix of group and one-to-one provision as recommended by the National Institute for Health and Clinical Excellence (Lundahl, Risser & Lovejoy, 2006; National Institute for Health and Clinical Excellence, 2006). A recent economic study suggests that every £1 invested in an evidence-based parenting programme yields benefits to society of £14 over 25 years, with about a third of these benefits taking the form of savings in public expenditure (Bonin *et al*., 2011). On any reckoning this is an outstandingly high return.

Despite the evidence for these programmes, fewer than 10% of parenting programmes audited in 2010 met sufficient standards of evidence to demonstrate proven effectiveness (Scott, 2010).

The current economic and policy context

Strategic developments in children's services and in parenting are taking place at a time of significant economic, political and policy transition in England and Wales. Developments also come at a time when evidence is growing regarding the benefits of early intervention.

In May 2010, the Coalition Government assumed power in the midst of a global economic recession and implemented a range of measures to improve public finances. These included significant cuts in public expenditure affecting the provision of public services and also support for the voluntary sector (Kane & Allen, 2011). These changes occurred at a time of widening health inequalities (HM Government, 2009).

A series of high-profile reviews, including Frank Field MP's review into child poverty (Field, 2010), Graham Allen MP's review of early intervention (Allen, 2011a; Allen, 2011b), Dame Clare Tickell's review into early years provision (Tickell, 2010) and the Munro Review of Child Protection (Munro, 2010; Munro, 2011), have done much to inform evolving policy and service provision for children and parents.

Overlapping themes in these reviews include the need:

- for a shift towards early intervention rather than investment in later, more costly reactions to health and social crises;
- to expand the use of evidence-based programmes;
- to narrow health inequalities and achievement gaps for disadvantaged children;
- for stronger cross-sector co-operation in support of improved outcomes for children.

The Government has responded by introducing a number of broadly supportive policy initiatives including:

a) providing initial investment for the establishment of an Early Intervention Foundation to support the quality and dissemination of research knowledge and practice supporting outcomes for children and parents;

b) expanding the health visitor workforce (by 4,200 by 2015) with the aim of providing the best possible start for families, bolstering the 2–2½ year developmental check and identifying and supporting the most vulnerable families through improved multi-agency working (Department of Health, 2011a);
c) strengthening school readiness through early identification of barriers to progress and the extension of free early education to the most disadvantaged two-year-olds;
d) piloting initiatives in selected local authorities focused on:
   - increasing the proportion of families in greatest need completing evidence-based parenting programmes, and
   - increasing the proportion of families with children under five years who are identified as being in greatest need and have sustained contact with children's centres;

e) targeting intensive interventions toward the most troubled families in local communities (Department for Education, 2010);
f) extending the Improving Access to Psychological Therapies (IAPT) programme to children including evidence-based parenting programmes;
g) introducing a Pupil Premium into schools for the most disadvantaged children (HM Government, 2011);
h) re-stating its intent to use Sure Start children's centres in local communities to deliver proven early intervention programmes for families in the greatest need (HM Government, 2011).

The Government's mental health strategy, *No Health without Mental Health*, mirrored this shift towards early intervention, proposing a life-course approach focused on 'starting well, developing well, working well, living well and ageing well' (Department of Health, 2011b). The strategy also reinforced the importance of resilience in mental health and wellbeing.

A number of relevant Health Outcomes framework documents are currently under development setting out key targets for Public Health England (Department of Health, 2012a), the National Health Service (The Health and Social Care Information Centre, 2012) and children's outcomes (Department of Health, 2012c). These include some indicators relevant to parenting, including acting early and intervening at the right time, measures on school readiness and numbers of first-time entrants to the youth justice system.

Changes to the Ofsted framework for inspecting schools suggest a general shift in emphasis from strengthening health and wellbeing and 'care, guidance and support of pupils' (Ofsted, 2009) to a more narrow consideration of one in which pupil behaviour is assessed in terms of its impact on

achievement and the broader learning community (Ofsted, 2012a; Ofsted, 2012b). In other words, behaviour is not currently recognised in this framework as a developmental marker for poor outcomes in children.

Ofsted inspectorate frameworks covering children's services and safeguarding procedures have a very broad focus on quality and the safety of children but currently include minimal references to parenting programmes and no prompts for inspectors to consider quality in parenting programmes.

Current risks to the expansion of parenting provision

Although government policy is broadly supportive of improving access to evidence-based parenting programmes for those in greatest need, a considerable gap exists between the promise of early intervention and the implementation of this policy on the ground. Key risks to the effectiveness of current drives to expand provision include the following.

Funding complications and risks

Early intervention requires a 'spend now, save later' approach to commissioning, which can be difficult to achieve, particularly when public sector budgets are under immediate pressure. Investment in early intervention can also be problematic when the agencies that pay for these services do not directly benefit from the financial benefits associated with improved long-term outcomes, which may instead accrue to a wide range of other public sector bodies. New funding mechanisms may be needed to resolve these problems.

New commissioning architecture

We are also entering a period of extensive reform of health commissioning with the implementation of the Health and Social Care Act 2012 and with powers transferring from Primary Care Trusts to GP-led Clinical Commissioning Groups. In addition, each upper tier local authority will have a Health and Wellbeing Board (in shadow form at present but properly in place by April 2013). The purpose of this Board will be to influence commissioning through strengthening collaborative working between health and social care, to support greater community involvement in decision making as well as undertaking Joint Strategic Needs Assessments. The Act also places a statutory duty on government to act to reduce health inequalities. Although these changes offer opportunities for promoting and sustaining early intervention, it is currently difficult to assess what priority this will receive in the new commissioning architecture.

Implementation matters

Finally, identifying effective programmes is only a starting point when seeking to improve outcomes for vulnerable children. The benefits of proven interventions risk being undermined and sometimes even reversed without careful attention to how these programmes are implemented on a larger scale (Fixsen *et al*., 2005). The essential ingredients of effective implementation have become an area of scientific investigation attracting increasing international attention (Fixsen *et al*., 2005; Durlak & DuPre, 2008; Cross & West, 2011; McArthur *et al*., 2011).

Delivering evidence-based programmes as intended improves the chances of replicating the results achieved under research conditions. This entails well-specified interventions (often set out in manuals), with a clear target group, a transparent theory of change, delivered by a skilled, well-trained and supervised workforce. In the case of family-based programmes, sustained efforts are needed to maintain high rates of take-up and low rates of drop-out among eligible parents.

Cutting corners on implementation is a false economy. Improvements in outcomes from well-implemented programmes can be two to three times as large as those from poorly implemented ones. In extreme cases, poor implementation can actually make children's behaviour worse rather than better (Scott, Carby & Rendu, 2008).

Key findings

- Severe childhood behavioural problems are strongly predictive of poor long-term outcomes across a wide range of domains.
- 5 per cent of children experience problems sufficiently serious to merit a clinical diagnosis of conduct disorder, but a much larger number have less severe problems and are also at risk.
- Recent policy developments broadly promote the expansion of early intervention, but the significance of early childhood behavioural problems is often overlooked.
- A number of family-based programmes have been demonstrated to improve behaviour, with enduring benefits.
- Without careful attention to how programmes are implemented, vital opportunities to improve children's outcomes may be squandered and money wasted.



3 Scale of provision and targeting

We know that the majority of parents of children with severe behavioural problems seek help. We also know that even those at the extreme end of the behavioural spectrum seldom get the timely help they need. This chapter explores how services target the families who need them most and considers what findings tell us about how far available provision may be meeting current levels of need.

Summary of literature

Prevention programmes can be divided into two broad categories:

a) Universal programmes, which are designed for everyone in a local population.
b) Targeted programmes, which come in two types:
   - selective programmes that target candidates on the basis of risk factors such as maternal mental illness or punitive parenting practices in the case of childhood behavioural problems;
   - indicative programmes that target candidates based on the early signs or symptoms of a problem such as persisting childhood physical aggression.

Universal parenting programmes (those accessed by whole populations) generally have less proven effectiveness (Moran, Ghate & van der Merwe, 2004). Furthermore, offering programmes to all parents has been shown to prevent at-risk groups from participating in beneficial services (Belsky *et al.*, 2006; Eisenstadt, 2011).

Evidence-based programmes have clear target groups; it is important to match programmes and the target population carefully because:

- programmes have proven effectiveness with particular target groups (Olds *et al.*, 1997)
- children with the highest risks benefit most from intervention (Olds *et al.*, 1997; Hutchings, Bywater & Daley, 2007a; Reid, Webster-Stratton & Baydar, 2010)
- programmes focused on children with the most severe problems have the highest returns (National Collaborating Centre for Mental Health, 2010)
- poor targeting can be wasteful (Karoly *et al.*, 1998).

Effective targeting of evidence-based programmes for children with severe behavioural problems is critical. Without it, the most vulnerable children risk missing vital opportunities to improve their outcomes (Social Research Unit, 2011a):

- Seven out of ten parents of children with severe behavioural needs seek help or advice from professionals (Green *et al.*, 2005).
- Only around two out of ten parents get the help they need if parenting programmes are offered universally (Spoth *et al.*, 2007; Prinz *et al.*, 2009).

- Recruitment rates increase when programmes are specifically targeted towards those with higher needs (Redmond, Spoth & Trudeau, 2002; Haggerty *et al*., 2006).
- In 2010, less than 10% of family-based programmes in local communities had a proven track record for enhancing outcomes for children with early behavioural problems (Scott, 2010).

There should be a continuum of evidence-based services, with the more intensive and specialist services reserved for those with the highest levels of need (Statham & Smith, 2010). This approach is also known as progressive universalism, defined as providing 'support for all, with more support for those who need it' (HM Treasury, 2010).

Does provision match need?

Historically, few parents of children with early behavioural problems have received the help they needed despite most seeking help and advice from services (Green *et al*., 2005). Our national survey aimed to build a picture of the extent to which estimated need is currently being matched and met by national provision.

We sought estimates of the numbers of parents annually completing evidence-based parenting programmes in local areas from local parenting leads. In practice, it was not always easy to identify parenting leads who held data for all programmes delivered in the locality (e.g. delivery could be by Child and Adolescent Mental Health Services (CAMHS), local authority teams, schools or voluntary sector providers) and completion data were not always aggregated.

One hundred and sixty leads participated in the national survey, but only 63 respondents were able to provide some data on the number of parents completing these programmes in the last year. Responses suggested that on average around 300 families a year were fully completing programmes in each of these 63 local areas.

Responses varied considerably across a range from 20 parents per year at one extreme to 1,500 parents per year at the other. Some of this variation will, of course, be explained by discrepancies in who responded to the survey, their access to full locality data and differences in population size between areas, but it is nevertheless clear that the scale of provision of parenting programmes varies greatly around the country.

Table 1 analyses a subset of national survey responses in more detail to add some greater context to these findings. It compares the number of parents completing a parenting programme annually in five selected areas with the estimated number of children with behavioural problems in any one-year cohort between the ages of 3 and 11.

These figures suggest the scale and importance of variation between areas and also the apparently very low level of provision in some localities. For example, in area A, only 25 parents completed a programme in 2011 even though there are at least 150 children with severe behavioural problems in each one-year cohort in this area. In other words, current provision is sufficient to provide support for only about 1 in 6 of those with the greatest need and for only about 1 in 25 if need is defined more broadly to include those with moderate as well as severe problems. Provision relative to need is higher in areas B and C but still only sufficient to address the needs of about half of those with the most severe problems.

Table 1: Analysis of survey responses on the provision of parenting programmes relative to need

	Area A	Area B	Area C	Area D	Area E
Estimated number of children in each one-year age cohort with severe behavioural problems (5% of all children)	153	62	81	95	804
Estimated number of children in each one-year age cohort with severe or moderate behavioural problems (20% of all children)	610	247	324	379	3,160
Estimate of number of parents completing programmes in 2011	25	30	50	300	1,200

At the other end of the scale, 300 parents in Area D completed a parenting programme in 2011, compared with an estimated 95 children in the severe needs category and 379 children in the severe + moderate needs group. It cannot, of course, be assumed that all those in the severe needs category actually benefited from a parenting programme, but equally it is clear that if provision is well targeted, it is more than sufficient to support all those in this group. Similar conclusions could be drawn for Area E.

More than half of survey respondents told us that 'need outstrips the offer' in their local area for children with severe behavioural problems. One respondent also highlighted that local commissioners and providers experienced some difficulties gauging 'the real need' in local communities.

Targeting and meeting need

Lessons from Sure Start implementation and from Birmingham City Council's strategic attempts to improve outcomes for children with early behavioural problems indicate that children's centres and parenting programmes can be well attended and popular; but places are taken up predominantly by those with lower-level needs, at the expense of those with higher-level needs and risk factors (Social Research Unit, 2011a; Social Research Unit, 2011b). In some instances, unintended exclusion from these services has coincided with a deterioration in the prospects of some of the most disadvantaged families in local communities when compared with control groups (Belsky *et al*., 2006).

Well-targeted and well-implemented programmes have the greatest chance of achieving change for children, parents, communities and for the public purse (Olds *et al*., 1997; Asmussen, 2011; Centre for Excellence and Outcomes in Children and Young People's Services, 2011). Particularly, evidence-based programmes generally demonstrate the greatest positive effects for those with higher risk factors or with more severe behavioural problems (Olds *et al*., 1997; Hutchings *et al*., 2007b; Reid, Webster-Stratton & Baydar, 2010). These programmes also have proven to be more cost-effective for those with a higher severity of needs (Hutchings *et al*., 2007b; Reid, Webster-Stratton & Baydar, 2010).

Effective targeting strategies and clear eligibility criteria are therefore critical to maximising the impact of programmes.

Approaches to targeting

A range of targeting practices was observed during our study. Whilst Family Nurse Partnership programmes were highly targeted, there was less consistency in targeting methods for parenting programmes with approaches varying from area to area and sometimes within case study localities.

Family Nurse Partnerships and targeting

Family Nurse Partnerships adopted a highly targeted and systematic approach towards recruitment for this resource-intensive programme. The criteria for accessing this intervention have been well established through research and were clearly set out as part of the programme, internalised by front-line workers and monitored by local and national programme managers as part of supervision.

Identification criteria were also well publicised to referrers.

> *"We have fidelity targets to meet so they have to be a certain age; it has to be their first pregnancy barring a miscarriage or stillbirth. They've got to be in a certain area. The commissioner said they had to have a [local] GP. So [referrers] have certain criteria that they are aware of."*
>
> Manager, Family Nurse Partnership

Programme staff demonstrated good understanding that careful selection of the right parents maximised their chances of replicating positive results and outcomes and also achieving longer-term costs savings.

Parenting programmes and targeting

Highly targeted parenting programmes

In two local areas, families were identified and matched with programmes through a gate-keeping process. Practitioners used programme selection tools to identify at-risk children and signs of risky parenting practices linked to childhood behavioural problems, or they used a bespoke tool (developed and implemented with multi-agency partners and based on local data) looking for a range of indicators associated with childhood and family vulnerability in their local area.

Parents identified as needing help in these areas were then referred to the parenting team and followed up with a home visit and in-depth assessment of parenting needs. In one local area, families needed to meet three criteria from a 'basket' of thirteen risk factors to access courses.

> *"Once we get the referral it doesn't necessarily mean that the parent will be able to access the programme because then obviously we have to do the assessments to see if the parents are suitable and talk to the parent to see if it's actually what they want. We'll do specific questionnaires to see exactly what that parent might need or might require support with."*
>
> Manager, parenting team

Those not eligible for this level of support received lower-intensity support (either brief interventions or sometimes lower-intensity brief workshops) delivered through a range of partners including:

- health visitors
- parent/family support practitioners working either in schools or attached to local children's centres (some delivered by the voluntary sector)
- other children's centre staff.

Those with complex and multiple needs in both localities were targeted through the Family Intervention Project or recovery team. These were established originally to work intensively with families involved in local anti-social behaviour and now also focused on the Government's agenda to improve outcomes for the most troubled families in local communities (Department for Education, 2010). Both family intervention teams in these local areas were using Triple P programmes as part of their toolkit of interventions. Both areas described trying to link together a range of multi-sector services to provide the right intensity of approach to meet different parents' levels of need.

Mixed targeting

Two other local areas expressed a strong commitment to making available evidence-based parenting programmes to all parents in local schools, not just those presenting with the greatest need (explained in greater detail in Box 2).

In both localities, universal access to parenting provision was seen as intrinsic to an overarching strategy to normalise parenting and improve the overall health and wellbeing of all local families. Offering the programme to all families was also identified as a means of reducing the stigma associated in some literature with targeted parenting programmes (Offord, 2000). One of these areas was also aiming to implement all five levels of Triple P across the entirety of the local population as a preventative measure to bring down excessive numbers of at-risk children entering the care system. This aim mirrored activity in South Carolina in the USA where population-wide implementation of Triple P led to reduced numbers of child protection registrations and placements in care in comparison with control sites (Prinz *et al*., 2009). All-level and whole-population implementation of Triple P has also been piloted in Glasgow; although the new Scottish mental health policy supports targeting of parenting programmes towards children identified with early conduct problems (Scottish Government, 2012).

In practice, both our local areas combined an 'open offer' of evidence-based programmes to all parents, with 'behind the scenes' targeting to ensure that parents of children with behavioural problems or high-risk factors were also engaged and supported onto the course. Both areas also ran some groups specifically for very high-risk parents.

On some occasions, parents talked of being confused about eligibility criteria for programmes where universal and targeted approaches were combined.

> *"There was a bit of confusion about whether you had to be referred by your health visitor or [if] you can just go on it."*
>
> Mother, programme attender

The targeting dilemma

Ensuring programmes are offered to those that will benefit the most can produce better outcomes.

In summary, targeting for Family Nurse Partnerships, a relatively high-cost intervention, was consistent and clear with criteria monitored and overtly advertised to other agencies. However, targeting methods for less expensive evidence-based parenting programmes were less consistent. On the one hand, some parenting leads expressed a strong commitment to ensuring programmes were well-targeted with tight systems in place to support selection and to prevent predominant access by the 'interested well'; in contrast, others held strong beliefs about the need to de-stigmatise access to

Box 2: Approaches to mixed targeting in two areas

In one local authority area, some Strengthening Families, Strengthening Communities parenting programmes were offered to all parents in schools; however, the school (in partnership with parenting support workers) also remained vigilant for indicators of need in children and parents. When needs were identified, the parenting support worker engaged with parents using outreach methods.

> *"We work closely with the schools and attendance welfare, and we've got a student social worker, so all the time we're talking to parents. But my main job is to go out and I'll sort of do that in a way that's not obvious: teachers will talk to me, head teachers will talk to me and the attendance welfare [will say] 'this family would be good if you can get them engaged'.*
>
> Parenting Support Worker, based in schools

Some targeted Strengthening Families, Strengthening Communities groups were also run in this area, including for families with multiple and complex needs.

> *"We will do outreach work. We will home visit ... make sure that they attend, make sure that they benefit, make sure that we target their needs. With the targeted [approach] you negotiate with them, you tell them why they need to attend."*
>
> Parenting Support Worker, based in schools

In this area, parenting programmes were also commissioned by a local Arms Length Housing Management Organisation and included both universal and targeted provision on local estates. Targeted groups were organised for parents whose tenancy was in jeopardy or with risk factors observed by housing officers during routine visits. Open access groups were organised in communities where housing organisations wished to strengthen community cohesion. Training was provided by Family Intervention Project workers to help housing officers identify significant and relevant risk factors. Specialist programmes were also available for the local Bengali community.

In another area, children's centre work was targeted towards higher-risk families identified by health visitors and early years staff.

School-based level four Triple P parenting programmes were promoted as 'open to all'. However, in the background, higher-risk families and children were also targeted via school link workers. Another parenting programme, *Families and Schools Together* (McDonald *et al*., 1997), was also commissioned as a universal programme in some schools. The parenting team in this area delivered Triple P level five (designed and evaluated as effective for those with the highest needs) to families with the most complex needs including with parents of children on Child Protection Registers.

parenting programmes through all parents having equal access to these programmes, albeit with some behind-the-scenes targeting.

Targeting decisions were further complicated by other factors; for example, some funders had slightly broader aims than the reduction of childhood behavioural problems (such as community or school cohesion, or promoting family wellbeing). Some also wished to retain some measure of universal provision in communities which had experienced radical cuts in universal resources for parents. Universal provision was also said to be preferred by schools wanting to provide programmes accessible to all children in their learning community.

In Birmingham, the Brighter Futures initiative sought to resolve this targeting dilemma by selecting a suite of evidence-based programmes which aimed to match need with appropriate intensity and cost of intervention. As part of this selection process, commissioners chose a combination of proven universal and targeted programmes, including:

- Promoting Alternative Thinking Strategies (PATHS) – a universal school-based social and emotional learning programme with a strong evidence base for improving children's behaviour. (School-based programmes are outside the remit of our study.)
- The Incredible Years programme and Teen Triple P programmes were targeted at families of children with early childhood behavioural problems, with recruitment facilitated through use of the Strengths and Difficulties Questionnaire, a validated instrument for measuring behavioural problems and other dimensions of mental health among children and young people which compares individual scores to national norms (Goodman, 1997).
- Family Nurse Partnerships.

Birmingham's portfolio of programmes is in the process of being evaluated by the Social Research Unit for its impact on children's prospects and its cost-effectiveness.

Key findings

There is currently significant variation around the country in the availability of parenting programmes. Provision in some areas appears insufficient to meet the needs even of those children with the most severe problems.

Evidence-based parenting interventions have proven results with clearly defined populations. Programmes should, therefore, be carefully targeted in order to generate the best outcomes for children and to ensure maximum impact and efficiency.

We found a range of targeting methods being used during this study:

- some areas actively sought out only high-risk groups, while
- other areas promoted more open-access programmes, with some behind-the-scenes targeting of higher risk children and families.

This means that high programme uptake does not necessarily imply that parents attending groups are those whose children will gain the greatest benefit from these interventions.



4 Identifying need and seeking help

Improving access to evidence-based parenting programmes relies on a subtle and complex chain of events, some of which take place out of view within the context of 'the right to family privacy'. First and foremost, parents have to recognise or agree that their child's behaviour is significant or causes concern in some way. Parents may face dilemmas about whom to share concerns with; and they may equally be reliant on a number of professionals routinely in contact with them (or whom they approach for help) to register the significance of what they see and hear and to identify appropriate action.

This chapter discusses how parents of children with severe behavioural problems identify themselves or get identified for parenting programmes and explores the barriers that some parents meet.

Summary of literature

Research suggests that the help-seeking process involves distinct stages of activity including:

- parental recognition of the problem behaviour
- the subsequent decision to consult a professional
- recognition of the child's problem by professionals (Verhulst & Van der Ende, 1997; Zwaanswijk *et al*., 2003).

Parental help-seeking behaviour has been linked to a number of factors, including the amount of distress or burden parents experience in raising their child as opposed to severity of child behaviour (Zwaanswijk *et al*., 2003).

Three categories of parent have been identified in children's centres with different patterns of behaviour when seeking help (Garbers *et al*., 2006):

- autonomous users who take up services independently
- facilitated users who may need more encouragement to take up services
- conditional users who will need more support to take up services.

Parents seeking help

The majority of parents of children with severe behavioural problems proactively seek help and advice to address their concerns; however, few go on to access effective support (Casey, 2012).

Understanding parents' motivations and the barriers they face when seeking help is a critical starting point when seeking to improve identification and referral experiences.

Facilitators and barriers to seeking help

Research has indicated that parents are more likely to seek help because of the distress that they experience as a result of their child's behavioural problems (Zwaanswijk *et al*., 2003), rather than based on the severity of their children's behaviour per se. In our local area interviews, parents described similar drivers motivating them to seek help, including feeling overwhelmed, frustrated or embarrassed by their child's behaviour.

> *"It's embarrassing for me when we go out and he's kicking off and everybody's looking and saying, oh just smack him."*
>
> Mother, programme attender

> *"I thought, wow, I'm having a hard time with the behaviour; I really need to do something about it. My role models for parenting weren't the greatest and I didn't want to do the same thing. I just needed a few more tricks really. I just couldn't get through. So I just wanted to do something about it and be a good parent, well that was my motivation."*
>
> Mother, programme attender

They also described how their children's problems directly affected parental and family wellbeing.

> *"[I hoped] it could make things better and stop all the arguments and the fighting; it was tearing us apart. I remember thinking to myself that I'd rather be in Afghanistan than be here right now. It was just horrible."*
>
> Mother, programme attender

> *"[We wanted] to find a way to establish some level of calmness and peace for quite clearly a disturbed little girl or confused or frightened little girl. I think it knocked us both for six because we didn't know how to deal with it … our other child was so different. She's very forceful and we'd lost some power, some control."*
>
> Father, programme attender

For many, however, embarrassment, stigma and feelings of personal failure could also prevent or delay identification.

> *"There's a stigma isn't there about going to a parenting group. 'Why are you going to a parenting group?' It's as if I've got a problem. There's quite a lot of negative stuff about it, not necessarily from parents, but from other people."*
>
> Mother, programme attender

> *"I do think a lot of people will have the same sort of thing at home but they just don't let on. Because they probably feel there is a stigma attached."*
>
> Mother, programme attender

Some parents talked of having to be quite persistent in their attempts to improve parenting, particularly in the face of judgemental attitudes from their wider family, employers and peer groups. Some also talked of the importance of professionals' approaches in making them feel more able to discuss their fears openly. Stigma and feelings of blame generally acted as a barrier to seeking help.

Some parents had been motivated to seek help by a specific crisis such as their child being placed on the Child Protection Register, risk of losing their tenancy or the police being called.

> *I began to see what was happening and I felt it's my fault that [my son's] like this and he was put on the Child Protection Register and when [my daughter] was born, she was put straight on it and that really woke me up that I could lose her as well... It's really scary.*
>
> Mother, programme attender

Word-of-mouth recommendation was identified by some as an important driver for awareness in parents who were unsure about taking action.

> *Having spoken to friends or people who are close to me who had noticed I was a bit hacked off or a bit down about things – the [number] of people who have been interested since they've seen things have begun to improve. They've asked how [my daughter] is doing and I'm like 'so much better, so much better'. A few people have actually asked for more information and said 'I reckon I could do with that. I don't talk about it, but one of my kids is being a bit of a nightmare'.*
>
> Father, programme attender

Underestimation of poor child behaviour as a marker for support

A common challenge faced by both parents and professionals was recognising poor child behaviour as something other than general 'naughtiness'. One parent, whose son had very extreme, violent and distressing behavioural problems from an early age, talked of her struggle to understand the full extent of her son's vulnerability.

> *At first I actually thought he was just a generally naughty boy. So, to other people it's going to look like he's a naughty boy. But learning not just what he's got [but] what other kids have got [helps]. Then when I'm out and I see a kid playing up, I'll know there's something wrong with that kid, instead of me saying 'he wants to stop that, he wants to get a smack'.*
>
> Mother, programme attender

Parents who had not considered attending groups doubted that severe child behavioural problems would benefit from parenting programmes unless that behaviour had specific health or developmental dimensions.

> *[If] it's like that ADHD thing ... something like that, yeah, I'd go for advice and stuff. If my child needed it [I'd go], but not for me no. I wouldn't go [to] have someone tell me [what to do].*
>
> Mother, programme non-attender

> *I wouldn't [attend a parenting programme] now; if she's just been naughty, I'd just control that myself. But if it were like physical then yeah.*
>
> Mother, programme non-attender

Professional understanding and recognition of behavioural problems

Teachers and other professionals in routine contact with children sometimes shared parents' confusion about both the longer-term developmental risks associated with severe childhood behavioural problems and the opportunities to intervene early to prevent the escalation of future mental health, developmental, educational or social problems in children. In one area, specialist mental health workers also struggled with the mental health dimensions of severe childhood behavioural problems and, despite the potential impairment faced by these children, identified behaviour as a criterion for exclusion from specialist mental health services.

> *We're a mental health service. And if what you're left with is behavioural, then we would tend not to accept that. We would look at what other alternative services would be better.*

Manager, CAMHS

Most evidence-based interventions for affected children in local areas were not delivered by specialist mental health services, to avoid the risk of labelling and stigma at an early age. However, a small proportion of children with the most severe needs may require more thorough specialist professional involvement to recognise severe behaviour problems early, provide therapeutic treatment and offer ongoing support (Oxford *et al*., 2003; Rowe *et al*., 2010). These families may also need ongoing monitoring and systems to help them re-access timely support should problems deteriorate later on.

For example, one parent noted very extreme and qualitatively 'different' behaviour in one of her children from the age of two years; she also described high family risk factors for mental illness in her extended family. She waited for many years to access help in spite of numerous visits by non-specialist health and social care professionals.

> *It was coming to the stage that he was telling me he was going to kill me. I said, 'No you're not because I'm your Mum'. He went, 'No, I'm going to kill you'. Then it stops for a bit and then he'll come back with a vengeance. The last time he was telling me he was going to kill me, he even said, 'I'm going to make it look like an accident'. He controls me. It's him that controls me and I can't get him out of it.*

Mother of child age six, programme attender

She was originally denied access to parenting support until a clearer diagnosis crystallised and was struggling in the meantime to manage her son's very challenging behaviour without support.

> *I wouldn't mind going on some of these courses, but [they] said because [he] hasn't actually got the diagnosis yet, it's a waste of time me going until I know exactly what it is. But it wouldn't bother me if I did waste [time]; it's all there to be learnt.*

Mother, programme attender

Eventually, she was helped to access a parenting programme by the school family support worker and then finally accessed additional educational specialist help to assess underpinning problems.

This contrasted with another parent's experience where specialist input had been mobilised swiftly for a pre-school child with similar clear (but as yet undiagnosed) early developmental difficulties. While specialist services were working on an accurate diagnosis, this parent accessed two parenting programmes supporting her management of her son's behaviour and complementing specialist intervention and assessment.

Systems for dealing with different severity of risk and need

Parents' experiences of seeking help highlighted some variation across sites, particularly in terms of the degree of collaboration between parenting teams, specialist CAMHS teams and sometimes special educational needs teams. Both parents and professionals also talked of occasional duplication, 'bounced-back' referrals, lack of clarity about who provided what and frustrations as they tried to get the help they needed.

Some parenting leads recognised the ongoing challenge of developing a clear continuum of care, spanning universal services, parenting teams, school educational support teams, Improving Access to Psychological Therapies teams and CAMHS services, linking children with a range of cross-sector services addressing a different range of behavioural needs. Research suggests that a small number of children, particularly those with more severe or co-morbid problems (e.g. Attention Deficit Hyperactivity Disorder (ADHD) or Callous and Unemotional Traits) may require input from a range of services to address more severe needs (see Box 3) (National Institute for Health and Clinical Excellence, 2008). A small number of parents with multiple or complex needs (e.g. those with personality disorders) may also need ongoing support to promote their children's future outcomes (Reyno & McGrath, 2006).

Box 3: Conduct Disorder, Callous and Unemotional Traits

Certain sub groups of children with the most severe, aggressive and persistent difficulties are identified with Callous and Unemotional Traits; these children face some of the worst outcomes. The literature suggests that they may benefit from being seen as qualitatively different from other children with severe early behavioural problems (Vasey *et al*., 2005), requiring holistic assessment and ongoing intervention, complementing and supplementing that provided through evidence-based parenting interventions (Frick & White, 2008) even before psychiatric diagnosis or developmental difficulties can be crystallised. Reinforcement of positive parenting techniques (Kochanska & Murray, 2000), promoting developmental progress and developing empathy in these children are all identified as particularly important as part of the package of holistic care (Frick & White, 2008).

Some areas were anticipating receiving additional funding for cross-sector training for evidence-based parenting interventions through the Improving Access to Psychological Therapies (IAPT) programme (NHS, 2012). If well implemented across sectors, this initiative could provide the opportunity to integrate health, social care and voluntary sector parenting provision. It could form part of a clearer model of stepped care for childhood behavioural needs, matching intensity of provision with severity of need, thereby supporting greater clarity in local areas about who provides what for whom, at what stage and in collaboration with which partners. To be effective, any model of care would also need inbuilt systems to monitor ongoing progress. Some children, for example, may sustain improvements temporarily or even for some considerable time but may then experience later deterioration in their progress and circumstances prompting a need for further swift support.

Different categories of parent

In common with Garbers (2006), we have identified three main categories of parent based on an analysis of their 'journeys' to parenting programmes and level of support needed to access services.

Volunteer parent

The 'volunteer' parent had some level of awareness of their children's behavioural problems or was very open to suggestion during routine conversations. Most were unaware of the link between

parenting techniques and children's behavioural responses, but they acknowledged a certain amount of distress associated with raising their child and were genuinely keen to get help.

> *"I said, yeah, well I'm finding my son challenging at two, and they said, have you done the Triple P? And I said, well I'm about to have another baby, I'm concerned, oh my gosh, I want to do this, and so I was sent some information from Triple P in the mail, I thought that was interesting. But then I did have to actively follow up, I want to do it, I want to do it, I want to do it."*
>
> Mother, programme attender

> *"Social services got involved with me and my partner because my partner had a drinking problem and my middle [child] was very hard to handle. I asked my social worker for help and she put me on the Triple P."*
>
> Mother, programme attender

> *"It was actually somebody from the Child Development Centre and I said I wouldn't mind doing a parenting class."*
>
> Mother, programme attender

These parents seemed to require minimal input from those they approached for help. Their search for help was facilitated through:

- Brief, clear, culturally sensitive, engaging and non-stigmatising information for parents (e.g. 'each child is different and there are some really effective parenting support groups where you can pick up tips and techniques proven to help').
- Speedy referral and proactive follow up from parenting teams to confirm interest and clarify next steps.
- Subsequent pre-course preparatory work as detailed in programme manuals (e.g. pre-course telephone or other contact or home visits).
- Having a clear point of contact to troubleshoot any emerging barriers that might affect engagement; a small number of parents talked of experiencing problems with access even after expressing a strong initial commitment to attend programmes.

Sceptical parent

The 'sceptical' parent does not always see their child's behaviour as problematic. Even if they do, they can be wary or offended by suggested links between parenting styles and the management of problematic child behaviour. A few parents were also highly anxious of group experiences.

Parents who were ambivalent about or unaware of the need for support often described the critical preparatory role played by persistent and proactive 'promoters'. These were often workers in routine contact with these families. Our research findings pointed to a range of partners completing this important preparatory work with parents, including health visitors, children's centre staff, teaching staff, social workers, domestic violence professionals and parent support workers in schools.

> *"I felt pushed. I didn't even really want to come. In the end, I came to shut the bird up. But once I came here I really enjoyed it, seeing the girls every week … having a coffee and having a talk, and you do learn. Because I thought I was the perfect parent, but I'm not. I thought I knew it all. When the attendance officer said 'you might pick up tips', [I said,] 'But I've already got a teenager and he turned out alright'. Now coming here you see there are different ways to go about things."*
>
> Mother, programme attender

> *I had a social worker because my daughter was on a child protection plan because of things that had happened and I did say at the beginning that I didn't think it was my kind of thing but I would always give it a try.*

Mother, programme attender

Sometimes, professionals in time-critical contact with parents relied on access to other practitioners who could complete this preparatory work. For example, GPs would sometimes refer to health visitors, school nurses, or school support workers (e.g. parenting or educational workers).

In one area, a school link worker working with Bengali parents confirmed the importance of proactive outreach work with under-served BME populations, particularly those identified in the school as potentially more suspicious or affronted by offers of parenting support. This worker felt that such additional motivational work to support identification was required in about 10% of his recruits for each group. Indeed, research shows that with under-served populations, such as Black and Minority Ethnic (BME) parents, relationships with staff can be a key factor in successful engagement, with 90% of parents citing the personality and trustworthiness of their recruiter as a key factor (Gross *et al*., 2001). Another study found that practitioners who were from trusted social networks (e.g. church or school) were able to enhance recruitment, possibly because they were seen as offering credibility and a personal connection between the programme and the cultural community (Harachi *et al*., 1997).

Overwhelmed or 'historically disengaged' parent

A few parents faced multiple challenges, including mental and physical health problems, substance misuse, debt and entrenched deprivation, and could easily feel overwhelmed by parental responsibilities. These multiple problems presented significant barriers both to their attendance at parenting programmes and to their ability to reflect on their parenting.

> *For me, generally, if I'm not feeling confident I won't go out. I'm a nervous person generally. I have to be forced to go. Like my benefits being taken away if I don't go to the job centre. I tried CBT [for anxiety] but I had to get to a place and stopped. Anything like that causes anxiety. You need to fix yourself by going, but it was making me ill. I'd rather not go than disappoint the therapist.*

Mother, programme non-attender

> *If people are still using drugs or alcohol, there is an element of chaos in their life, and it does make turning up for appointments really difficult. We taxi them to [our substance misuse service] and we still find that there's always an excuse. Oh, I had to do this, or I had to do that, or I forgot I had an appointment.*

Practitioner working with substance misusing parents

Other parents, with patterns of historical and entrenched disengagement, were described as being highly suspicious of offers of help and were consequently reluctant to engage with services. Some disengaged families were described by interviewees as having particular mental health problems such as personality disorders or 'unresolved attachment issues', while others had previous long-term negative experiences with services or with authority. The most disadvantaged of these families, who are described as having 'entrenched systemic multi-generational viewpoints' and low aspiration, are likely to meet the criteria for the Government's Troubled Families policy; indeed many areas during this study were in the process of analysing caseloads to inform government and local practice supporting the development of improved care pathways for these families.

Some historically disengaged or overwhelmed families needed one-to-one support to unpick their own experiences of being parented and help with a range of systemic challenges in their day-to-day life as well as support with positive parenting techniques. Some practitioners interviewed during this study and voluntary organisations such as UK Chance, Family Action and the National Society for the Prevention of Cruelty to Children (NSPCC), for example, used an intensive mentoring system to facilitate engagement, helping parents move forward from their own damaging parenting experiences and support positive attachment with their children.

However, making blanket assumptions about the inability of families with complex needs to engage with group programmes was seen as unhelpful by those experienced in working with these parents. Practitioners felt that 'you get surprises', with some of these parents benefiting from 'being alongside other parents and getting some mutual support'. However, practitioners also cautioned against seeing programmes 'as a little bit of a cure all'.

In conclusion, parents' comments suggested that they were often at different stages in recognising the significance of children's problematic behaviour and in accepting the impact positive parenting techniques might have on their children's behaviour and future health and wellbeing. Stigma was a common theme with some 'sceptical' or 'overwhelmed' parents, describing feeling offended or patronised at the offer of a parenting skills programme.

Parental scepticism and reluctance was overcome, however, by skilled practitioners and referrers building effective relationships. Families facing multiple challenges were often described as requiring more intensive support involving persistent and flexible working. In common with Family Nurse Partnerships, practitioners claiming some success in engaging these parents described the importance of establishing long-term relationships, helping parents with their own 'faulty parenting and family templates', carefully assessing feasibility of group work attendance, 'preparing' parents for change and empowering movement forward. This is echoed by recommendations in the literature, which suggest that positive, supportive relationships facilitate under-served families' access to services (Ingoldsby, 2010; Asmussen, 2011; Lindsay *et al*., 2011).

In some cases, a contingency plan to deliver one-to-one evidence-based parenting programmes was in place as part of broader wrap-around work. Although more expensive to deliver, the multiple risk factors and costs accumulated by these families and children in the longer term are likely to justify this investment by commissioners in one-to-one work for a small number of these families. National Institute for Health and Clinical Excellence (NICE) guidance for parenting interventions recommends an 80:20 split between group and individual evidence-based parenting programmes in local communities (National Institute for Health and Clinical Excellence, 2006). In some areas, Family Intervention or Family Recovery Teams were delivering Triple P parenting programmes as both group and one-to-one interventions.

Key findings

- Many parents do not spontaneously see behaviour as something amenable to intervention. When parents do seek help, they generally approach professionals who may not be aware of the implications of early severe behavioural problems or may lack clarity about how to refer parents on to effective help.
- Initial discussions between services and parents about children's behavioural patterns provide critical opportunities to identify parents who may benefit from programmes.

- Some parents will be more accepting of an offer of support than others; those living the most challenging lives will require a greater intensity of initial support to motivate them to attend programmes.
- A very small number of high-risk children and high-need families may need more intensive and longer-term multi-agency support to reinforce positive parenting techniques.



5 Referral

Once childhood behavioural difficulties have been identified, effective, prompt, supportive and well-informed referral is essential to strengthen parents' motivation and to ensure prompt receipt of evidence-based programmes.

Summary of literature

Around three-quarters of parents of children with severe behavioural problems approach professionals with their concerns:

- most seek advice from teachers, general practitioners or practice nurses (Green *et al*., 2005; Lindsay *et al*., 2008)
- GP surveys reveal general under-awareness of the significance of childhood behavioural problems and of the range of parenting interventions available (Family Lives, 2012)
- schools and GPs refer into parenting programmes with varying degrees of success (Klasen & Goodman, 2000; Family Lives, 2012)
- some schools do not regard parenting support as their responsibility (Social Research Unit, 2011b; Walker & Donaldson, 2011).

The earliest meeting with the referral source determines parent attendance; the way referrers first present programmes can promote engagement before a parent arrives at a first session (Staudt, 2003; Vitaro & Tremblay, 2008; Whitakker & Cowley, 2010).

Key transition points are identified as important motivational opportunities in terms of parents' willingness to consider parenting support. These include:

- the birth of a child
- pre-school
- transition to high school (Vitaro & Tremblay, 2008).

Personalised recruitment seems more effective than a generic and impersonal approach (Schlernitzauer *et al*., 1998); encouraging trusting relationships particularly with under-served families can promote engagement (Utting, 2009; Ben-Galim, 2011).

Referral experience

The majority of parents taking part in our study talked of valuing timely linkage with the next available scheduled parenting programme. A minority experienced delays, with two parents in two different sites describing waiting periods of between four and five years to receive help for their children's behavioural issues. Delays occurred despite seeking advice and support from a variety of professionals, including social services, doctors, CAMHS, schools and health visitors.

> *"We spent four years asking for help from social services and no-one would help us and the only person who would work with us was the school. It took one night for my ex-partner to get drunk and come back and cause an argument to get me the help I asked for four years ago. Maybe if we'd had help, maybe it wouldn't have reached that point, maybe we wouldn't have reached that crisis."*
>
> Mother, programme attender

Referral routes

In our study, a broad range of stakeholders were referring into parenting programmes and Family Nurse Partnerships, including:

- social workers
- health visitors
- early years workers
- educational staff
- school nurses
- CAMHS
- adult-focused services (including mental health, substance abuse, housing)
- criminal justice
- services involved in addressing violence in the home
- midwives.

However, our national survey suggested that the number and appropriateness of referrals varied from service to service. Most of the parenting leads we surveyed were happy with referrals from health visitors, early years workers and social workers; conversely, approximately half of respondents were unhappy with referrals from adult services (e.g. substance misuse and adult mental health) and GPs.

Interviews with professionals in our four case study sites highlighted:

- inconsistencies in referral sources between sites and sometimes within individual areas
- mixed awareness of the significance of behavioural problems in children
- mixed buy-in from professional groups to the identification and referral of affected children and parents.

We also know from research that the majority of parents of children with severe behavioural problems proactively seek help and advice to address their concerns. Around three-quarters of parents of children with severe behavioural problems approach professionals with their concerns; most seek help from teachers (60%) with around a third also seeking advice from general practitioners or practice nurses (Green *et al*., 2005; Lindsay *et al*., 2008). Yet, only a small proportion of parents whose children have these behavioural vulnerabilities find their way to parenting programmes after airing their concerns with professionals (Klasen & Goodman, 2000; Family Lives, 2012).

Although some inconsistency in referral patterns is to be expected, our findings suggest that some professions have vital opportunities to identify and support the right parents onto these programmes. Successful referral of the right parents is the first step in improving outcomes for the children with the poorest life chances.

Key opportunities for referral

Interviews with parents and practitioners identified two main opportunities to refer parents into effective programmes:

- routine contacts, i.e. services with routine contact with parents and children
- opportunistic or crisis-related contacts with parents.

Parents who wish to disclose concerns are generally drawn to certain favoured settings and professionals and these settings can be critical conduits for early identification and referral. Our findings also confirm the importance of effective partnership working and whole-system commitment to parenting; this acts as the foundation for successful identification and referral of parents and children most likely to benefit from evidence-based programmes.

Favoured routine contacts

Schools

Parents are most likely to share concerns or seek advice in schools. This provides staff with an important routine opportunity to help identify eligible parents (Lindsay *et al*., 2008). Effective identification relies on understanding of and buy-in from schools concerning the relationship between behaviour, school attainment and broader life chances. It also relies on whole-school commitment to making the most of opportunities for referral.

Just over half of respondents in the Centre's national survey were generally happy with the number and appropriateness of referrals from local schools. However, during visits to local areas, we found sizeable variability between schools in their awareness of and commitment to supporting early intervention for children and families with behavioural problems, a pattern also highlighted in previous research (Klasen & Goodman, 2000; Social Research Unit, 2011b; Walker & Donaldson, 2011). Some school staff did not see supporting behaviour as part of their core 'bread and butter' aims, despite the significant barrier posed by conduct problems to school attainment levels (Green *et al*., 2005). Recent changes to the Ofsted School Inspection Framework also discourage schools from considering the significance of behavioural problems for children's future longer-term outcomes, focusing instead on the impact of such problems on attainment and the broader school community (Ofsted, 2012a; Ofsted, 2012b). Previous studies suggest that schools do not generally see parenting programmes as an obvious response to behaviour problems (Social Research Unit, 2011a).

In local areas, parenting teams were working hard to collaborate with schools and referrals emerged via a number of routes including through:

- family support/link workers based in schools (sometimes supervised by parenting teams), either referring to parenting teams or delivering programmes directly

> *"There's parents that are vulnerable; parents that are in crisis, and you sort of identify them through children's behaviour, children being late for school, and just their family set-up. But there's a lot, there's not just one; it's a whole range [of signs]. When there's a parents' evening, there might be parents that open up to a teacher [who says] 'OK, we've got [a school link worker], I'll get her to contact you'. There [are] all these things going on."*
>
> Parent Support Worker, school

- school nurses
- staff referrals to parenting teams (including head teachers, welfare officers, attendance teams and special needs coordinators)

> *"The main teacher at my daughter's nursery mentioned that [the parenting lead] had contacted local schools in the area and [said] there were some spaces [available]. The way my little girl is, they thought it might be an ideal thing to see if we would benefit [from attending]."*
>
> Mother, programme attender

Many parents in a Bengali focus group particularly reinforced the important opportunity provided by school parents' evenings and advice from an authority figure (such as the head teacher) in encouraging parents to support children's behaviour and educational attainment through accessing parenting programmes.

Some schools in local sites made few if any referrals to programmes or were more laissez-faire. As one head teacher explained: 'I just leave it to [parents] to take up'.

General Practitioners

GPs were also a favoured first contact for parents, with one study suggesting that around a third of parents of children with the most severe behavioural problems approach GPs for advice (Green *et al*., 2005) and another suggesting that around half approach GPs for help (Family Lives, 2012).

Although doctors acknowledged that on average around ten parents a week presented with parenting problems in surgeries (Family Lives, 2012), the same survey also highlighted that just under two-thirds of GPs were unfamiliar with NICE guidance on parenting interventions (National Institute for Health and Clinical Excellence, 2006) and even fewer (around 7 per cent) were aware of local parenting provision. GPs either provided advice themselves directly to families or referred children to specialist CAMHS.

Another survey completed by the Royal College of General Practitioners indicated that over three-quarters of GPs were unconfident in their ability to secure appropriate and timely services through specialist CAMHS referral processes (Royal College of General Practitioners, 2011). Our findings echo these previous studies with the national survey noting that only 22% of parenting leads were happy with the number and appropriateness of GP referrals.

The GPs we interviewed acknowledged that referring parents into parenting programmes was 'not necessarily something we think of'. Those recognising the significance of behavioural problems in children tended to refer to specialist CAMHS instead of parenting programmes despite noting that CAMHS could be slow to react to referrals.

Overall, GPs felt that a general lack of knowledge of parenting programmes prevented effective referrals and that they would 'happily refer if we were more conscious of it'. As such, GPs were keen to have more information on parenting programmes and there was general agreement to the need for a clearer system for referrals.

> *"If you're not aware of guidelines for how to treat these conditions or where they should be treated, you're likely to refer inappropriately. It needs a kind of flow chart [showing] 'this is what you do in this instance; these are the outcomes based on NICE guidelines; this is where you should be referring'. I think that would help communication."*
>
> General Practitioner

One parent interviewee gave some insight into how these links can work when she described receiving help from a health visitor who 'came to our house because I went to my GP'. Links between parenting teams and GPs were also fostered in some areas through proactive promotion of parenting programmes at practice team meetings and by including GPs in systematic multi-agency meetings.

Other routine opportunities for referring parents

Health visitors and children's centres were identified by a number of parents as having been instrumental in helping them to access parenting programmes. These professionals often worked in partnership with locality parenting teams, sometimes co-delivering or leading parenting programmes. Many also had clear, well-established ways of referring into parenting programmes.

> *Quite often you go in to do the short intervention first and realise that they need a bit more, so you would then invite them onto the group. Sometimes it's just a specific behaviour that they're worried about, sleep is quite a common one and [also] things like tantrums. So you just deal with those specific things.*

Manager, health visitors

Both parents and practitioners mentioned the critical opportunity presented by developmental checks between ages two and three for parents to routinely share concerns about behaviour and other developmental worries. One worker described this multi-agency process of identification as follows:

> *The two-year review I do as well, in partnership with the health team. [There's] a check list: a guide to prompt families into identifying different areas and discussing development. And through that we can pick up any kind of delays or concerns around a child's health and development. Then we would discuss with the parents about behaviour management, how they do it, are there any issues, is it manageable?*

Early Years Educational Psychologist

In Wales, health visitors make routine use of the Strengths and Difficulties Questionnaire during early developmental checks (Goodman, 1997). Use of this tool goes hand in hand with a carefully considered and pre-planned script when discussing parenting issues and screening results. Benefits of parenting programmes are then sold to parents as an opportunity to pick up additional techniques when children are identified as 'more challenging to parent'. This routine screening reportedly supports greater openness about children's behaviour and a more systematic and proactive approach that links parents to parenting programmes early (Hutchings *et al.*, 2007a).

Some parents stressed the importance of raising awareness as early as possible in parents about the significance of early behaviour as a key marker for healthy development.

> *You need to put things in place at the beginning on how to manage behaviour.*

Mother, programme attender

A few parents felt that information about managing behaviour and accessing parenting support should be routinely provided at the pre- and post-natal stage to help parents to recognise early warning signs more easily, to identify when they might need extra help, and to help signpost parents to relevant services.

Crisis-led or opportunistic contacts with parents

Some parenting teams, multi-agency partners and parents described further opportunities for identifying children with behavioural difficulties, either emerging from crises or due to a chance contact with another service (e.g. adult mental health, substance misuse or housing).

Social workers

Some parents accessed programmes through their social workers as a result of child protection registration and other concerns.

> *"I've been having some problems with my son so I basically referred myself for the service through the social worker."*
>
> Mother, programme attender

Other parents talked of needing additional persuasion to attend but identified the quality of their relationship with their social worker as critical to their willingness to try the programme.

Some professionals working with families affected by domestic violence also referred into parenting programmes and in one area workers had been trained to deliver Triple P.

Housing

Housing officers in one area were using routine 'tenancy welcome' meetings to identify and consider parents' needs. One worker explained how, in his view, preventive work mobilising early support (including early parenting support) helped stabilise tenancies, support community cohesion, reduce anti-social behaviour and ultimately, in his view, reduce associated costs. Furthermore, in his local authority area, the Arms Length Housing Management Organisation (ALMO) commissioned evidence-based parenting programmes directly. Housing officers were trained by parenting teams to identify basic parenting needs and risk factors. They had clear referral routes to social care and parenting support through a single referral gateway.

Adult services (e.g. substance misuse, adult mental health)

Our national survey identified the need to strengthen referral links with professionals whose primary focus is working with adults. Interviews in local sites suggested that children's severe behavioural problems were at risk of being overlooked by professionals who saw adult needs as their prime focus. The literature suggests that added promotional work with specific key professionals working with adults may pay dividends in terms of referring eligible families and children. For example:

- parents with mental health issues are twice as likely to have children with severe conduct problems as other parents (Green *et al*., 2005)
- partner cruelty to the mother has been found to be a significant and robust predictor of early onset conduct problems (Barker & Maughan, 2009)
- children with a parent in prison are almost twice as likely as their peers to display conduct problem behaviour (e.g. persistent lying and deceit, as well as criminal behaviour) (Murray *et al*., 2009).

Research suggests that practitioners working in adult services including the criminal justice system and in prison visitor centres have important opportunities to pick up families that would benefit from parenting programmes and could support initial brief motivational work to develop parents' readiness

to engage with parenting programmes. Given the positive effect that these programmes have been shown to have on parental mental health (Barlow *et al*., 2009; Stewart Brown, 2010), linkage with adult mental health services may pay dividends for the whole family.

Other research has linked both parental mental illness and low income with poorer treatment outcomes from attendance of parent training programmes (Reyno & McGrath, 2006) suggesting that additional ongoing work may be required to promote positive outcomes for children in these circumstances.

Barriers and facilitators for referral

A range of barriers emerged that affected referral processes and the efficiency with which parents found their way to evidence-based parenting programmes. These included:

- complex referral pathways
- lack of agreement over effective referral tools
- lack of information and weak promotion of programmes to referrers
- lack of partnership buy-in to the parenting agenda, linked to perceptions of irrelevance of this work to other agencies' core outcomes.

Complex referral pathways

The referral systems we examined for parenting programmes were in some cases very complex with a range of agencies delivering programmes, a range of agencies referring in and, in some instances, a variety of referral methods (see Box 4).

Box 4: Referral systems in one locality

In one locality, parenting programmes were offered by the parenting team, two separate voluntary sector organisations, the Family Intervention Project, specialist CAMHS, a number of children's centres and a cluster of schools linked together as part of a consortium. Interviews suggested that scheduling of programmes was not always clear to parents or to professionals. These services generally had different referral methods, ranging from very simple referral forms for internal use (e.g. only including name and number of parent), to more complex multi-agency forms, such as the Common Assessment Framework (CAF), an assessment tool used across many children's services in England to identify a need for coordinated support from a number of agencies.

The simplicity, clarity and consistency of referral routes varied both between and within our case study areas.

> *"It's bitty and it hasn't been pulled together. There isn't a system. There isn't a vision."*
>
> Social Worker

> *"There has to be a better way if there's lots of us who are not aware of what's going on, what's available. I think that if it were more well-planned and structured, people would understand it better. It's when things happen sometimes here, sometimes there, well, it's happening this term, it's not happening this term; it's too much for people who are already very, very head-full to take on board more information about something that happens occasionally, whereas it could be well structured with a year plan."*
>
> Health Visitor

> *"It's finding the right services to refer into, pinpointing the exact service. Because there are lots of different services that deal with lots of different things, with family support particularly [it] can be a bit confusing for us sometimes who to get the right referral to."*
>
> Housing Officer

Practitioners and referrers also described multiple referral methods including:

- referring parents through a single gateway or 'front door of social care'
- completion of the Common Assessment Framework (CAF)
- completion of a bespoke referral form backed up with advertised eligibility criteria developed by parenting teams
- contact and discussion between referrers and parenting teams
- making a request for services through other agencies (e.g. Family Intervention Projects)
- through multi-agency referral panels (e.g. team around the family, teenage pregnancy panel)
- self referral through contacts on local parenting websites
- referral via other parents attending the programme.

Most areas had prioritised work to simplify referral pathways by developing a single gateway for referrals, either a 'first port of call for virtually all notifications of concern about children' or a clear gateway for parenting referrals.

> *"It is mainly through that one key post holder – if anybody's got a referral where [parenting] is an issue and somebody needed the support it's so much easier to access because we've got somebody with the knowledge."*
>
> Manager, adult mental health

This development was positively received by interviewees such as housing workers, adult workers and GPs less familiar with children's and parenting services, who felt it added greater 'coordination and a structure' to local referral processes.

Another local area had a spread of entry routes to programmes but, according to some parents, not all routes worked efficiently, sometimes requiring persistent follow up. A few self-referring parents talked about the difficulty of making contact with the right person even when bespoke websites were available with contact information.

Referral to Family Nurse Partnerships

The target group for Family Nurse Partnerships is very specific (i.e. first-time teenage mothers) and as a result referral systems appeared simpler to understand and clearer than those for other evidence-based parenting programmes. Teams advertised criteria for accessing the scheme in their local areas. They felt under pressure to maintain caseloads at full capacity so resources could be used most effectively and opportunities to support their target client group were maximised. One team kept

track of referral pathways noting dips in referrals and following up with renewed promotional activities with partner agencies.

Lack of agreement on effective referral tools

Most localities were in the process of refining referral tools. Reaching agreement about the most effective referral tool was a particular challenge and a clear tension arose between referrers' and providers' views of what constituted a successful referral process. For example, most schools and parenting teams advocated using the Common Assessment Framework (CAF), a ten-page form designed to help assess and support vulnerable families, while health visitors, GPs and social care workers preferred simpler and less resource-intensive referral forms.

Providers wanted enough information so they 'don't have to go chasing the parent' or referrers for more. Referrers did not want to be saddled with onerous referral systems that they sometimes considered 'time consuming', 'too wordy' and 'a bureaucratic nightmare'. A number of interviewees felt that the Common Assessment Framework could be used as a 'thorough assessment' but it 'was not the best system because we don't get the information we want,' and that it was a 'lengthy process'. Generally, many felt there needed to be a 'better system'.

In one area information collated from CAF forms had additional usefulness (beyond referral) to strategic planners as it was also providing important information on the priority needs of local parents. Two localities were in the process of developing a bespoke referral form to improve the usefulness of referral information.

Information for referrers

Previous research into implementation has highlighted lack of information as a barrier for parents accessing support (Green *et al*., 2005; Coe *et al*., 2008). Our findings suggest that poor information can also be a barrier for referrers.

A number of referrers from different services described poor knowledge of evidence-based parenting programmes for children with severe behavioural problems.

> *"I think we would happily refer if we were more conscious of it. I wouldn't even know how to refer. They're not there promoting themselves, giving out messages to GPs. The thing to do is to remind people – look there's a lead GP, go and talk to the surgery, talk to the lead GP once a month. I want to know who you take, what you offer and how to refer."*
>
> General Practitioner

Interviewees felt that providers could be 'more savvy' about promoting their programmes to referrers.

> *"I think people don't understand what they're referring to and therefore send an awful lot of inappropriate referrals. I think it's quite difficult when people don't understand what a parenting programme is and what it can be used for."*
>
> Manager, parenting team

Promotional techniques

Parenting programme providers in our case study sites used a variety of methods to inform referrers about referral pathways. Some were reported by referrers to be more successful than others.

Leaflets

Responses from interviewees suggested that leaflets were not successful on their own in promoting parenting programmes to referrers without 'that follow up conversation'. In one locality, a programme provider sent out printed information to schools, hoping to engage parents of at-risk children in a parenting programme. However, some schools misunderstood the aim of the information and inappropriately 'photocopied the flyer and put it in the book bag' of selected children who they identified had behavioural issues, causing some offence and resistance to programmes.

Outreach, promotion and networking with referrers

Proactive outreach to referrers by programme providers through presentations or multi-agency networking emerged as a promising way to develop understanding of referral pathways.

Family Nurse Partnership staff recognised the importance of mapping potential local referrers and following this up with repeated promotional work during recruitment drives. One voluntary sector manager also emphasised the importance of systematic networking and promotional work with other professions to facilitate referrals.

A number of parenting coordinators and practitioners in local areas were also attempting to improve awareness of their programmes through proactive and regular promotional work with referring agencies.

> *"You can send leaflets out, but I think knowing who's there is much easier because then you feel more confident about picking up the phone and, 'Oh, this is who I'm referring to, or this is the service I'm referring to'. But I think face-to-face contact is the best."*
>
> Parent Support Advisor, schools

> *"We're doing some outreaching in the individual health centres, so we're having that much more contact with our health visitors, so the referral process is really good."*
>
> Family Support Worker, children's centre

> *"There's four family support workers and we individually go into GP practices with the health visitors to keep that close link and whenever referrals are made we get hold of [them] straightaway, so communication is not distant."*
>
> Family Support Worker, children's centre

Having a promotional 'champion' locally who could contribute to this work was also considered helpful both as a local contact point and as a way to embed parenting programmes strategically with other multi-agency developments.

> *"And whilst it's everybody's business I still think you need your little champion to be the driver."*
>
> Manager, adult mental health

Link workers

In many localities, parent support workers or advisors were based in school communities promoting awareness of parenting programmes and issues; in some sites these workers were supervised by parenting teams and often led parenting programmes. These workers were able to work closely with parents on a range of issues (e.g. behaviour, parenting, school attendance) and acted as important bridges between communities, parents, schools, children's centres and other local services (e.g. housing, debt services).

Key findings

- There is wide variation in the speed and quality of referral pathways to parenting programmes.
- Referrers are frequently the first point of contact for most families seeking help, as such they have an important opportunity to motivate and engage parents in parenting programmes.
- Referral pathways to parenting provision can be complex and unwieldy for referrers unfamiliar with children's services. Single gateways have been successfully used in some localities to simplify referrals.
- There is currently little agreement on ideal referral tools for parenting programmes.
- Poor information is a barrier to referrals; systematic networking and promotional outreach by parenting teams can support the referral process.



6 Engagement

Introduction

Engagement is central to achieving successful outcomes in parenting programmes. However, previous studies and our own research suggest that providers struggle to enrol and retain those who would benefit the most from parenting programmes. This chapter reviews the main barriers to engagement and how these might be addressed.

Summary of literature

Around a third of parents offered a parenting programme will enrol on a course (Patterson *et al*., 2002; Baker *et al*., 2011).

Drop-out rates vary widely from 20 to 80%, with rates reportedly higher in parents of children with more severe behavioural problems (Gibbs *et al*., 2003; Ingoldsby, 2010).

Low levels of engagement reduce the effectiveness and efficiency of parenting programmes (Prinz & Miller, 1994; Berkel *et al*., 2010) and also their cost-effectiveness (Kazdin, 1996; Bunting, 2004; Baker *et al*., 2011).

Barriers to engagement include:

- Problems relating to the location and timing of programmes: transportation and childcare are widely recognised as major barriers (Kazdin, 1996; Snell-Johns *et al*., 2004; Coe *et al*., 2008; Nix *et al*., 2009; Ingoldsby, 2010).
- Clear information strengthens parents' intentions to participate in parenting programmes (Matsumoto *et al*., 2009) and equally a lack of information is a major cause of non-engagement (Green *et al*., 2005; Coe *et al*., 2008).
- Outreach working methods are seen as an effective way of engaging parents, especially those who are otherwise hard-to-reach, but these are not always used effectively (Garbers *et al*., 2006; Ben-Galim, 2011; D'Arcy, 2010; Social Research Unit, 2011a; Social Research Unit, 2011b).
- Stigma can make it difficult for families to accept or seek provision (Department for Children, Schools and Families, 2010; National CAMHS Support Service, 2011; National Collaborating Centre for Mental Health, 2010).

Ways of increasing engagement include:

- Practical barriers can be addressed, especially through the use of local, parent-friendly venues and the provision of crèche facilities (Gross *et al*., 2001; Garbers *et al*., 2006; Mason & Broughton, 2007; Ben-Galim, 2011).

- Providers that actively focus on engaging parents from the very beginning have higher take-up and lower drop-out rates (Lindsay *et al*., 2011); it has also been suggested that a parent's experience of the earliest meeting with the referral source has a major influence on their attendance (Whitakker & Cowley, 2010).
- Descriptions of programmes during early contact need to focus on promoting skills, techniques and opportunities provided through programmes to parents, rather than emphasising their risks (Vitaro & Tremblay, 2008).
- General literature on referral and recruitment to evidence-based interventions reinforces the superiority of personalised approaches over more impersonal approaches to recruiting parents (Schlernitzauer *et al*., 1998).
- Positive relationships between practitioners and parents increase engagement and participation (Staudt, 2003; Ingoldsby, 2010; Asmussen, 2011; Lindsay *et al*., 2011); parents who are ready to change are more likely to engage in programmes (Ingoldsby, 2010); 'motivational interviewing' (which has proved effective in fostering behaviour changes in health settings) (Rollnick & Miller, 1995; Ruback *et al*., 2005) is promising as a therapeutic approach to enhance families' intrinsic motivation to engage in activities (Nock & Kazdin, 2005) but is under-used in work with families.
- A small number of high-need families and children with more complex behaviour problems (e.g. children with Attention Deficit Hyperactivity Disorder (ADHD) or Callous and Unemotional Traits) may need ongoing support with positive parenting techniques (Jones *et al*., 2007; Frick & White, 2008).

Barriers to engagement

In our national survey of parenting leads very wide variations were reported both in enrolment and drop-out rates from area to area with:

- between 10% and 70% of parents not attending programmes after being offered a place
- and between 3 per cent and 50% failing to complete after starting parenting programmes.

Practical barriers

92% of survey respondents said that practical issues (e.g. timing, venue, crèches and access to interpreters) were either very important or important barriers to engagement. This is very much in line with the findings of published research (Kazdin, 1996; Snell-Johns *et al*., 2004; Coe *et al*., 2008; Nix *et al*., 2009; Ingoldsby, 2010).

Parental characteristics

Most respondents to our national survey and interviewees in our case study sites felt that parental characteristics (e.g. chaotic lives, lack of confidence) were as much of a barrier to engagement as practical issues. In fact, 91% of respondents saw parental characteristics as either a 'very important' or an 'important' barrier to engagement.

Many felt that parents living chaotic lives have 'too many other things going on in their lives that are interfering' or are 'simply not ready to be in a group and can't take anything in'.

> *"She's just not in that right place. I'm not saying it's wrong. I'm just saying it's not right for her now ... she's not yet stable on her methadone programme and she's still at threat of domestic abuse. Do you really think that she can concentrate on giving time out to three under fives?"*
>
> Manager, Family Intervention Project

Studies provide a generally mixed picture of the impact of parental characteristics on engagement and drop-out. Some literature associated particular personal and contextual factors, such as single-parent status, socio-economic disadvantage, parental mental illness, ethnic minority status, and living in a low-resource neighbourhood with reduced engagement and increased attrition (Snell-Johns *et al*., 2004; Reyno & McGrath, 2006; Mendez *et al*., 2009; Nix *et al*., 2009; Ingoldsby, 2010). On the other hand, Reyno and McGrath (2006) observed that personal and contextual factors (e.g. deprivation and maternal mental ill health) were not predictive of higher drop-out rates but did result in poorer treatment outcomes.

Issues with promotion

Previous studies highlight the importance of information on a parent's intention to participate in parenting programmes (Matsumoto *et al*., 2009), and how a lack of information can stop parents from seeking support for their child's behavioural problems (Coe *et al*., 2008). For example, in our study many providers use leaflets to promote services, but leaflets alone appear to have little impact.

> *"We sent out loads and loads and loads of information and what happened was that the information was posted on the professional side of the door down here, so it didn't go out to parents."*
>
> Practitioner, parenting team

> *"For me, I go to playgroup or the school. I don't go to any other place. You can't get leaflets in the park. [School] is the only place I go."*
>
> Parent, programme attender

Outreach methods of working can include supermarket 'road shows', local press coverage, schoolyard outreach to parents before and after school, visits to schools and setting up coffee mornings where parents can drop in to learn more about services (Lindsay *et al*., 2011). These are seen as positive promotional activity, both in the literature (Garbers *et al*., 2006; D'Arcy, 2010; Ben-Galim, 2011; Social Research Unit, 2011a; Social Research Unit, 2011b) and in our interviews.

> *"The outreach has made a tremendous difference. It's been fantastic. It's enabled us to get a lot more parents involved in activities that are beneficial both to themselves and to the children and ultimately the school and the community."*
>
> Head Teacher, primary school

Locality interviews suggest that outreach can be piecemeal and dependent on the individual practitioner.

> *"That's why my groups are always full and other people's may not be. It's not worth a parent's time and my time and the money not to do the outreach."*
>
> Practitioner, voluntary sector organisation

Similarly, over half of providers in the national survey felt that lack of outreach or other active means of engagement was either a very important or an important barrier to engagement.

Stigmaw

It has been suggested that stigma can make it difficult for families to access services (Department for Children, Schools and Families, 2010; National Collaborating Centre for Mental Health, 2010; National CAMHS Support Service, 2011). Nearly two-thirds of all respondents in our national survey felt that

stigma was a very important or an important barrier to engagement. Both parent and provider interviewees were concerned with stigma, with four separate themes emerging:

- stigma associated with attending a parenting programme (e.g. fear of being labelled a 'bad parent', stigma associated with having a badly behaved, 'naughty' child);
- stigma associated with programmes being held in a particular location (e.g. some parents were reluctant to access parenting programmes offered on a council estate, others were reluctant to go to programmes offered in schools – particularly if parents had negative school experiences);
- stigma associated with services offering programmes (e.g. social service involvement was seen as very stigmatising);
- stigma as a result of disclosing personal details in group settings (e.g. parents afraid of being stigmatised as a result of revealing something at a group session).

How sites facilitated engagement

Interviews with parents, qualitative responses from the national survey and findings from research highlighted several examples of promising practice surrounding engagement in parenting programmes. These included:

- addressing practical barriers
- location and venue
- supporting readiness to change
- facilitating initial engagement:
  - using referrers to promote programmes effectively
  - using effective language
  - meeting with parents before the course
- maintaining engagement:
  - offering catch-up sessions
  - offering support throughout the programme
- engaging parents in one-to-one programmes.

An overarching theme for all successful engagement was the importance of establishing positive relationships with parents.

Addressing practical barriers

It is already well established that addressing practical barriers, such as providing a crèche, offering flexible timing, helping with transport, or ensuring disabled access or interpreters, improves engagement (Gross *et al*., 2001; Garbers *et al*., 2006; Mason & Broughton, 2007; Ben-Galim, 2011). The majority of parents and many practitioners interviewed confirmed the importance of childcare provision as an enabler of attendance, particularly when there was more than one child in the family.

> *"I couldn't come if there wasn't a crèche because he's such a tiny baby. My son goes to pre-school, that's great, drop him off and then come, that's fine, that's easy, he's old enough, but [I couldn't do that with] a tiny baby."*
>
> Mother, programme attender

> *I couldn't [go to start with] because of childcare and things like that. Then they sorted it out with social care [for me] to get childcare. So I've had help to be able to go on this course.*
>
> Mother, programme attender.

Practitioners also felt crèche provision was linked to better engagement.

> *We've only just started to run crèches again and maybe that is why this course is so full.*
>
> Early Years Worker, children's centre

Despite the importance of crèches to engagement, this service was often prone to cuts, and most localities had either ended provision or had been forced to think very creatively about how they might rationalise childcare costs.

Location and venue

For some parents, having access to a convenient venue close to home was considered important since a few parents were noted to have very limited mobility beyond their local home areas.

> *Some parents might not have [left their housing] estate. So to say [to them], 'go on a programme in another part of [our locality]', you might as well tell them to go to Paris.*
>
> Manager, parenting team

Unfortunately, most localities reported that access to convenient local venues, such as schools, children's centres and community centres was limited and becoming increasingly dependent on funding.

Many venues that had previously been free (e.g. schools, church halls) were charging for use and providers were unable to find money to pay for these. In one instance, a locality had been able to avoid this issue (see Box 5) through creating closer links with schools and children's centres. Most parents supported programmes being run in school venues or in children's centres, although for a small number with poorer experiences of formal services, children's centres, schools and other more official venues held negative associations.

> *I don't like the centre's layout, the smell, the lights are quite clinical, same feeling as a hospital with notice boards. When I'm in [the children's centre] I'm thinking – get me out of here. Everyone's too close ... I'd like it to be more relaxed, more homely, no reception area.*
>
> Parent, programme non-attender

One area had previously been able to attract some harder to engage parents through converting a local disused council house into a less formal drop-in and group setting.

Box 5: Developing closer links with schools and children's centres

One locality had developed strong working partnerships with schools and children's centres in their area, with 60% of schools in the locality buying in services through service level agreements. In this locality almost all primary schools and a number of children's centres had taken responsibility for offering evidence-based parenting programmes (i.e. training staff, providing venue, recruiting parents), ensuring programmes were offered across the whole of the locality.

Supporting readiness to change

Interviews with parents and practitioners linked parents' motivation and readiness to change with enrolment, retention and successful outcomes in parenting programmes. Some noted that parents with entrenched problems were often placed on courses before they were 'ready' which hindered engagement.

> *"I don't think she wanted to change things to be honest."*
>
> Parent talking about a friend who had dropped out of a parenting programme

> *"If there's absolutely no motivation to change, there isn't really any point of referring to a parenting programme."*
>
> Manager, Family Intervention Project

Many practitioners felt that one-to-one preparatory work needed to be completed before some parents would be ready to engage in a programme, either focusing on removing 'underlying issues' such as debt or mental health problems or on influencing motivation to change.

Some practitioners and referrers saw readiness to change as a dichotomous state – parents were either 'ready' or 'not ready'.

> *"I put it down to you're just not ready to change, but when you are ready, come back."*
>
> Practitioner, voluntary sector organisation

The broader literature focusing on readiness to change interprets decision making as a dynamic process which involves passing through various stages (see Box 6) and which can sometimes be promoted through very minimal intervention.

A key starting point for referrers and practitioners appears to be accurate assessment of parents' motivation to make changes. Once assessment has been completed, professionals support the process of change through:

- helping the person consider the pros and cons of making changes
- providing information to help with decision making
- collaborating on setting goals
- supporting and encouraging parents to maintain changes.
  (Prochaska *et al*., 1994; Miller & Rollnick, 2002)

There is emerging recognition of the potential role played by motivational interviewing in the parenting field (Asmussen, 2011) and this therapeutic approach was overtly identified by Family Nurse Partnership nurses as pivotal to their work in encouraging attitudinal and behaviour changes.

Motivational interviewing involves the use of therapeutic techniques to help people achieve health and behavioural change (Rollnick & Miller, 1995; Miller & Rollnick, 2002). One study tested a brief motivational intervention designed to increase participation of ambivalent families with some success (Nock & Kazdin, 2005). The interventions were designed to be delivered in three 5–15 minute 'doses' and involved:

- providing parents with information about the importance of attendance and adherence so that they have the best chance of the intervention working;
- supporting parents' motivational statements about the benefits for them of attending and sticking to the techniques;
- helping parents to anticipate barriers to attendance and develop a contingency plan.

Box 6: The cycle of change and parenting

Pre-contemplation – 'I don't have a problem'

Aleesha had been struggling with the behaviour of her five-year-old son for some time. Also, as a result of domestic violence, the local social work team had begun working with her and her partner. Aleesha didn't get on with her social worker; although stressed by her son's behaviour, she was offended when the social worker first suggested that a parenting support programme might help her with her son's behaviour.

Contemplation – 'Sometimes I wonder whether I need to do something about this'

The domestic violence continued. Aleesha got pregnant again. Her unborn daughter was also placed on the Child Protection Register. This shocked Aleesha and she wondered if she should do something about her situation. She got a new social worker with whom she had built up a good relationship and who was helping her with practical problems which were overwhelming her. The social worker gave her information about the parenting programme explaining how it might help her with a few really practical techniques. She left her to think about it but then followed this up the next time she saw Aleesha.

Preparation – 'What can I do about this?'

After the social worker raised the issue again, Aleesha decided to go to the programme. She felt uncomfortable about going to the group for the first time. Her worker reassured her, explaining that everyone felt the same but that 'once you're there, that will change'. The worker linked her up with the group facilitator who visited her before the start of the programme, reassuring her and explaining clearly what would happen on the course.

Action – 'I'm determined to get this sorted and I know what I need to do'

Aleesha attended the group and began to enjoy and value both the experience and the helpfulness of the strategies for managing her son's behaviour. She saw changes almost immediately in his behaviour.

Maintenance – 'I can see the benefit, I really need to keep this up now'

She continued using the techniques with success over the next four weeks. She also felt much better and more confident as a result of her experiences on the course, leading to other quality of life improvements. These included making changes to her relationship with her partner and coming off tranquillisers which she had used since the age of 16 years to manage anxiety.

Lapse – 'I've let things slip and things have gone backwards. I need to re-establish control'

Over a two-week break at Christmas, Aleesha found herself using less of the techniques and saw an almost instant deterioration in her son's behaviour. She shared what happened with the group and was able to re-establish control. Her social worker provided ongoing support after the course finished, reinforcing the techniques she had learnt.

This example is based on an interviewed parent's experience.

Given the low intensity of this input, the intervention was observed to have an encouraging effect on attendance levels and an even greater effect on parents' ability to persist with learnt techniques in comparison with those not prepared in this way for attendance.

In some local areas, practitioners (e.g. health visitors, early years workers, social workers, family support workers and school link workers) fulfilled this important motivational role by undertaking outreach work with those identified as ambivalent towards either attending groups or adapting their parenting style. However, findings suggested inconsistencies in approach and some scope to improve systematic follow up to develop the motivation of high-risk families who avoided or dropped out of programmes.

Effective motivational work also relies on a whole-system commitment to parenting and to brief intervention from referrers as well as from other workers falling outside the immediate parenting team. There is emerging recognition of the potential role played by motivational interviewing in the parenting field (Asmussen, 2011) and this therapeutic approach was overtly identified by Family Nurse Partnership nurses as pivotal to their work in encouraging attitudinal and behaviour changes.

Facilitating initial engagement

Using referrers to promote programmes effectively

It is suggested that that one way of engaging parents is to ensure referrers are promoting services at the earliest opportunity (Whitakker & Cowley, 2010). A number of respondents clearly felt that getting referrers to promote programmes effectively had the potential to improve engagement.

> *"The retention rates were really good because the parents knew what to expect beforehand. They were given that motivation to continue because they knew what to expect and knew what the outcomes would be."*
>
> Extended Schools Partnership Officer, extended schools services

However, interviews in localities and qualitative responses from the national survey suggest that referrers are generally unaware of their potentially critical role in the engagement process or are unsure of how to promote programmes effectively.

> *"Often referring agencies do not understand what a parenting programme entails. The best predictor of making changes in behaviour relates to motivation and so it is really crucial that referring agencies 'engage' parents [in] the referring process."*
>
> Response from national survey

> *"During the referral process there has to be information, and I think that's what's missing ... healthy information rather than saying, 'you're being targeted into that'. Before we've even made contact with them there's suspicion. Sometimes we've had referrals where the parent didn't even know the referrer or why they were being referred."*
>
> Parenting team

Using effective language

Interviews with parents and providers suggest that language and 'being able to offer it in the right way' can play an important role in engagement.

> *"The name of the book [Strengthening Families] even makes me think 'What? Do I have a weak family?' Don't call it a course ... more a meeting with friends."*
>
> Parent, programme attender

> *"People can be very easily offended and, even though you've no intentions of questioning people's parenting skills, the offer of help can be seen as a putdown."*
>
> Parent, programme attender

The literature also highlights the critical role played by referrers in framing initial invitations in a positive way to maximise the chances of engagement (Vitaro & Tremblay, 2008). To overcome potentially stigmatising language that would reduce engagement, interviewees had two suggestions for how parenting programmes could be promoted. Firstly, using language associated with a non-judgemental, strengths-based approach was seen as crucial.

> *"We managed to have a good attendance because we didn't say 'parenting course' at all, we said 'parents support groups' and when we went to the coffee mornings we spoke about how this was going to be a chance for people to exchange ideas and talk about their parenting."*
>
> Practitioner, Family Intervention Project

> *"[We say] you can always learn from other people or pick up new tips."*
>
> Early Years Worker, children's centre

However, there was also some suggestion in interviews that different selling points may need to be highlighted with different gender groups; so for example, whereas 'support' rather than 'training' was acknowledged as a broadly attractive 'hook' for some mothers, a father talked about initial fears about being involved in a 'talking shop' and valued instead the focus on the practical development of skills.

Secondly, focusing on the benefits for children was also seen as an effective way of promoting parental engagement. Interviews with parents suggest that they were more inclined to attend a parenting programme if they felt the programme could improve their child's future health and wellbeing, job prospects and general life outcomes.

> *"I think it was just thinking about how I could improve the children's lives really, and how it could make things better."*
>
> Parent, programme attender

> *"Some of the [feedback is] just fantastic, you know: 'the Triple P course has helped me unlock her sunnier side', the child's sunnier side! That particular parent thought her child was introverted and sad and not able to enjoy herself."*
>
> Early Years Worker, children's centre

One parent particularly emphasised the need for providers to be aware of parents' views when deciding on appropriate language. For example, using vocabulary which had specific positive associations for parents such as 'benefits', and avoiding language with more negative connotations such as 'parent training'.

Meeting with parents before the course

Emerging research suggests that providers who focus on engaging parents from the very beginning have higher take-up and lower drop-out rates (Lindsay *et al*., 2011). In fact, a number of parenting

programme practitioners highlighted the importance of preparing parents through some sort of pre-course contact.

> *If I look at the [nine] people who are my course at the moment, there are probably only two who have turned up from seeing a poster. The rest are people that I know or I've made that phone call and explained the course to them. People are quite suspicious of going to new places and 'What's it going to be about?', whereas if they know who they're going to, it breaks barriers.*
>
> Parent Support Advisor, school

Pre-course contact, including phone calls, home visits or coffee mornings, was felt to be particularly effective with under-served parents. This was reflected in parents' comments as well.

> *If you had someone to talk to about it before, then yeah, I think that would probably encourage me more.*
>
> Parent, programme non-attender

The use of preparation to engage parents varied between services and agencies more than it varied between localities. For example, most practitioners felt that preparation was important, but not all were able to put this into practice. In general, practitioners who reported being able to prepare parents for courses were those who worked in teams where managers valued the role of preparation in engagement and where preparation was considered part of the practitioner's core duties.

Conversely, practitioners felt that pre-course contact was jeopardised when resources were limited, when linked services were being cut or when referrals were rushed.

> *But that's the difficulty, if it's last minute referral because there's going to be a case conference, you're not going to get as much opportunity to put in a home visit or anything first.*
>
> Early Years Worker, children's centre

> *Most services are so slimmed down now that they're expected to be able to just go along themselves. I think people with barriers don't just go along. So you need a broker of some sort whether that be a family link worker or a school.*
>
> Practitioner, voluntary sector provider

Maintaining engagement

Offering catch-up sessions

All areas offered catch-up sessions to parents who had missed a session, as recommended in most parenting programme handbooks.

> *We tend to hassle parents quite a lot if they don't come, we'll give them friendly catch-up sessions. It's more an encouraging call to come back.*
>
> Managers, voluntary sector organisation

> *We are pretty tenacious and we'll keep texting. We'll keep phoning. We will be knocking on the door and saying, 'Oh, really sorry you didn't make it, please do come'.*
>
> Programme Facilitator

However, the consistency of this offer of catch-up sessions and the tenacity of follow-up varied between local areas and even within localities. At best, some localities were able to offer parents up to two catch-up sessions, delivered via home visits. At worst, some services were unable to offer any catch-up sessions due to limited time and resources.

Offering support throughout the programme

The literature remains equivocal about the benefits of providing support alongside parenting programmes as a strategy to reduce attrition by under-served parents or those facing multiple challenges in their daily lives (e.g. mental health problems, substance misuse, deprivation etc.).

Prinz and Miller's study (1994) indicated that drop-out could be reduced by supplementing programmes with supportive discussions focused on broader issues than children's behaviour. There is, however, little analysis of the impact of offers of support on parental drop-out.

Most providers in this study felt that offering support during the course was an effective way to ensure under-served parents remained engaged in programmes.

> *"Just because we give them something doesn't mean they're going to feel confident or able to exercise it. So I ended up working alongside the most difficult to engage parents, providing them with counselling at the same time [as] we were doing the [parenting programme] and the retention rates were much better."*
>
> Community Team Worker, CAMHS

It was also felt that parents who had experienced poor parenting themselves or with chaotic lives or multiple problems needed, on occasions, the support of a dedicated worker to help embed key learning points from the programme and to help them deal with sensitive issues emerging from the content .

> *"Having [support] running alongside [the programme] for difficult to engage families is really important."*
>
> CAMHS programme provider

This type of support was offered in most of our locality sites, though who was offering it varied between local areas. For example, in some cases programme practitioners had some flexibility built into their contracted hours to offer extra support to parents who appeared to struggle with the programme. In other cases support was offered only to parents already involved in targeted services (e.g. those involved in social care or Family Intervention Projects). In one locality, a team of support workers working under the parenting team was available to offer help alongside programmes.

Engaging parents in one-to-one programmes

The fact that parents drop out of parenting programmes was considered a major issue for most providers. It is well known that high drop-out rates affect parenting programme effectiveness (Gibbs *et al.*, 2003; Vitaro & Tremblay, 2008; Ingoldsby, 2010), yet there is relatively little research highlighting which strategies work most effectively to prevent drop-out.

One group of practitioners with evidence of effective practice in re-engaging parents who drop out are nurses in the Family Nurse Partnerships, who target teenage parents on a one-to-one basis over a prolonged period. Nurses assiduously tracked personal attrition rates and believed that tenacity, collaborative approaches with parents and 'elastic tolerance' were the keys to their success.

> *"We'll keep in touch by little text messages saying, 'Hi, hope you're okay, still here if you want' – not putting any pressure on them and they come back. I did some really good work with [one of my FNP clients] and yet she did disengage for a time, so maybe it's about the fact that we don't give up, maybe that's what keeps the attrition low."*
>
> Nurse, Family Nurse Partnerships

This 'elastic tolerance' is built into the core model elements of FNP, which stipulate that clients cannot be discharged from the service until contact has been lost for six months.

> *You keep that client on for six months and initially we thought, 'well they're not going to come back' [but] when they want to come back, they come back.*

Nurse, Family Nurse Partnerships

In comparison to FNPs, other parenting programme providers had a much shorter timescale to build relationships with programme participants and were also unable to work with parents for extended periods of time. Parenting teams relied on partners to re-engage and support the motivation of parents who failed to engage or complete programmes.

Establishing positive relationships

One overarching theme that emerged was the importance of establishing a positive relationship and an effective therapeutic alliance between practitioners and parents, especially in engaging the under-served.

> *One particular parent said, 'Well, because you're running it I will come', because she's built that relationship with [me].*

Family Support Worker, Children's Centre

This is in line with what we know from research, which suggests that families that have a positive relationship with practitioners are more likely to engage and are less likely to drop out of parenting programmes (Ingoldsby, 2010; Asmussen, 2011; Lindsay *et al*., 2011).

Positive relationships may also facilitate engagement in more difficult situations. For example, research suggests that when parenting programmes are compulsory (e.g. through a parenting order) up to 75% of parents drop out after initial attendance (Patterson & Chamberlain, 1988; Orrell-Valente *et al*., 1999; Harpaz-Rotem *et al*., 2004; Nock & Ferriter, 2005). Yet in our study, in a number of instances, parents' close relationships with key workers (e.g. family intervention project worker, parenting support worker) appeared to help retain parents in programmes, despite the fact that attendance was part of a mandatory court order.

Conversely, it emerged that in some cases a poor relationship between parents and practitioners or referrers led to negative perceptions and non-engagement in parenting programmes. For example, in one locality a parent's negative relationship with her social worker stopped her from accessing support.

> *My first social worker, I didn't get on with her at all, it felt like she was talking down to me all the time. They asked me to do things for her and I'd do it and it's not good enough. There was always something more they wanted.*

Parent, programme attender

In the end, it was this parent's positive relationship with the head teacher at her daughter's school that facilitated her engagement with a local parenting programme.

> *The head teacher that's there now, I can sit down with him, I can talk to him, laugh, cry, scream and he will listen. He'll give me updates on how [my daughter] is getting on at school. I communicate with the school and stuff, that's good.*

Mother, programme attender

The role of developing positive relationships with parents fell to a number of different practitioners across the locality sites, including members of the parenting team, school staff, workers in children's centres and a number of practitioners working in adult services (e.g. substance abuse, domestic abuse and adult mental health). In general, however, the extent to which relationship building was seen as part of a practitioner's core work (with time allocated accordingly) varied greatly between localities and services.

In terms of parenting programme practitioners, those struggling to build relationships with parents were generally those not funded to prioritise engagement activity. In one locality, financial constraints had led one provider to cut back their services. This in turn had led workers to de-prioritise preparatory activity; in practitioners' views, undermining parental engagement and retention rates.

> *"It does come down to those relationships. We've started to call some of the parents. We're reaching barriers, such as they don't know us. I think they're a little bit suspicious of what we're doing."*
>
> Practitioner, voluntary sector organisation

Key findings

- Barriers to engagement take a number of different forms, some of a very practical nature and others which are more intangible but nevertheless very important, such as lack of readiness to change among some parents.
- Providers have tackled these barriers by ensuring programmes are easy to access and include crèche facilities, by encouraging other agencies to promote programmes in motivational ways and using methods which maximise engagement. This includes careful use of language when explaining the course and by facilitating pre-course meetings.
- Providers have also sought to maintain parents' engagement by establishing positive relationships during the course, helping those who miss sessions to catch up and offering additional support during the programme where this is needed.
- Because the effectiveness of parenting programmes can be so severely compromised by low take-up and high drop-out, the funding of programmes should always allow for some expenditure on resources aimed at minimising the adverse impact of barriers to engagement. Services should also systematically collect and monitor take-up and drop-out data for parenting programmes.



7 Recruitment and practitioner skill

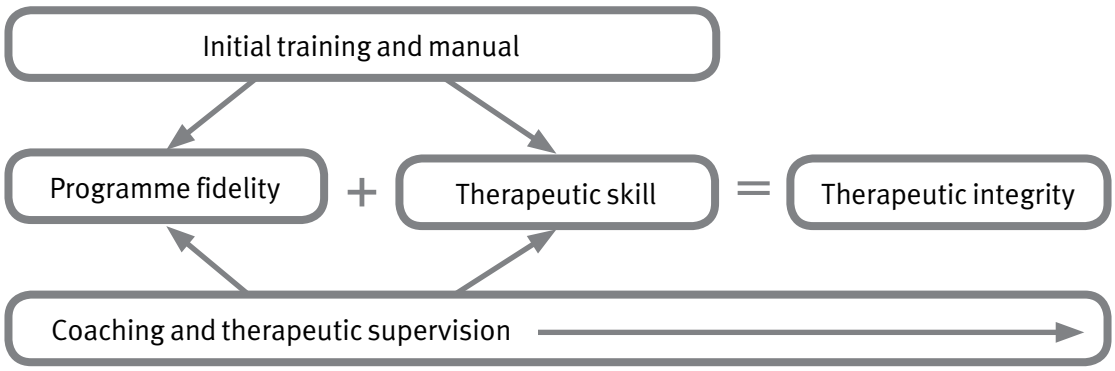
The quality of the workforce delivering evidence-based programmes is strongly associated with better outcomes for children with early behavioural difficulties. Clear guidelines state that evidence-based parenting programmes should be delivered by appropriately trained staff following programme-specific training (National Institute for Health and Clinical Excellence, 2006). This chapter will investigate recruitment patterns and challenges associated with training for evidence-based parenting programmes and the qualities and skills identified by wider research and by interviewees as important to the achievement of good outcomes. Wider workforce development issues such as coaching, supervision and quality control will be covered in Chapter 8.

Summary of literature

Practitioners are an important part of the change process in evidence-based programmes. The achievement of improved child behavioural outcomes relies on programmes being delivered with therapeutic integrity (Andrews, 1994) (see Figure 5). Therapeutic integrity results from a synthesis of:

- adherence to the programme content – the extent to which the therapist follows the content of the programme manual and delivers it as intended (Scott *et al*., 2008)
- therapeutic alliance – 'how well, both personally and collaboratively, client and therapist get on together and agree on goals' (Kazdin *et al*., 2006; Scott *et al*., 2008)
- highly developed therapeutic skills – supported through training and supervision
- worker skill – the ability to deliver the core ingredients of an intervention in a range of conditions and contexts. Worker skill is considered particularly critical, with one study finding that child behavioural outcomes improved significantly with each increase in skill rating and that the least skilful practitioners actually made children's behaviour worse (Scott *et al*., 2008).

Figure 5: Diagram of therapeutic integrity



Better programme outcomes are associated with higher practitioner qualification levels, e.g. being trained in mental health, being a nurse, and going on later to become a certified programme coach (Scott *et al*., 2008). In US studies of Family Nurse Partnerships, programme effectiveness and outcomes are greater in programmes using nurses rather than volunteers, despite matched training in the programme (Korfmacher *et al*., 1998).

Para-professionals (e.g. volunteers and parents) can effectively deliver well-specified evidence-based parenting programmes but rely on high-quality training and consistent coaching to develop and maintain skills and to ensure that the programme is delivered in the way that it was intended (Christensen & Jacobson, 1994; Asmussen, 2011).

Consistent recruitment criteria are not generally applied when selecting candidates for training in the delivery of evidence-based programmes (Lindsay *et al*., 2008; Coates & Sayal, 2011).

Staff training is an important part of the implementation process and has been associated with improved fidelity (Fixsen *et al*., 2005; Lindsay *et al*., 2008; Social Research Unit, 2011b).

All these findings imply that attempts to reduce programme costs by employing inadequately trained workers are likely to prove a false economy.

The national survey

Around half of respondents to our national survey were broadly happy with staff training (40%), the quality of the workforce (42%) and staff turnover (53%). However, one-third had frequent or very frequent concerns about the training of their staff, while one-quarter had concerns about high staff turnover. Fewer had anxieties about the quality of their staff (16%).

The workforce

The types of practitioners trained in evidence-based parenting programmes in our four local areas varied between sites but included:

- parenting team practitioners
- children's centre staff (particularly early years workers and some health visitors)
- schools (e.g. deputy head teachers, teaching assistants, school liaison officers, parent support workers, targeted mental health in schools workers)
- family intervention/recovery practitioners
- nurses
- voluntary sector providers
- social care
- domestic violence workers
- CAMHS staff
- parents
- youth offending team staff.

Qualification levels also spanned a wide range, with examples of local parents recruited and trained to deliver programmes, pre- and post-registration nurses and post-graduate staff (including one doctorate-level programme facilitator) all delivering programmes. By the end of this study,

programmes being led by local parents had 'fizzled out' as a result of dwindling funding and reduced coordination.

Higher skill levels have previously been associated in research with better outcomes for children and parents (Korfmacher *et al*., 1999; Scott *et al*., 2008). In one study, staff with the lowest level of skill were observed to have made children's outcomes worse (Scott *et al*., 2008). Therapeutic skill is also deemed critical in broader implementation literature (Andrews, 1994; Scott, 2008b). In an attempt to improve workforce standards and add value to official training, one local area had embarked on an area-wide workforce development strategy. They aimed to raise the quality of parenting staff through introducing a rolling 12-module programme supporting an NVQ equivalent qualification. The parenting lead completed an audit of skills and used appraisal processes to match candidates with relevant modules.

Group work facilitation skills (e.g. managing group dynamics and facilitative rather than didactic or presentational skills) were identified most frequently by managers and practitioners as areas for development in practitioners' skills.

Managers, on the other hand, talked of the need to develop their data analysis skills to help them monitor outcomes for individual practitioners and to track programme outcomes more effectively. A few interviewees talked of their concerns at the ongoing costs of training and re-training staff as they moved on.

Recruitment

In recent years, programme-specific training in evidence-based parenting interventions has been funded by the (former) Department for Children, Schools and Families through the Parenting Early Intervention Programme (PEIP), with support from the National Academy of Parenting Practitioners (NAPP). From 2006, all local authorities in England were helped to deliver one or more of five selected evidence-based parenting programmes. A large number of practitioners were trained in the delivery of programmes during this period, with differences noted between local authorities in who was selected for training (Lindsay *et al*., 2011).

Many strategic and parenting leads sought to 'mainstream' evidence-based programmes through offering free training to a range of agencies throughout their local areas.

> *"Our strategy at that time was to train staff in mainstream services with the idea that they would then influence and impact on service delivery within the mainstream and the parenting programme would be more sustainable. We were clear that we wanted to have that kind of coverage and wanted to train colleagues across the age range."*
>
> Strategic Lead, Schools and Community

PEIP funding had stopped by 2011 and many local authorities were facing major cuts to budgets. Most areas described themselves as being in the process of reviewing their workforce development strategy during our study, mapping and reviewing their current available workforce to re-assess steps forward. A common frustration in the aftermath of this expansion period was that it was 'very easy to put people on training and then they never deliver'. Interviews with multi-agency stakeholders and survey responses indicated that the underpinning reasons for this lack of programme delivery by newly trained staff included:

a) errors in the selection of trainees (e.g. people attending to boost professional qualifications and CV; people being forced to attend training)
b) managers who had originally approved the training opposing delivery on the basis that it was unrealistic or too time consuming, took staff away from core work, no longer dovetailed with key performance indicators or was no longer feasible due to recession-led workload pressures
c) shifting and occasionally conflicting initiatives absorbing training and delivery time
d) staff moving on and the ongoing expense of training replacements
e) lack of confidence in lapsed delivery skills
f) scepticism or lack of belief in the programme.

> *"The core business of the service or other priorities have got in the way. [Although] our idea about mainstream practitioners using parenting in their practice still has some merit, I'm not sure we would do it again in that way in the future."*
>
> Strategic Lead, Schools and Community

> *"I think managers failed to understand adequately or didn't prioritise parenting interventions as opposed to other types of service delivery."*
>
> Practitioner, parenting team

A key learning point for most areas was the need for a more discerning and targeted approach to recruitment both for those accessing structured training for evidence-based programmes and for those delivering training in localities.

> *"[The parenting lead] will often look at the skill sets of everyone across the team, because some people are trained in three or four parenting programmes and some, like newcomers, might be trained in none. So within the team [training] is allocated on who perhaps hasn't had any training or who's got gaps in their knowledge."*
>
> Manager, children's centre

> *"If we get offered training or we've got some money for it, then we try and pick the people we know will deliver."*
>
> Manager, parenting team

Parenting and strategic leads identified very specific qualities and skills that they were looking for as part of any recruitment process.

> *"We were looking for people who could facilitate others: basic generic group work skills and also qualities about interpersonal interaction. We asked people to go through a process which involved some written work against a tip sheet and also participation in a group discussion on an area of practice, which was observed and scored by a number of experienced practitioners against a set of criteria."*
>
> Strategic Lead, Schools and Community

Because of an ongoing national evaluation, training and recruitment for Family Nurse Partnerships continued to be coordinated by the national implementation team in collaboration with local areas. Young people were included on recruitment panels on some occasions and candidates were required to demonstrate a series of skills and qualities through a variety of structured activities.

Previous research has noted an absence of appropriate selection criteria for staff trained in evidence-based parenting programmes (Lindsay *et al.*, 2008; Coates & Sayal, 2011). Although more research is required in this area, Fixsen (2005) observes that the selection process (including a range

of relevant selection activities) for all levels of staff supporting evidence-based programmes may be fundamental to the effective delivery of the 'core components' of these programmes and to maximising the chances of positive effect (Fixsen *et al.*, 2005). Parents and young people should also routinely be included as part of the staff selection process.

Practitioner skill and knowledge

Interviewees in locality sites recognised a very wide range of skills and qualities contributing to the effectiveness of evidence-based programmes. These included:

- being open and honest
- confidence – 'I think it's about having the confidence to deliver and believing in what you deliver'
- a committed person
- respectful
- reliability
- empathy/emotional warmth – 'You have to be warm; you have to show them warmth'
- able to draw out what parents can do well
- capacity to get alongside parents
- non-judgemental
- ability to use a mixture of open and closed questions e.g. 'So when this is happening, what is your child learning from that? Is that what you want?'
- being able to reflect back what people are saying to you
- good listening skills, good communication
- being able to acknowledge feelings but not get drawn into all the stories
- basic generic group work skills and ability to facilitate others
- ability to manage conflict and deal with resistance
- work within a multi-cultural environment
- creating a safe and supportive environment for learning
- encouraging parents to develop new skills
- motivational interviewing.

For Family Nurse Partnerships, some additional descriptors emerged which reflected the one-to-one delivery of the FNP programme, the closer relationship developed with parents, the prioritisation of engagement and the specific role of the nurses as a positive 'model' for teenage parents. Important practitioner characteristics and skills were seen to be:

- tenacity and persistence
- elastic tolerance (particularly when parents missed appointments)
- role model
- empowering young people rather than doing things for them.

Other clinical skills included engagement and the ability to avoid taking rejection personally and the use of motivational interviewing. Reflective practice and openness to continuous learning were also identified as critical skills for Family Nurse Partnership teams. Reflective practice involves the ability to reflect on action as part of a process of continuous learning (Schön, 1983).

> *The nurse has to be very highly skilled to be able to work out what it is that the client needs and to deliver it in the way that the client needs.*

Manager, Family Nurse Partnerships

Family Nurse Partnership practitioners were conscious of being a positive adult influence for their clients, something which is identified in a breadth of literature on risk and resilience as an important protective factor potentially affecting adolescent outcomes such as reduced violence, involvement in sexual activity and substance misuse (Oman *et al*., 2003; Aspy *et al*., 2004).

> *Maybe you are a role model, because some of their mothers are not the role model that they necessarily want. Some of the mothers want to be their friends, and maybe they think 'I've got enough mates, I actually want somebody who's a bit stable, solid, secure'.*

Nurse, Family Nurse Partnerships

This need for a role model was echoed by a few parents who recognised that they had not had the most positive parental relationships themselves and were seeking compensatory perspectives and skills.

> *I didn't have a normal life and I was always on the streets [or in] squats from when I was 16 and I was immature. I didn't have a 'normal' perspective.*

Parent, programme attender

Family Nurse Partnership practitioners also talked of the therapeutic challenge of maintaining the boundary of a relationship which was long term and which could be very intense.

> *You have to really listen to what they're saying and not just pretend to listen, because they'll see that straight away. You have to care, but you also have to maintain that professional boundary, so you don't overstep and become a friend to them. They have to be clients, you cannot become a part of their lives in any other way than [as] a professional. You need somebody with very high professional standards, but who can also show that they're warm, empathetic and they care about what happens to that client.*

Manager, Family Nurse Partnerships

Many of these characteristics and skills are identified in research as fundamental to effective practice and the promotion of change as part of evidence-based practice. Asmussen (2011) notes that practitioner skill in the delivery of evidence-based programmes involves:

- creating a safe and supportive environment
- questioning parents in a way that leads to openness and maintains appropriate balance
- encouraging parents to develop and apply new skills
- relating the learning to each family's story line.

Staff trustworthiness, empathy and listening skills have been associated with the formation of an effective therapeutic alliance supporting parents' motivation to maintain engagement with programmes (Orrell-Valente *et al*., 1999; Kazdin *et al*., 2006) and contributing to positive changes in parenting practice (Moran *et al*., 2004; Bell, 2007; Eames *et al*., 2009; Eames *et al*., 2010). Webster-Stratton identified collaborative facilitation, skilled questioning and particularly Socratic questioning techniques (e.g. the use of guided questions to help parents consider their beliefs around parenting and explore workable solutions) as central to helping parents understand and process the need for change (Webster-Stratton & Herman, 2010). Motivational interviewing techniques have been identified as effective in facilitating parents to work through resistance to change (Prochaska *et al*., 1994; Miller & Rollnick, 2002).

The picture that emerges is of an engaging, empathetic and trustworthy practitioner whose practice goes far beyond just delivering the essential ingredients of a programme manual. They have highly developed communication, collaborative, therapeutic and group facilitation skills, combined with the ability to employ these complex skills in a responsive yet disciplined and reflective manner.

What parents wanted from practitioners

All parents agreed that the qualities and skills of the facilitator or practitioner were important for them in terms of their attendance and attitude to the programme.

> *"I definitely think who you've got running the course definitely is a big thing. It is for me, anyway."*
>
> Parent, programme attender

Parents had slightly different priorities in their explanations of what they wanted from practitioners delivering evidence-based programmes. Many more parents than practitioners valued practitioners who had children themselves (and sometimes those with behavioural difficulties).

> *"She's been through the same thing, so when we're saying that our child is doing this, she's saying well [her son] was doing that but we started doing that and he seems to be all right with that. It's worth us thinking, well, if it's going to work for her it might work for us. So it's a bit easier for us [but] I think it's both experience and the training."*
>
> Parent, programme attender

Parents from a Bengali focus group also valued a worker who spoke their language and understood their community, life and cultural experiences. Having a practitioner with shared attributes has been noted previously in research to contribute to the efficacy of programmes (Orrell-Valente *et al*., 1999).

Other practitioner skills valued by parents included:

> *"They've got to be nice and know what you're going through. They don't want to be I'm better than you. You want someone that is down to earth generally."*
>
> Mother, programme non-attender

> *"You wouldn't want someone who's straight-laced, you need someone who can break ice and make things light-hearted."*
>
> Parent, programme attender

> *"You don't want to feel like someone's preaching to you ... not condescending."*
>
> Father, programme non-attender

> *"They knew what they were talking about."*
>
> Mother, programme attender

> *They were really nice when we had the discussion they came across as really lovely ladies, you know, knowledgeable, if they didn't know the answer, they said that they would go and find out and come back to [you]. They are all totally committed, really sincere and very professional and were able to take on other people's circumstances and treat people as individuals.*
>
> Father, programme attender

On most occasions it was clear that adept practitioners reduced parents' awareness of the structured nature of programmes. However, a few talked of practitioner-related difficulties which had impeded their engagement, either because of a need to rush through content or because of an inexperienced and unconfident facilitator.

A number of parents explained that the biggest barrier for them would be 'someone who's just preaching from a book'.

Key findings

- Recruitment for evidence-based parenting programmes has expanded over recent years thanks to former government funding, but a significant proportion of trained workers did not eventually deliver programmes.
- Family Nurse Partnership recruitment and training are more stable because of ongoing central government involvement.
- Workers needed to aim towards developing therapeutic integrity, namely, delivering the key ingredients of the programme seamlessly – using both a strong alliance with parents and a range of highly developed skills to support change.
- The key skills that were identified for practitioners include an engaging, empathetic and trustworthy approach; highly developed communication, collaborative, therapeutic and group facilitation skills; and the ability to work reflectively and responsively.
- Parents also valued practitioners who were themselves parents and who had experienced similar challenges and life experiences to their own.



8 Delivering programmes as intended

Delivering programmes as they were intended is vital for successful implementation and to achieving desired outcomes. This involves both recognising the essential ingredients which lead to better outcomes and faithfully replicating them (i.e. delivering a programme with fidelity).

Fidelity is the faithful implementation of these essential programme components. Changes to the programme's components could have unintended consequences on programme outcomes and reduce their ability to change behaviour (Arthur & Blitz, 2000; Webster-Stratton & Herman, 2010). Evidence-based parenting programmes use manuals and programme-specific training to ensure that fidelity is maintained. In addition, those in charge of managing programmes can use programme-specific supervision as an opportunity for continuously developing learning and the monitoring of outcomes and delivery.

This chapter looks at the issues of delivering programmes as intended, including the use of supervision and monitoring, as well as the extent to which programmes are adapted and extended at the local level.

Summary of literature

Successful implementation of evidence-based programmes relies on recognising the essential components which lead to better outcomes and faithfully replicating those activities and conditions (i.e. delivering a programme with fidelity) (Fixsen *et al.*, 2005; National Collaborating Centre for Mental Health, 2010).

When practitioners deliver evidence-based programmes as intended, good outcomes are more likely to be achieved (Forgatch *et al.*, 2005; Eames *et al.*, 2009; Furlong *et al.*, 2012); positive results have been observed when delivery achieves 60–80% fidelity to the original model (Durlak & Dupre, 2008); likewise, when programmes are not delivered as intended, poor outcomes can occur (Fixsen *et al.*, 2005).

Good quality supervision and coaching plays an important part in ensuring programme fidelity and quality assurance and contributes to the overall efficacy of evidence-based programmes (Peterson *et al.*, 1988; Payne & Eckert, 2010; Lindsay *et al.*, 2011).

Effective supervision and coaching:

- builds on programme training encouraging a process of continuous learning and developing necessary skills;
- supports compliance with the original programme components;
- encourages reflective practice;
- is both regularly scheduled and responsive to requests for expert consultation.
  (Durlak & DuPre, 2008; Cross & West, 2011; Torrey *et al.*, 2011).

Broader implementation literature on evidence-based practice stresses the importance of specially trained clinical supervisors, with the use of specific therapeutic adherence measures (Scott, 2008b).

Programmes can be adapted successfully but must not interfere with the core components of the programme (Durlak & Dupre, 2008); some adaptations (e.g. language or cultural adaptations) are considered more appropriate than others (e.g. changing the number or length of sessions, using untrained practitioners or fewer staff) (Asmussen, 2011).

Our findings

Results from our national survey indicate that parenting leads were generally happy with their ability to deliver evidence-based parenting programmes as intended (see Table 2). Overall, only 13% of respondents felt there were problems in delivering a programme as intended.

Table 2: Extent to which workforce issues were a problem for respondents in the national survey

	% very frequently or frequently a problem	% rarely or never a problem
Failure to deliver the programme as intended	13%	55%
Supervision	27%	53%

In comparison, visits to locality sites revealed considerable variability in terms of the degree of attention to and importance placed on fidelity and the mechanisms and systems used to ensure compliance with successful programme models.

Supervision

A 'train and hope' approach is not sufficient to equip workers to deliver evidence-based programmes effectively (Stokes & Baer, 1977). Studies indicate that a mix of programme-specific supervision and coaching is an essential driver for encouraging desired skills when implementing evidence-based programmes (Fixsen *et al*., 2005). Supervision in this context is an activity usually distinct from operational and clinical supervision associated with workers' day-to-day employment. It focuses specifically on promoting and supporting the key essential ingredients of an evidence-based programme which are associated in research with maximising positive outcomes.

Effective supervision and coaching:

- is regular and structured but also offers opportunities for *ad hoc* consultative learning
- builds upon and reinforces programme-specific training and standards supporting continuous learning
- uses and develops reflective learning
- develops practitioner skill
- supports evidence-based adaptations

- uses a variety of techniques to feed back on performance, encouraging greater compliance with the programme and supporting desired behaviour changes
- enables the supervisor to pick up broader barriers to implementation (e.g. organisational problems, poor targeting).
  (Fixsen *et al*., 2005; Groark & McCall, 2008; Asmussen, 2011)

Spectrum of approaches

Locality visits revealed a number of methods used for programme-related supervision, including:

- peer coaching
- scheduled individual sessions
- supervision by national programme monitors
- external supervision by a psychologist
- *ad hoc* consultation with parenting leads or peers.

As suggested by the literature, good quality, programme-related supervision focuses in a detailed and systematic way on supporting practitioners to deliver programmes with fidelity as well as on developing therapeutic skill. The extent to which this quality of supervision occurred in localities was variable.

In some instances, our findings suggested confusion over what was meant by supervision, with case management supervision (i.e. that related to day-to-day work outside the programme) sometimes being confused with programme-specific supervision.

There were examples of programme-specific supervision being delivered in an opportunistic as well as a planned manner. Nurses in the FNP programme described how informal support from other team members occurred alongside more formal supervision and made a fundamental difference to their professional skills.

> *"I think because we feel quite safe in the team, we're OK to [say] 'I did this visit and it just went pear-shaped'. We will talk about that either within supervision or informally."*
>
> Nurse, Family Nurse Partnerships

> *"I've always been a reflective practitioner, I've always considered myself open to new ways of working, but looking back this has probably been the only thing that has made me change [the way I work] in any fundamental way. I think it's really important that we [understand] how this learning is disseminated. It's had such a powerful impact on me in a way that helps to change how other practitioners work."*
>
> Manager, Family Nurse Partnerships

Indeed the FNP supervision experience appeared to encourage reflective thinking and facilitate a supportive team environment, while also developing practitioners' ability to monitor their own fidelity.

> *"You listen to other people talking: you think, 'Oh, I've gone off track a wee bit, I need to pull back', and so you do that."*
>
> Nurse, Family Nurse Partnerships

> *"The girls will come into supervision and say 'I've not seen this client for x amount of weeks, I'm really struggling to get hold of them' and we'll discuss ways of re-engagement in [both] group and individual supervision."*
>
> Nurse, Family Nurse Partnerships

> *"It's about being open and always questioning what you are actually doing."*
>
> Nurse, Family Nurse Partnerships

Furthermore, in considering the differences between the commissioning of FNP and other evidence-based parenting programmes locally, one strategic manager acknowledged that there were very different intensities of supervision commissioned for these programmes. The tighter structure for FNP was due to a firm requirement from programme developers that the programme would only be made available to local areas if they signed up to a tight and clearly specified process of supervision and coaching.

> *"Supervision is a pivotal part of FNP, the national unit dictates that these things have to be in place. Now if you look at other parenting programmes, they'll say that you've got to have a trainer but they don't necessarily say, you've got to have the supervision or anything like that."*
>
> Strategic Lead, Public Health

In the case of broader evidence-based parenting programmes, approaches to supervision varied considerably from place to place, and in some areas within localities. Supervision of these programmes depended primarily on the degree to which the parenting team line-managed those delivering programmes, and on the resources and time they had to supervise and coach practitioners directly.

Models of supervision and coaching observed for parenting programmes during this study included:

- a parenting lead working with a senior practitioner (whose special interest was fidelity) supervising and coaching colleagues in the parenting team on adherence to the programme
- parenting leads delegating this responsibility to operational line managers, some of whom were trained in the programme, while others were not
- the practitioner having two supervisors, one the worker's operational line manager overseeing broader workload, the other taking direct responsibility for coaching the practitioner on implementation and fidelity related issues
- the use of peer supervision
- the use of *ad hoc* consultancy and telephone calls for additional support.

Interviews with practitioners also pointed to differences in the importance placed on fidelity during supervision. In a few instances, supervision had halted altogether. Practitioners usually linked this to budget cuts (e.g. staff shortages, limits on staff time and priority on finding funding over other tasks).

> *"[Supervision] is not being offered now because the funding changed and so it's not been authorised by the parenting team."*
>
> Early Years Worker, children's centre

Peer coaching

The availability, frequency and content of peer coaching varied between localities. Some areas offered termly meetings, organised and led by managers or senior members of the parenting team with a specific focus on maintaining programme fidelity. In other cases, peer supervision was less predictably available, with little input from the parenting team, seen more as a way of sharing good practice and 'helping each other out' rather than as a means of ensuring fidelity to programmes. As a rule, peer

coaching was more commonly used as the main source of supervision when parenting practitioners were based outside parenting teams (e.g. children's centres, schools, FIP teams).

Training for supervisors

Discussions with practitioners also pointed to variations between programmes and local areas in how much training was expected and available to those supervising these programmes. Some supervisors had no experience of delivering programmes, some had received training but had no experience delivering, others had training and experience, and in a few instances supervision was provided by a senior practitioner with highly developed clinical skills. With FNP, training for supervisors was facilitated not just through training, but supervisors also had access to coaching themselves and had regular materials supplied to help develop their team's skills.

> *"And along with the formalised teaching we also get workbooks from the national unit that we work through as a team. Part of my role is to facilitate that learning for the team."*
>
> Manager, Family Nurse Partnerships

One commissioner felt strongly that there was real scope to improve the training of supervisors for all evidence-based programmes. However, he also noted the resource implications of this proposal:

> *"You need to train the supervisors, so there's another problem there if you're using an evidence-based programme and there are very few supervisors around. Where do you get the supervision? There's a kind of time lag in developing these programmes; it can take quite a few years to get people trained up to the level of supervisor."*
>
> Deputy Director, CAMHS

What do practitioners value?

Overall, practitioners and managers valued supervision and recognised its importance. However, differences emerged with less experienced staff seeming to prefer direct supervision from 'experts', while more experienced staff were satisfied with peer or group supervision.

Practitioners with less experience were concerned with delivering programmes as intended and valued guidance and support to help them to embed good practice and to help with judgements about appropriate adaptations.

> *"I think we need supervision from a senior person because [we're] feeding back ... and as a team making those little tweaks to the course."*
>
> Early Years Worker, children's centre

Highly skilled and experienced practitioners on the other hand were less troubled about their access to regular supervision although the literature still emphasises its importance even for more experienced staff (Payne & Eckert, 2010; Lindsay *et al*., 2011). One such practitioner described the effect of experience on practice and supervision:

> *"[Supervision] needed to be quite strong in the beginning [because] you weren't sure about things ... you were like 'Oh, what's that about? What's that strategy? I don't really understand how to do it?' [But] the more you do it, the more you know that you know it."*
>
> Early Years Worker, children's centre

Nurses working in Family Nurse Partnerships (FNP) were also quite flexible in their approach to supervision. On balance, they felt they developed more, professionally, from regular, weekly team

supervision with their manager and peers in comparison with more formal one-to-one supervision with their manager. FNP research looking into the main reasons why parents on the FNP programme had better outcomes with nurses than with para-professionals (Korfmacher *et al*., 1998) suggests that nurses, as a result of their professional skills, were able to make good clinical judgements about appropriate adaptation in their one-to-one work. Para-professionals, on the other hand, needed tighter supervision to promote fidelity.

Monitoring

Programme fidelity was monitored via two primary mechanisms:

- pre and post measures completed by parents, related to course outcomes (e.g. parenting skills, depression and anxiety scales)
- fidelity checklists completed by practitioners after every session, focused on the essential ingredients of the programme (e.g. which videos were shown, how much time was spent on different parts of the manual).

In two local areas additional information on families was collected (i.e. family background, education, parenting, worklessness, health). Some managers and practitioners delivering evidence-based programmes outlined difficulties with getting timely access to good quality information to inform practice development and decision making.

Most localities were still developing ways to analyse their programme-related data, with one locality outsourcing the analysis to a university.

> *"We felt [the analysis of outcomes] was really important on the Strengths and Difficulties Questionnaires and the questionnaires we do pre and post for Triple P. I wouldn't have the time to analyse all those, so we pay to send them off and they send us back a report."*
>
> Manager, parenting team

In one area, multi-agency strategic work had facilitated the development of a computer based 'tracker' system which helped both managers and practitioners to track families' needs, outcomes and progress following the programme. One school described how the tracker could be used:

> *"You can track children that have been on a Families and Schools Together programme. We can look at the impact on their learning from primary through to secondary [school]. We will be able to track where they've been and what they've had and the impact it has on their learning."*
>
> Head Teacher, school

There were, however, no systems in place that allowed practitioners to compare the outcomes achieved by parents on their programme with national or local outcomes. This limited the ability of practitioners to understand how their practice affected outcomes compared with national norms and to use these results to inform their future practice.

In contrast, Family Nurse Partnership practitioners were able to assess their progress regularly by inputting evaluation measures collected from their paperwork into a web-based reporting system which analysed how well they were adhering to the clinical applications of the programme (Korfmacher, Kitzman & Olds, 1998). One manager who had previously worked in health visiting felt the FNP approach went beyond 'number crunching':

> *Working in FNP [has] made me very conscious about how important it is to have the evidence that you're getting some outcomes; you know there's no point delivering something if you can't evidence those outcomes. I think maybe some services out there are not as clear about that. I'm not saying that some programmes may not work but I think that the evidence to back up those programmes and what outcomes they achieve may not be [there].*

Manager, Family Nurse Partnerships

Overall, FNP nurses were very much aware of how their delivery of the FNP programme compared with national standards of programme fidelity and outcomes for their clients. During interviews FNP nurses often knew their individual retention rates and were able to discuss concerns in team meetings when they could see their progress slipping.

Quality assurance

Implementation research indicates that the assessment of implementation, including ongoing fidelity monitoring and quality assurance, is a key factor in the successful implementation of evidence-based practice (Durlak & DuPre, 2008; Torrey *et al*., 2011).

> *You can argue that if you're meeting those fidelity measures then your outcomes are likely to be the same as they were for the [randomised controlled trials] and therefore your outcomes are likely to be good as well.*

Manager, Family Nurse Partnerships

Systems of quality control were variable from area to area with some sites controlled locally and others controlled by a national organising body. In most localities, parenting team managers were responsible for monitoring and controlling the quality of evidence-based parenting programmes. However, the extent to which managers were able to monitor and control programme quality varied between localities.

In one local area, the manager and senior practitioners in the parenting team were involved in a very tight system of quality control. They had a clear understanding of all parenting programmes being run in their locality, insisting that anyone outside the parenting team wanting to deliver a course would be subject to fidelity checks. They used a variety of techniques to ensure the parenting programme was delivered in the way it was intended, including observing practitioners during sessions, ensuring newly trained practitioners delivered with a senior practitioner and carrying out extensive practitioner evaluations.

> *We do [fidelity checklists that come with the programme] at the end of every session as well as at the end of the programme and [the practitioner evaluation] goes to [the parenting team manager]. She'll identify from that anything that needs to change. It'll be discussed as well in team meetings.*

Senior Practitioner, parenting team

In other areas more limited use was made of observations, extensive practitioner reviews, or the use of experienced practitioners to support the delivery of newly qualified practitioners in other localities.

In contrast, the parenting team in another local area was still in the process of developing their systems of quality control as budget cuts had significantly reduced the ability to overview practitioners' adherence to the programme. As a result, there were several examples of programmes not being delivered in the way they were intended, with some untrained practitioners delivering or

instances where one practitioner was delivering instead of two. A few practitioners had expressed concern that without more robust quality control, people had 'pretty much free rein to run it how they like'.

In FNP, quality assurance was, in part, overseen by the national FNP unit:

> *"We also use the FNP advisory board in the quality assurance process, so they get that data and every year we have an annual review where the national unit come, look at the data, look at how the team are performing, look at the outcomes and, so that's part of the quality assurance process as well."*
>
> Manager, Family Nurse Partnerships

For the most part, FNP nurses were responsible for their own quality assurance, monitoring their delivery and outcomes for their clients, and comparing these with national standards. The FNP system certainly offered more opportunities for practitioner-led quality assurance than other programmes.

Overall, the underlying differences between localities' ability to control quality appeared to be linked to the role of the parenting team within the locality. Localities that were more likely to engage in quality control were those where key members of the parenting team (i.e. managers and senior practitioners) placed priority on this aspect of delivery and had the resources to devote attention to fidelity monitoring and quality assurance as a key part of their role.

Key components of good quality assurance appeared to be:

- monitoring outcome data to identify when fidelity is slipping
- observation of staff delivering programmes with debrief sessions to reflect on practice
- systematic use of practitioner evaluations (i.e. using programme-specific fidelity checklists)
- ensuring newly trained practitioners deliver with a senior practitioner
- timely feedback of performance data (e.g. practitioner evaluations, observations) within a supportive and trusting context.

Adaptations

Guidance occasionally suggests that evidence-based programmes may be adapted from their original design. Acceptable adaptations appear to be those that are negotiated with the programme developer (or supported through a reflective supervision session in the case of Family Nurse Partnerships) (Asmussen, 2011). Changes might include adapting the programme to better reflect the culture or language of the community in which it is offered, altering the programme to accord with an organisation's calendar, or to reflect the preferences of the staff members facilitating (O'Connor *et al.*,

Table 3: Acceptable and less acceptable adaptations to programmes

Acceptable adaptations include:	Less acceptable adaptations include:
■ changes in language ■ changes in images ■ changes in cultural references	■ changes in number or length of sessions ■ changes in key messages, topics or skills ■ using untrained practitioners ■ using fewer staff ■ missing out exercises

2007). While it is generally acknowledged that some adaptations may be justified (e.g. changes to help the programme resonate with a specific target audience), changes to the content, duration, or delivery style of the programme can diminish its effects (O'Connor, Small & Cooney, 2007; Asmussen, 2011) (see Table 3).

A range of adaptations were observed across localities:

- increasing the number of sessions (e.g. eight weeks instead of six)
- offering a higher-level intervention before a lower-level intervention has been tried
- changing how contact was made (e.g. making home visits instead of phone calls)
- missing out catch-up or preparation sessions
- changing language
- delivering with one practitioner
- delivering with untrained practitioners.

Comparing these adaptations with the relevant literature, it is clear there were cases where practitioners were making some potentially problematic adaptations to programmes. Yet, there were also marked differences in how these problematic adaptations were managed.

Practitioners made adaptations based either on their own personal preference or on feedback from parents. Most sites had felt the need to increase the number of group sessions, seeing this as a way to boost engagement.

> *"So we changed the structure of the course slightly due to feedback. We added an extra group session and took away one of our telephone sessions as a result of feedback from parents. We just took it on ourselves because it was what we needed to do to make our group work better."*
>
> Early Years Worker, children's centre

All localities, including those that had relatively high levels of quality assurance, appeared to make changes to programmes without consulting their developers. Only in one instance were adaptations planned and negotiated with programme developers, when a Family Recovery Project practitioner delivering Triple P had wanted to make a number of changes to the programmes.

> *"I spoke to Triple P and they said, yeah, as long as you're delivering the actual work you can stretch it over so many more weeks. So we ran it over eight weeks rather than five. We didn't do the telephone consultations; we did the home visits. Then months down the line when I was still talking to [the developer] Triple P put something on their website saying that you can alter it."*
>
> Practitioner, Family Recovery Project

In some cases adaptations had developed due to financial constraints. For example, one provider was unable to use two trained practitioners to deliver a parenting programme, despite the fact they saw this as a potential problem for fidelity.

> *"We always delivered with two trainers and recently we've had to cut down to one trainer, which is quite a big change really. We're not quite sure what the challenges are going to be for that. And in terms of fidelity they're a bit more vulnerable in terms of sticking to the programme."*
>
> Manager, voluntary sector organisation

Another worker explained how she had a tendency to avoid role-play in her work due to a lack of confidence in delivery; she resolved this eventually by co-working with someone more confident in using this technique and was able to appreciate the difference it made to the group's learning.

Localities where potentially problematic adaptations were made as a response to budget cuts were also those where overall monitoring and quality control mechanisms were still under development.

Extensions: post-programme support

Providers sometimes extended programmes by offering post-course support that embedded learning from the intervention. Most practitioners identified a need for some form of post-programme extension, for example through booster sessions.

> *"So there's no follow up and it's just 12 weeks and that's it. We're expected to change lifestyles and everything else and that's just not the way it is, is it? A lot of parents once they've had some of these things pointed out, they do work well and keep things in practice, but they do need someone to just keep reminding."*
>
> Head Teacher, primary school

The need for post-course support was also picked up by one practitioner working with a parent who had previously completed FNP.

> *"[A parent] was feeling quite down. So I asked her a number of questions and realised she had [completed] FNP, [but] afterwards she didn't quite know what to do with herself."*
>
> Manager, children's centre

Current research into evidence-based parenting programmes has little to say on the role of post-programme support, and there is relatively little guidance on how programmes may be extended. This may be linked to the fact that in most cases research rarely extends beyond the first year after the intervention (Barnes *et al*., 2011; Furlong *et al*., 2012). However, broader research and guidance acknowledges that some children with more complex needs may benefit less from positive parenting programmes, requiring more holistic assessment of their needs and ongoing work to help parents consistently apply techniques (Frick & White, 2008; National Institute for Health and Clinical Excellence, 2008). Some parents who themselves have multiple needs may also need help with wider challenges (e.g. substance misuse and mental health problems) affecting their own and their children's progress. For example, the children of parents with more severe psychiatric conditions have been observed in one study to benefit less from standard evidence-based parenting interventions (Reyno & McGrath, 2006).

For some programmes, such as *Families and Schools Together* (FAST) and *Strengthening Families, Strengthening Communities* (SFSC), one of the distinct goals is to develop sustainable community cohesion that continues after the programme sessions have finished. Generally this translated into peer groups that continued to meet after the course had finished, sometimes with the support of programme practitioners. In one area, practitioners tracked these post-programme activities as part of their monitoring of parent outcomes. Practitioners generally reported that interest 'dwindled out once the initial excitement had gone', though one area found that a parents' forum at a local children's centre was a good way of seeing parents and to 'follow up on what's going on in their lives'.

In some cases, practitioners delivering programmes would identify parents requiring more support and would take responsibility for supporting them through one-to-one support.

> *When we finished the course, we recognised the fact that she still needed help, so I offered to visit her at home and just run through it on a one-to-one. And that really worked for her: me just going in, supporting her and her partner, who wasn't able to attend group.*
>
> Early Years Worker, children's centre

In other cases, practitioners would make a more general offer of support to parents.

> *So once the course is finished we'll give everyone our telephone number at the office; we invite them to phone us at any point.*
>
> Early Years Worker, children's centre

One local area was in the process of piloting a more formal offer of post-programme support, using an educational psychologist to work individually with parents who felt they needed extra input after their parenting course. Though still relatively new, the practitioner had parental feedback that indicated the support was successful.

> *[One woman with two children involved in CAMHS] said she was really glad that she had done it because it felt very different to other professional involvement that she had before. She felt she'd been listened to and got practical support in the way that she needed it in terms of practical ideas to deal with her child. She'd actually never had that from anyone before, so she felt she was happy to have this service on top of everything else because it was meeting her needs. Some of the other professional involvement she had felt like assessments and she never got anything back.*
>
> Educational Psychologist

Generally, post-programme support was inconsistent and not always targeted in a systematic way, based on risk factors in the literature. On the plus side, it was often based on who practitioners identified over the course of a programme as needing additional support.

Key findings

- Programme-specific supervision can play an important role in building on training and supporting continuous learning; however, it is inconsistently used to support the quality of what is currently provided. There was some misunderstanding about the exact purpose of supervision/coaching and its critical role in:
  - supporting delivery as intended,
  - providing ongoing training in programme-specific skills,
  - helping with complex clinical decision making.

  Some supervision was delivered by managers not trained in evidence-based programmes.
- Practitioners delivering parenting interventions generally struggled to monitor their own practice. There was limited scope for practitioners to compare their individual performance with national or local standards.
- Training for supervisors was largely not available for those delivering standard evidence-based parenting programmes; on the other hand FNP supervisors received external supervision and regular learning sets to develop supervisory expertise.

- Tight quality assurance and coaching systems should be included as a core part of what is commissioned to support the effectiveness and improve the chances of economic returns on investment in evidence-based programmes.
- There was mixed evidence about programme adaptation. On some occasions adaptations had been negotiated with developers; on others they were the result of weaker fidelity or budget cuts.
- There was also little evidence–informed discernment of which parents and children might require further support and follow up.



9 The strategic infrastructure for parenting programmes

Strategic and organisational activity provides an important infrastructure for the effective implementation of evidence-based parenting provision. However, planning operates in a complex world influenced by a range of fast changing and potentially competing priorities. This chapter explores the role played by strategic activity in facilitating well-implemented programmes and tracking improved outcomes for children with behavioural problems.

Summary of literature

Research into the distinct contribution made by organisational and strategic structures to programme effectiveness is at an early stage (Fixsen *et al*., 2005). However, the available evidence suggests that effective implementation requires:

- a broadly hospitable political, economic and strategic environment facilitating cross-agency collaboration and shared commitment to the desired outcomes of evidence-based programmes (Fixsen *et al*., 2005; Durlak & DuPre, 2008);
- stable and sustainable funding (Fixsen *et al*., 2005; Durlak & DuPre, 2008);
- an outcome-focused approach (Friedman, 2005; Cox & Hughes, 2007; Asmussen, 2011);
- the availability of good quality comprehensive data with well-developed systems for exchanging reliable information about need, consumer experiences and outcomes as well as performance of individuals, teams and organizations (Fixsen *et al*., 2005; Cox & Hughes, 2007; Asmussen, 2011);
- clear, SMART (specific, measurable, achievable, realistic and timely) goals, negotiated and owned in partnership with other key partners and measured against regular process and outcome evaluations; (Virgo, 2009; Goodal & Vorhaus, 2011);
- a high-level local champion who acts as advocate, coordinator and programme supervisor (Goodal & Vorhaus, 2011);
- involvement of parents and other local interests in the selection and evaluation of programmes (Fixsen *et al*., 2005).

The broader policy context

There is currently broad policy support at national level for early intervention and the expansion of evidence-based parenting interventions. Support from government was welcomed by many interviewees during visits. Many of these developments had led to a period of continuous review as local authorities had attempted to weave new initiatives, funding and opportunities into strategic activity.

Managing change

However, we also identified a turbulent and potentially 'hindering' (Fixsen *et al*., 2005) strategic environment characterised by 'massive change' culturally, operationally and financially, requiring urgent energy to sustain progress. As with other aspects of implementation, experiences varied widely from area to area (See Box 7).

Box 7: Commissioning changes in schools

During the course of this study, schools were in the process of assuming greater commissioning responsibilities for pastoral services provided in their settings via the introduction of the Pupil Premium. They were also dealing with the transfer of some commissioning responsibilities from local authorities to schools themselves. The establishment of new school academies (state-maintained independent schools often set up with the help of private sponsors) in some local communities was also changing commissioning and partnership relationships.

Parenting programme providers were generally vigilant of the greater commissioning powers of schools. Indeed, some parenting teams had anticipated recent commissioning changes and had made proactive efforts early on to consolidate working partnerships, to publicise referral systems and to promote the evidence-based benefits of programmes to head teachers in these settings. Tighter collaboration was accomplished through a variety of other means including:

- seconding parenting practitioners into learning communities or into school support services such as attendance teams
- using incentives to encourage school staff to run groups (e.g. to help cover the costs of a crèche, to cover ongoing training and support materials in evidence-based programmes)
- training educational staff and school liaison staff to deliver programmes
- parenting teams providing consultancy and supervision to support those delivering parenting programmes in school settings
- developing a strategic lead for local learning communities with a specific responsibility for parenting developments.

One local area was still in the process of re-negotiating links with schools after recent commissioning changes; as a result practitioners observed that school delivery in the area had been somewhat undermined.

Many practitioners and leads talked with resignation and sometimes frustration about practice and commissioning landscapes characterised by shifting sands, a 'stop start' approach and transition.

> *"You get something set up and the goal posts move. This [is the] state of flux that we've been going through over the last four or five years as things change nationally and funding streams end and others start up, and people come and go. [It's] quite disappointing when you lose key players. But that's what happens, so we move on and build new relationships, but that just takes time, doesn't it?"*
>
> Head Teacher, primary school

> *There has been a lot of change, there's a frustration with that I think – that things change before they're properly embedded.*

National survey respondent

A number of strategic and parenting leads also reflected that 'managing the change' and anticipating further potential 'derailments' absorbed a significant part of their time.

Changes mentioned by interviewees included:

- the multiplicity of policy directives and developments affecting this area of work (some linked with the election of a new Government) stimulating ongoing review of local strategic plans
- straitened economic circumstances requiring widespread cuts, rationalisation of remaining services and 'smarter' working.

> *Our strategic director is under so much pressure to make the books balance. We haven't really had any funding; we've sort of scrabbled around to find [our senior practitioner] a few hours here and there just to keep [her] onboard.*

Manager, voluntary sector organisation

Sustainability of funding

Respondents described an array of funding streams for evidence-based parenting programmes, some of which were relatively stable but many of which were non-recurrent and insecure. In some areas a number of funding streams were being pulled together into a single 'pot' to fund parenting work, mirroring the ambition of the previous administration's Total Place pilots based on integrated funding and service provision (HM Treasury, 2007).

The funding streams identified during this study included:

- the Early Intervention Grant
- the (now former) extended schools budget
- 'Inclusion' budgets
- Arms Length Housing Management Organisation funding
- public health monies
- Primary Care Trust or NHS contributions
- Improving Access to Psychological Therapy funds for training
- community budgets – supporting work with 'Troubled Families'
- school budgets (former extended schools monies and Pupil Premium monies)
- charitable funds
- corporate social investment.

> *The school sees the benefits of it and they're happy to put some funding in, but I do [also] work closely with Waitrose and ASDA. I've just got some money from them and the [local] Community Foundation, so I do look externally to try and bring some money in as well. But I think that because I built up those partnerships when there was money, then people want to be part of successful things.*

Parent Support Worker, school

Many interviewees commented on the contrast between the unavailability of funding now, in comparison with three years earlier when government 'pump-priming' money was supporting initial roll-out of proven parenting programmes.

> *If only we'd had less money at the beginning that had gone on longer and there had been a way of ring-fencing [it]. You know, just the lack of ring-fencing is a nightmare from our point of view.*

Practitioner, parenting team

A common concern during interviews with strategic leads and practitioners was a 'worry that the finances might not be here in the future'.

> *If you want security in this world, you need your money to be from the core budget, base budget, because that's mainstreamed. The people who are not secure are the people who have their money from the Early Intervention Grant, from grants from local government, all of that sort of thing. They're here today gone tomorrow.*

Parenting Commissioner

> *We require funding from the local authority Early Intervention Grant to continue and their priorities change from year to year.*

National survey respondent

The national survey echoed this change in fortunes in financial circumstances over recent years, with parenting leads reporting the following reductions in funding over the past two financial years:

- In the financial year 2011/12, 71% of parenting leads had experienced reductions to their budgets for evidence-based parenting programmes, with about a third indicating substantial reductions.
- Half of parenting leads also reported reductions to their budgets in the previous financial year.

Strategic leads discussed the challenge of funding investments in early intervention requiring a 'leap of faith' with 'efficacy being demonstrated long term: sometimes a few years, sometimes a generation' later.

> *We weren't quite sure what the outcome or what the impacts were going to be. We're investing all this time; let's hope it's going to pay off.*

Manager, parenting team

Commissioners also faced the difficulty, at a time of significant and pervasive public spending cuts, of finding additional money (either new money or through disinvestment in other services) to divert towards evidence-based programmes, while at the same time needing to provide services for young people who had not had the benefit of early proven help and thus still generated a demand for acute services. In the immediate future, as local authorities shifted to this culture of early intervention and awaited for returns to be generated over time, commissioners faced the additional expense of 'double running' costs (Beecham & Sinclair, 2007) and investments in early intervention competing with funding for required acute services.

> *The real problem in this is long-term investment. You're investing now to save in ten years and that's really difficult for people to get their heads round. That's a big cultural change for organisations, because people will say, 'we're dealing with this now, we can't deal with what [will happen] in ten years'. How do you balance that? How do you make that pay off? That's a big challenge.*

Director, CAMHS

> *It's not a statutory service and we've made the budget balance this year, but there'll be more money to find next year; it's not great.*

Policy Lead, local authority

In the immediate future, a shift to preventive services will almost certainly cost money (Beecham & Sinclair, 2007). While in the long run preventive intervention may well lead to improvements in the life chances of children, it will not lead to financial savings in the short term. For this reason a shift towards these preventive services must either come from 'new money' or depend on economies in current services. As well as the challenge of tracking outcomes over lengthy periods, interviewees also noted that savings were often distributed across a range of public sector budgets, to the benefit of services such as criminal justice which had little strategic link with children's services and no responsibility to re-distribute savings.

For a number of parenting leads 'non-recurrent monies' led to a 'hand-to-mouth' approach requiring prolonged 'scrabbling around' and persistence to seek out future funding opportunities. 'Chasing' funding opportunities occupied a significant amount of the parenting leads' time.

Funding and quality of provision

A few interviewees raised concerns about the impact of sustained cuts on the quality of evidence-based programmes. Some local leads expressed fears that poorly informed commissioning could result in decision makers cutting corners and commissioning the bare bones of what was required to make a programme work effectively.

> *My worry is that you sometimes might get people who strategically don't understand the models and would just commission the two hours of the programme. [But] it's not just the two hours of the programme; it's prep time for the practitioner and it's money for a crèche, money for transport, money for food. So how well do you think people understand that at the strategic level? Here, I think they understand it quite well. I don't know if they always remember it but I think there is that understanding. I think we're quite fortunate in that [there are] people who are still linked to the operational work and also really committed to families.*

Policy Lead, local authority

There were, indeed, signs of cuts which were affecting quality and effectiveness:

> *All the things we know make the course effective; [making things] slightly more challenging than they were before.*

Manager, voluntary sector organisation

For example, crèches had been cut (or availability reduced), despite evidence from research of their importance in engaging and retaining parents on the programmes (Kazdin, 1996; Snell-Johns *et al.*, 2004; Social Research Unit, 2011a; Social Research Unit, 2011b).

> *At the moment we're struggling very much with pressures. We can't finance the crèche and parents can't come if there's no crèche, so that's a bit of a block.*

Head Teacher, primary school

Furthermore, a few interviewees described outreach work being reduced as a result of cuts and workload pressures.

> *"Because of local funding we have had to cut back and so we've lost half: we've only got half a lead team which are half of family support and half of an outreach. They tell us that we can deliver the same but we can't really in reality."*
>
> Head Teacher, primary school

Such attempts to reduce programme costs are likely to be a false economy in the longer term if they significantly affect enrolment and retention rates.

In a minority of comments, the economic downturn and related public spending cuts were seen in a more positive light. A few felt that they had reduced duplication and simplified hierarchies which had previously acted as barriers to multi-agency working. In another instance they had led to closer working between the voluntary and statutory sectors.

Organisational components of effective implementation

Research has identified a variety of organisational factors supporting effective commissioning and high-quality implementation including:

- establishing a strong champion and proactive leader
- services being commissioned on the basis of need
- establishing shared multi-agency outcomes with clarity about measurement
- mapping services throughout a local area based on need
- facilitating strong administrative support to help implementation.

(McCormick *et al*., 1995; Gager & Elias, 1997; Mihalic *et al*., 2002; Kam *et al*., 2003; Fixsen *et al*., 2005; Cox & Hughes, 2007; Durlak & DuPre, 2008; Asmussen, 2011)

The 'champion' role

Implementation literature advocates the importance of adopting a local champion as a facilitator of implementation, although this proposal has not yet been robustly tested (Rogers *et al*., 2002; Fixsen *et al*., 2005). The functions of the champion vary depending on the stage of implementation but include:

- mobilising stakeholder support
- raising awareness of the evidence-based programme and particularly its cost-effectiveness
- identifying how programmes might contribute to broader outcomes
- securing consistent buy-in
- establishing feasibility
- collaborating with planning
- identifying opportunities to embed the plan
- liaising with the programme designer
- awareness of the 'shifting ecology' influencing implementation
- making adjustments while maintaining the key components of the programme
- ensuring the programme doesn't die through lack of essential financial and political support
- consistently advocating, cajoling, recognising, rewarding and encouraging
- sourcing other champions to maximise broader buy-in.

Fixsen (2005) also suggests the importance of having someone coordinating 'core drivers' of effective implementation such as:

- staff selection
- pre-service and in-service training
- ongoing consultation
- coaching
- staff and programme evaluation
- facilitative administrative support
- intervening with other systems.

Parenting leads in local case study sites had, on the whole, adopted the role of both champion and 'orchestrator' of the implementation process, often moving between front-line work and strategic planning. For example, in a number of local areas, parenting leads were promoting evidence-based programmes to stakeholders who had changeable or fragile buy-in: they kept a tight overview on fidelity, coordinated coaching, paid attention to risks to the programme and developed occasionally creative contingency plans; they liaised with stakeholders to develop strategy and shape outcomes, analysed or facilitated feedback of data; and they chased new funding streams. The role was potentially an extensive one and in sites where leads continued to carry other significant workload commitments, juggling responsibilities appeared challenging with pockets of weaker implementation revealed during some interviews in these local areas. This appeared a particular risk if tight systems of fidelity monitoring and effective coaching were de-prioritised. One survey respondent also underlined how absence of a parenting lead or commissioner in their local area had led to less-expert commissioners failing to prioritise parenting programmes in commissioning contracts with providers.

Generally, it was clear that the role of local champion made an important contribution in driving implementation, warranting further consideration in research. Given the potential health and economic benefits of well-targeted and well-implemented programmes, there would also appear to be scope for local champions to promote these benefits in strategic settings such as Health and Wellbeing Boards.

Inter-agency working and buy-in

A mixed picture emerged of multi-agency collaboration during this study. The majority of our case study sites talked of benefiting from collaborative relationships with a range of partners and strategic leads.

> *"I'm very lucky [here] because we're working very collaboratively."*
>
> Parenting Lead

However, qualitative responses in the national survey identified 'lack of multi-agency sign-up and delivery' as a concern in some areas. Even in case study sites there were pockets of poor multi-agency buy-in to evidence-based programmes, with inconsistent commitment from schools and poor awareness among many GPs. Both of these groups had potentially important opportunities to pick up childhood behavioural problems and act as a gateway to evidence-based interventions.

Strategic leads were uncertain about how much priority would be given to parenting and evidence-based programmes in the new Health and Wellbeing Boards and NHS commissioning structures and there was a lack of clarity about how to use these structures to support good quality implementation in the future. Many areas were in the very early stages of preparing for these changes.

Needs assessment and use of data

In most case study areas, decisions about spending were predominantly shaped through multi-agency needs assessment and through the negotiation and identification of shared outcomes. On occasions interviews with parenting leads and partners suggested that the rationale behind some commissioning decisions was not always transparent.

A good quality local needs assessment, together with mapping of local services, provides an important basis for shaping outcomes and developing strategy (Cox & Hughes, 2007; Asmussen, 2011). It provides objective information on the strengths and weaknesses of a population and encourages dispassionate decision making, reducing the risk of decisions based on vested interests and building trust between partners (Asmussen, 2011).

Many local areas had begun to map their local services and assess needs on an area-wide basis using local data.

> *"Our data isn't brilliant but across [our area] we've all got little bits of data, or shed loads of data, that we try to come together and share. We'll get the figures about the numbers of children on medications for ADHD, so we know we're one of the high prescribers. We know that [there] are a lot of the kids that are being referred [with] a lot of behavioural problems and a lot of conduct disorder type problems, so it's just trying to build on that. Some of it [is] hard data and some of it [is] more soft qualitative stuff or the actual knowledge of people doing that work on the ground."*
>
> Director, CAMHS

In many areas, Public Health Directors also appeared to be playing an increasingly important role providing population level data.

> *"We have probably in this department got quite a lot of influence because we have got the population information and the public health knowledge and application."*
>
> Lead, Public Health

There was, as yet, little evidence of parental and children's participation in commissioning and parents' and children's voices (where appropriate) were rarely systematically threaded into this needs assessment process.

Establishing shared multi-agency outcomes

A significant barrier affecting partnership commitment to evidence-based programmes was a lack of awareness that severe behavioural problems in childhood have major long-term implications for health, social care, education and criminal justice budgets. Where this awareness did exist, commissioning arrangements with limited-time horizons and the inability to re-distribute benefits that might be widely dispersed across a range of budgets could act as a barrier to the commissioning of programmes. Some areas were attempting to overcome these barriers through working with partners to establish shared outcomes designed to inform delivery.

In one area, the parenting lead had worked with a range of strategic partners (including the strategic lead for local learning communities) to negotiate a set of jointly owned outcomes, based on local needs-assessment data.

> *The people who are involved in a number of different elements will sit round the table and say, 'to get 95% of the population with 5 A to Cs including English and Maths is the best possible indicator of a prosperous and healthy future'. One of the things that you need [to get this] is full attendance at school, or near full attendance. How do you get full attendance? We don't know, let's have a look: who doesn't come to school? So you track back like that. How do you get those youngsters in school? One of the ways is parenting; it's only one of them. Another one might be social care, one might be wheelchairs, one might be school transport, one might be schools near home and one might be an interpreter. Then you say, right this is what we need and if you're doing true commissioning, you then draft a spec and say how can we get this cheapest? It's not looking for the cheapest, but the cheapest that can offer well.*
>
> Parenting Commissioner

Measuring impact

Finding ways of measuring and demonstrating both the longer-term but sometimes the shorter-term impact of evidence-based programmes was a challenge for local sites.

Some areas had developed 'tracker' systems with local partners in an attempt to improve their evaluation of joint action to improve outcomes. In one local area, a basket of thirteen indicators had been developed which included education, parenting, worklessness, and health. This data provided continuous feedback about local need but also acted as a tracker system measuring families' progress (see Box 8). Another area had the opportunity to interrogate educational data to track longer term outcomes for children whose parents attended parenting programmes.

However, a number of problems were also identified relating to the management and analysis of this data. These included:

- parenting leads requiring training and technical support to demonstrate their impact and make the most of available local data;
- the difficulty in drawing conclusions with any degree of certainty that a single intervention was responsible for any change, particularly in the absence of a clear comparison group;

> *And [the parenting programme] probably does [have an impact] but it's like anything it contributes towards, you could never say it was that one thing. And I think it's very, very difficult to measure that. I'd love some guidance on that.*
>
> Manager, parenting team

- IT systems still did not generally link up across different agencies and so were acting as a barrier to tracking outcomes;
- a concern about the over-reliance on quantitative data to provide a picture of progress without some supporting qualitative data;
- local authorities having no spare funds at present to bring in academic partners to support analysis;

> *Maybe if there were more academic partners involved then that might be a way to be able to [achieve that]. We've done some of that but I think we could do more.*
>
> Policy Lead, local authority

- challenges with taking a long-term approach.

> *I think that within local authorities it's quite difficult to commit to that longitudinal approach.*
>
> Policy Lead, local authority

Generally, measuring the longer-term benefits of evidence-based programmes was identified as a complex task, largely beyond the expertise of local strategic teams and requiring some technical support. Forthcoming plans to establish a national Early Intervention Foundation, linking research activity more closely with the development of evidence-based programmes, may support better information about long-term outcomes in the future.

Box 8: Basket of Indicators

> *"[We used] the Common Assessment Framework. All the CAFs were looked at and the top 13 indicators were put [in the basket]. You can use that research. The police can use it as well. They may do a piece of work which they think is about stopping fires, but if you actually look at those indicators, they're doing so much more than that. It gives you a common thing to measure against.*
>
> *So [with] our indicators they're all allocated five points. At the end of 18 weeks, how far have they moved? You can track that. So you might have not sorted it all out, but at least you've reduced the incidence of it and you can measure that. It's also used to look where we need to put the money. So in the learning communities, all the data's collected together. And if there are masses of children, say at 9 to 14 coming in, then we'd say, right, why are we working at 5 and 6? Because there's a limited amount of money, we've got to make sure we're working in the right areas. Even in the learning communities, if one of them is not referring in and there's not loads of need, then should we have a PSA [public service agreement] in there, or staff in there? So that's how they use the data."*
>
> Manager, parenting team

Key findings

- While the current policy context is supportive of early intervention, local authorities are experiencing multiple transitions, economic constraints and insecure funding.
- The management of this turbulent external environment and the 'scrabble' for new pots of money dominates the time of many parenting and strategic leads.
- Financial constraints can affect core drivers for programme effectiveness resulting in false economies.
- The role of the parenting lead as a champion and 'orchestrator' for evidence-based programmes seems important to the process of implementing and sustaining activity.
- Measuring the impact and value of evidence-based programmes is complex, with benefits accruing over long timescales and across a range of budgets with no mechanism for re-distributing savings.
- There is little parental involvement and participation in planning.



10 Conclusion and recommendations

Severe behavioural difficulties in childhood cast a long shadow, compromising future life chances in a variety of ways. Our study has highlighted that although most parents of children with these difficulties seek help, the services they approach generally have poor awareness of the long-term significance of early behavioural problems and of the availability of effective evidence-based interventions.

Even when parents and children are able to access support, shortcomings in implementation put the benefits of intervention at risk. These include: poor targeting of programmes, ineffective engagement of families, poor strategic support, and failure to deliver the programmes as intended and with therapeutically skilled staff. In extreme cases, badly delivered programmes can actually make children's problems worse, not better.

This publication represents the findings of the first part of the centre's study of the implementation of parenting programmes and aimed to identify and analyse the main barriers and enablers associated with their effective delivery. Based on the findings set out in this report, we make the following recommendations:

Recommendations

1. **National outcome and inspectorate frameworks should include targets relating to improved outcomes for children with behavioural problems and the quality of parenting programmes.**

   These should include the development of Child Health, Public Health and National Health Service Outcomes frameworks and also the statements of objectives for relevant regulatory bodies such as Ofsted. These generally fail to acknowledge the significance of early behavioural difficulties, whether as a developmental marker for poor long-term outcomes or as an opportunity for effective early intervention. Ofsted's children's services inspection framework currently makes no mention of parenting programmes; neither are there prompts to consider quality assurance in these services.

2. **The Department for Education and the Department of Health should spearhead a national campaign to broaden public and professional awareness of childhood conduct problems.**

   This campaign should cover both the profound impact of severe behavioural problems on children's life chances and the enormous potential benefits of evidence-based early intervention. Parents should be closely involved in this campaign, as well as relevant professional bodies such as the Association of Head Teachers, teaching unions, the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health. Our study has shown that parents want routine information to be shared in advance of problems developing, explaining how children can be different and may need different parenting approaches, the benefits of acting early to address behavioural problems and who to contact for help should they have concerns.

3. **Health and Wellbeing Boards should promote greater awareness of maternal mental health problems.**

   This should particularly focus on maternal mental illness in the peri-natal period as a treatable risk factor for conduct problems in children. Boards should also promote more systematic responses to maternal mental health problems, particularly anxiety and depression, emphasising routine assessment of broader family support needs, the role of parenting programmes in treatment plans and closer links between child and adult services.

4. **Health and Wellbeing Boards should promote the development of integrated pathways for children with severe behavioural problems.**

   These pathways should draw together health, education and social care activity. They should be underpinned by multi-agency agreements and include a continuum of evidence-based interventions for different levels of intensity of need. The pathways should have a clear entry point for parents seeking help and for those making referrals. Parents also stressed the importance of having someone to help troubleshoot problems with gaining access to appropriate support, particularly for those children with the most extreme and distressing difficulties.

5. **Health and Wellbeing Boards should review local arrangements for partnership working.**

   This should include the development of shared outcomes and associated monitoring systems. Strategic leads and partners particularly need effective technical support with evaluation to track the benefits of early intervention for families as well as the cost savings over time and across a range of non-related budgets (see also recommendation 10). This may be an area for development through the work of the planned Early Intervention Foundation.

6. **Joint Strategic Needs Assessments should include estimates of the numbers of children with behavioural problems.**

   The prevalence of early behavioural problems can vary from community to community and local areas need to ensure that they have sufficient provision to match local need. Estimates of the numbers of children with severe and moderate problems should be based on instruments such as the Strengths and Difficulties Questionnaire (SDQ) and compared with the local availability of parenting programmes.

7. **Health and Wellbeing Boards should ensure that parenting programmes are targeted at the families who need them most.**

   Routine use should be made of tools such as the SDQ in early years work and in schools to identify and support families in a non-stigmatising way. An average SDQ score could also be collected for each programme delivered in order to track the accuracy of targeting.

8. **Commissioners of parenting programmes should always ensure that contracts with providers include an allowance for expenditure on measures designed to maximise take-up and minimise drop-out, especially among socially-excluded and high-risk groups.**

   Commissioners should also systematically monitor take-up and drop-out data for local parenting programmes; they should have the ability to compare this data with national norms.

9. **Local children's services should improve staff recruitment and ongoing training.**

   This should cover: the development of clear competencies, selection criteria and procedures for the recruitment of staff delivering and supervising parenting programmes; arrangements for programme-specific coaching and supervision; and plans for the provision of training for staff in such skills as motivational interviewing, reflective practice, guided questioning, programme-

specific supervision and group facilitation skills. Parents and young people should also routinely be included as part of the staff selection process.

10. **Central guidance and tools should be prepared to support greater consistency across the country in programme-specific supervision, fidelity and outcome monitoring and other quality control systems for parenting programmes.**

    Practitioners need simple and responsive data systems allowing individual practitioners and managers to compare programme or local implementation outcomes with national averages. This system could mirror the work of the CORC (CAMHS Outcomes Research Consortium) learning collaborative which has supported national outcome monitoring and quality assurance in child and adolescent mental health work. This work could be taken forward by the Early Intervention Foundation perhaps in collaboration with CORC and others with expertise.

11. **Local children's services should identify a high-level champion and 'orchestrator' for family-based programmes.**

    Champions should be given sufficient time, resources and technical/analytical support to fulfil a complex role.

12. **Local children's services should provide parents with simple and engaging ways of getting support.**

    Parents wanted clearer information about who is able to attend programmes, clear and reliable access, appropriate contacts and prompt follow up after seeking help. They talked about the importance of how initial invitations to programmes were formulated and communicated; they also reinforced the importance of their bond with the referrer as an enabler for engagement. Practitioners talked of the importance of persistent and proactive promotion and 'elastic tolerance' in the face of initial scepticism on the part of some parents.

13. **Health and Wellbeing Boards, local commissioners and providers should ensure that parents have a greater role in the commissioning, planning and delivery of family-based programmes.**

    We found little evidence of parental involvement in strategic development or in the design of engagement strategies. In one area, an innovative parent-led delivery model had dwindled through lack of investment and coordination.

14. **The Office for National Statistics should undertake a new national survey of childhood mental health.**

    The last national prevalence survey of children's mental health took place in 2004 and is increasingly out-of-date.

Next steps

Building on the findings of this report, and in consultation with the practitioners and experts involved in its preparation, the second phase of our work will focus on practice development. This may include addressing some of the gaps already identified in the above recommendations, such as: working with a local area on the development of an integrated, 'stepped' pathway for childhood behavioural problems; working with parents to co-produce promotional strategies and materials to strengthen engagement; working with parents to develop a model of parent involvement and strategic feedback for Health and Wellbeing Boards; working with a local area to develop an effective targeting tool and strategy; developing a 'ready reckoner' to support commissioners and providers in assessing the potential cost savings generated by early intervention over time and by agency budget; and creating a supervision toolkit for practitioners involved in parenting programmes.



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Appendix: Questionnaire sent to programme leads across England, Northern Ireland and Wales.

Thank you for taking the time to complete this short survey.

We would like you to answer these questions to the best of your ability, on the basis of the experience in your locality.

Please note that we use the term 'parenting interventions' as a shorthand to describe a range of evidence-based parenting programmes for children under 11 with or at risk of severe behavioural problems (for example short-term parent training programmes such as Triple P, FAST, Incredible Years or Strengthening Families, as well as Family Nurse Partnerships where these are provided locally).

1. Who is your employing organisation?

- ❑ Local Authority
- ❑ NHS
- ❑ Voluntary Sector

Other (please specify)

2. Priorities: parenting interventions in my locality are a high priority

- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree

Additional comments /explanation (optional):

3. Funding: what is happening to the budget for parenting interventions in your locality?

	It has reduced a lot	It has reduced a little	It's the same as last year	It has gone up a little	It has gone up a lot
2011/2012	❍	❍	❍	❍	❍
2012/2013	❍	❍	❍	❍	❍

If readily available, estimates of actual percentage changes would be very useful.

4. Level of provision: what is your best estimate of the total numbers of parents completing parenting programmes each year in your locality?

5. Provision relative to need: the number of parenting interventions delivered in my locality roughly matches the number of families with children affected by severe behavioural problems.

- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree

Additional comments /explanation (optional):

6. Referrals: I am broadly happy with the number and appropriateness of referrals from the agencies listed below in my locality. Please tick all that apply.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
GPs	❑	❑	❑	❑	❑
Schools	❑	❑	❑	❑	❑
Health visitors/ Early years workers	❑	❑	❑	❑	❑
Adult mental health/adult substance misuse services	❑	❑	❑	❑	❑
Community safety teams/housing	❑	❑	❑	❑	❑
Social work teams	❑	❑	❑	❑	❑

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Criminal Justice agencies	❑	❑	❑	❑	❑
Voluntary sector providers	❑	❑	❑	❑	❑

Additional comments /explanation (optional)

7. Engagement: please give a rough estimate of the proportion of parents in your locality who:

1) Do not attend after being offered a parenting programme

2) Fail to complete after starting the programme

8. Barriers to engagement: to what extent are the following barriers to engagement and retention important in your locality?

	Very important	Important	Neither important or unimportant	Quite important	Not at all important
Practical barriers (e.g. Timing, parental awareness, venue, crèches, access to interpreters).	❑	❑	❑	❑	❑
Resources (waiting lists, insufficient resources to prepare parents for programme).	❑	❑	❑	❑	❑
Suspicion of programmes/ stigma.	❑	❑	❑	❑	❑
Parental characteristics (e.g. parents in chaos or in crisis, parental confidence/ social skills).	❑	❑	❑	❑	❑
Style of service (e.g. lack of outreach or other active means of engagement).	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

Additional comments /explanation (optional):

9. Workforce: to what extent are the following workforce issues a problem in your locality?

	Very frequently a problem	Frequently a problem	Occasionally a problem	Rarely a problem	Never a problem
Staff training	❑	❑	❑	❑	❑
Quality of workforce	❑	❑	❑	❑	❑
High turnover of staff	❑	❑	❑	❑	❑
Supervision	❑	❑	❑	❑	❑
Failure to deliver the programme as intended	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

Additional comments /explanation (optional):

10. Other: are other key issues critically affecting the delivery and implementation of parenting programmes in your locality?

11. Best practice: can you outline any examples of best practice in your locality in the delivery and implementation of parenting programmes (e.g. novel ways of reducing drop-out)?

Many thanks for your valued contribution to this survey. We will automatically send a link to this email address so that you can access the final publication when it is launched.

Please let us know if you would like to discuss issues in this survey in more detail.

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Realising a better future

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