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Early prevention of conduct disorder: how and why did the North and Mid Wales Sure Start study work?

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Abstract

Both the government and local service providers in the UK are becoming increasingly aware of the possibility of improving child outcomes through the delivery of parenting programmes. Government initiatives, such as Sure Start, Pathfinders and Flying Start are a positive step forward, yet programmes sometimes fail to work in service settings. This article describes the components necessary to deliver effective interventions, exploring the need to choose an evidence-based parent programme, implement it with fidelity and evaluate the outcome. It describes the steps taken in North and Mid Wales to do this and reports briefly on the successful outcomes achieved by delivering the Incredible Years Basic Parenting Programme to the parents of high-risk children in Sure Start areas.

Key words

conduct disorder; Incredible Years Parenting Programme; Sure Start; implementation fidelity

Introduction

Anti-social behaviour among children and adolescents is a large and increasing problem that has now become an important political issue. The governments in Westminster, Cardiff and Scotland are developing policies to prevent and reduce this anti-social behaviour (for example, Every Child Matters[1], Reaching Out: An Action Plan on Social Exclusion[2], Parenting Action Plan[3], Flying Start[4] and the Integrated Strategy for the Early Years) but the size of the problem is well established; the National Institute for Health and Clinical Excellence (NICE, 2006) reported that three per cent of girls and seven per cent of boys aged between five and ten years in the UK have clinical levels of conduct disorder. It is a condition that starts early and often persists, with 60% of three-year-olds with conduct disorder still exhibiting challenging behaviour at the age of eight (NICE, 2006). If left unresolved, these problematic behaviours may still be present in adolescence and adulthood and can include substance misuse, criminality, violence and significant ongoing mental health problems (Broidy *et al*, 2003; Coid, 2003).

Government-funded services are enabling authorities to develop services to address these problems. These include: Sure Start[5], the Pathfinder project[6] and the Family Intervention Projects (FIPs) in England[7]; Sure Start, Cymorth[8] and Flying Start in Wales; and the Integrated Strategy for the Early Years[9] and Sure Start in Scotland. But political will to prevent or reduce anti-social behaviour is not enough without informed evidence of both which interventions are effective and how to make them work in real life service settings. Unfortunately, this is not an easy task. Service providers have been faced with the problem of identifying an effective programme from the hundreds available and, equally importantly, finding out what

resources and levels of expertise are needed to implement the chosen programme effectively. The National Evaluation of Sure Start (NESS, 2005) in England has shown how hard it is to get this right. Since its launch in 2001 £3.1 billion has been invested in the scheme (Meadows, 2006), yet central Government failed to provide guidance about which interventions have proven effectiveness; service providers have therefore delivered widely differing services – some using existing evidence-based programmes and others developing their own (Belsky *et al*, 2006). As a result the £20 million non-randomised, area-based evaluation of the first three years of Sure Start in England suggests that what has been provided so far has failed to make a difference for the most disadvantaged families whose children are at highest risk of conduct disorder and serious anti-social behaviour (Belsky *et al*, 2006; Hutchings *et al*, 2007).

The disappointing results of the NESS evaluation appear to be in stark contrast to the existing research literature. Over 30 years of research has produced a wealth of findings demonstrating the benefits of structured support to parents of children with behavioural difficulties (Patterson, 1982; Gardner, Sonuga-Barke & Sayal, 1999; Webster-Stratton, 1998a; 1998b; Hutchings *et al*, 2007) although some programmes are considerably more effective than others (Hutchings, Gardner & Lane, 2004; Hutchings & Lane, 2005), particularly with high-risk and disadvantaged families (Reid & Webster-Stratton, 2001; Scott, 2005). Reviewing and interpreting these findings is a difficult and specialist task. As with all interventions for complex problems, differing methodologies are used on a multitude of target populations and findings differ with respect to for whom they are effective, how long the effects last and whether the programme has the tools for successful replication.

Sure Start in North and Mid Wales

For a variety of reasons, North and Mid Wales Sure Start services have delivered effective parenting support that has been rigorously evaluated and achieved successful outcomes with hard-to-reach families. As a result this work has influenced Government policy in terms of firmer guidance on the use of evidence-based programmes. Both in Wales (Parenting Action Plan, 2005) and more recently England (Reaching Out: An Action Plan on Social Exclusion, HM Government, 2006), the UK governments are now being more directive by specifying the use of parenting programmes with proven evidence of effectiveness (for example, the Parenting Action Plan (PAP) and Flying Start in Wales, and the Pathfinder and FIP project in England). This is a positive first step but there are still many challenges ahead for services to achieve effective implementation at a local level and the North and Mid Wales Sure Start project provides a useful demonstration of how to get this right (Hutchings *et al*, 2007).

The initial approach to Sure Start taken by the Welsh Assembly Government was similar to that in England. Money was given to support communities with the greatest numbers of children 'at risk'[10] but without guidance on what service to deliver or to whom. The bodies securing Sure Start funding in North and Mid Wales were varied and services were managed by health, education, Barnardo's, National Children's Homes and, in one case, a local voluntary committee. Several factors contributed to the development of effective services for high-risk children in North and Mid Wales.

- There was a local champion of evidence-based practice in the first author (Taylor & Biglan, 1998; Hutchings *et al*, 2004). She had a longstanding interest in preventing and treating childhood conduct disorder having worked in North Wales as a clinical child psychologist over the last 30 years. As a result she had good contacts with multi-agency service providers.
- There was a research team at the University of Wales Bangor, established in 1995, that provided information and consultation about what worked in terms of parenting support and had expertise in undertaking arms-length outcome research.
- There was locally available leader training, supervision and support in delivering the evidence-based Incredible Years (IY) Programme from the first author.
- Sure Start staff were already trained to deliver the IY programme and were enthusiastic about it. A survey reported their enthusiasm for the programme but also the difficulties that they were experiencing because of insufficient time, lack of administrative support and insufficient supervision. However, they saw great benefits for, and enthusiasm from, families that completed the course and leaders were anxious to continue to deliver the programme.
- Sure Start service managers were keen to make use of existing local expertise and enthusiastic about the idea of a research trial, so funding was sought for a research trial in which 11 centres would deliver the same programme and target families of high-risk children within Sure Start areas.

The Health Foundation agreed to fund an evaluation trial from October 2002 (£320,000 in total). This article briefly reports on the findings of the evaluation and discusses the reasons for these impressive results in terms of the need to adhere to five core principles that became apparent to the authors during their Sure Start replication:

1. Selecting an evidence-based programme for the target population
2. Developing a strategy for recruiting the target population
3. Addressing relevant service access issues
4. Ensuring implementation fidelity
5. Evaluating the programme delivery and outcomes.

1. Selecting an evidence-based programme for the target population

Thirty years of research have shown that some programmes have better evidence than others for reducing or preventing violence and anti-social behaviour, and some are either ineffective or counterproductive. For example, home detention with electronic monitoring for low-risk offenders did not reduce offending compared to standard community supervision without electronic monitoring (Sherman *et al*, 1997). More worryingly, a Cochrane Review[11] (Petrosino, Petrosino & Finchenouer, 2002) showed that a programme involving visits to prison by children at risk of offending was more harmful than no intervention at all, with these children subsequently more likely to re-offend than the control children.

There are many systematic reviews of parenting interventions, each using different inclusion criteria (eg. Mihalic *et al*, 2002; Barlow & Stewart-Brown, 2000; NICE, 2006). The review commissioned by NICE, for example, was rigorous in including only randomised controlled trials but did not include the need for independent replication or criteria needed for effective replication by others. The Center for Violence Prevention (University of Colorado) was funded by the US Government, Office of Juvenile Justice and Delinquency Prevention, to identify effective or 'blueprint' programmes (Mihalic *et al*, 2002). In their review of programmes they incorporated measures of both the quality of evidence for the programme and the likelihood that it could be delivered effectively in service settings. Their main criteria for identification of a programme as effective are that the programme has been evaluated in a randomised controlled trial (discussed later in this article), has been independently replicated (ideally in service as well as research settings), that outcomes have been followed up long-term, and that there are tools and materials to enable accurate replication by others. From 600 programmes reviewed only 11 met these stringent criteria. A further 21 met some criteria and were designated 'promising' programmes worthy of further research. Of the 'blueprint' programmes, the Incredible Years (IY) Basic Parent Programme (Webster-Stratton & Hancock, 1998) is particularly relevant to the high-risk pre-school children of most concern to preventive services. It has been researched and found to be effective with both clinical populations and high-risk pre-school children and their families (Scott *et al*, 2001a; Webster-Stratton, 1998b; Gardner, Burton & Klimes, 2006). Most studies of parenting programmes report that socially disadvantaged families do less well in such programmes than less disadvantaged populations (Dumas & Wahler, 1983; Hill, 1999). In the IY Head Start study (Webster-Stratton, 1998b), by contrast, parents of very high-risk children were targeted and did well both in terms of uptake and child outcomes. Thus, 88% of the 296 mothers who participated in the intervention completed half or more of the parenting sessions, and intervention families demonstrated improved parenting competencies and reduced negative child behaviours. Referring to this study Hartman, Stage and Webster-Stratton (2003) report that '*...as mothers are given opportunities to acquire further positive parenting skills, levels of economic disadvantage become less important in predicting treatment success or failure*' (p396). Further studies have shown the programme to be successful with Head Start parents who have mental health risk factors in addition to socio-economic disadvantage (Baydar, Reid & Webster-Stratton, 2003) and with more critical Head Start mothers and the most problematic children (Reid, Webster-Stratton & Baydar, 2004).

The four-year-old children in Webster-Stratton's (1998b) IY Head Start prevention trial (n = 426) are equivalent to the higher-risk pre-school children living in Sure Start areas in the UK that had not benefited from the Sure Start provision in England. Unlike Sure Start, Head Start services are not universal; they are targeted at families in high-risk communities that are on a low income and exhibiting other indicators of disadvantage (Webster-Stratton 1998b). Local Sure Start service managers and staff in North and Mid Wales were aware that without specific targeting, these high-risk families were unlikely to engage with the service. They also recognised that if these families could be recruited into the IY Parent Programme, in which their staff were already trained and experienced, it would be an opportunity to evaluate the programme with high-risk children living

in a very different cultural setting from that in which the programme was developed. Group leaders also made it clear that they needed additional supervision and resources to ensure fidelity in order to achieve good outcomes with this high-risk population. Service managers and the research team agreed to target three- and four-year-old children who were already scoring over the clinical cut off for behaviour problems on the Eyberg Child Behaviour Inventory[12] (ECBI) (Eyberg & Robinson, 1981), as reported by their primary carer. These children are at significantly increased risk of developing conduct disorder and later delinquency and were the very children that, it subsequently transpired, had not been helped by Sure Start services in England. Evaluation findings, with a sample of 19,000 9–36-month-olds, showed only very modest improvements for less disadvantaged children and weak but consistent findings that the most disadvantaged children did less well than comparable children in areas awaiting Sure Start funding (NESS, 2005). It seems likely that, when universal services were offered, they were more likely to be taken up by families that were less at risk of having children with conduct disorder; high-risk families were less likely to access the services (Belsky *et al*, 2006).

Unlike other areas, Sure Start services in North and Mid Wales, with the help of locally available expertise, chose a programme that had strong evidence of effectiveness with high-risk pre-school children and agreed to provide a service to a targeted high-risk population.

2. Developing a strategy for recruiting the target population

In the US Head Start Programme socially excluded families self-refer because of the financial (among other) benefits of participation, including free pre-school services for their children. In North and Mid Wales a different strategy was required to engage and recruit the parents of high-risk children. We drew on the expertise of health visitors, who visit all families with pre-school children and have extensive knowledge of child development. Area-based health visitors are well placed to identify children whose development and behaviour put them at risk of later problems, such as delinquency (Armstrong & Hill, 2001). A research health visitor was appointed to work with area-based health visitors to review their caseloads of three- and four-year-old children and identify those with behavioural difficulties with additional risk factors for the development of conduct disorder, juvenile delinquency and criminality tendencies (eg. family low income, single parenthood, several children and being young parents, or parents with criminal tendencies or drug/alcohol misuse problems – Patterson, DeBaryshe & Ramsey, 1989; Webster-Stratton, 1999; Hartman, Stage & Webster-Stratton, 2003). Most of the Sure Start services had a specialist health visitor on their team and many of these were involved in delivering the programme.

The local health visitor arranged a home visit during which the primary parent carer was asked to complete a checklist on their child's behaviour. The ECBI was administered and scored by the health visitor during the visit. The ECBI takes approximately 10 minutes to complete and consists of 36 items, each outlining a particular behaviour, eg. 'has temper tantrums'. Parents tick 'yes' or 'no' depending on whether they view this particular behaviour as a problem. Each item also has a 1–7 scale whereby 1 denotes 'never' and 7 denotes 'always'. Therefore two scores are yielded – one for problems and one for intensity of the behaviour. If the parent scored the child's behaviour as above the clinical cut-off on either of the two ECBI scales, intensity (127) or total problem (11), the child was identified as a potential target child and the ECBI results were fed back to the parent. The approach used by the health visitor was to say, '*It is clear from your report that your child has a number of challenging behaviours that concern you. These children can be harder to parent than most so you may find it helpful to come along to a group with parents of children with similar difficulties to see how you could help your child's development and readiness for school*'. This approach does not blame the parent, rather it returns to them the information that they have shared with us in completing the ECBI. This worked well. The health visitors had good relationships with most families and most, 178 of 221 identified by health visitors (81%), agreed to be visited by a member of the research team to learn more about the support offered. Of the 164 families visited and who were eligible at this stage, 153 (93%) agreed to take up the service. The eligibility criteria were as follows: the target child had to be three or four years old and residing with the primary caretaker; the target child had to demonstrate some problem behaviour as denoted by the clinical cut-off on either one of the ECBI scales; the primary caretaker had to be available at group session times; and the family had to live in a socially disadvantaged area. The 11 parents who were eligible and initially interested, but who did not consent to take part, declined for various reasons such as change of family circumstances, moving away or having an unwilling partner.

The IY Basic Parenting Programme is suitable for 2–8-year-olds but in a preventive intervention the earlier it is delivered the better, hence the age range of 3–4 years for this study. This programme can also be delivered as a treatment for conduct problems (eg. Scott *et al*, 2001a). There is also a programme for 8–12-year-olds and an infant toddler programme for 0–2-year-olds is currently being developed (see www.incredibleyears.com for more information).

So this approach succeeded in targeting and recruiting hard-to-engage parents with high-risk children. The strategy of arranging a home visit from a trusted professional, during which the parent shared information that was fed back in a non-judgemental way, was effective and most parents signed up for the support that was offered.

3. Addressing relevant service access issues

Access issues have to be considered for the chosen population. High-risk families have few resources and so gaining access to services is harder for them than for most families (Webster-Stratton, 1998b). Consequently they often do not engage with services (Hutchings *et al*, 1998). If they are to be successfully targeted there must be special attention paid to access and other issues that make their attendance more likely. Transport and childcare are clearly important in this respect but Webster-Stratton (1998b) also found in her Head Start trial that the provision of a family meal increased participation.

We ensured that all of the support that Webster-Stratton had provided was available to our Sure Start service providers and families. In Wales, our Sure Start centres were already providing crèches as a central part of their support to enable parents to gain access to a range of courses and activities. Where necessary these costs were supported with research funds because some services were providing the targeted parent group while also continuing to run universal access groups. Transport, usually by means of a taxi, was provided when needed as a way of ensuring access. This was important as in some rural areas the nearest bus stop would be a good 20–30 minute walk away and the use of public transport could be problematic for lone parents juggling young children, buggies and the additional paraphernalia that comes with having a young family. The provision of a meal for parents and children, which Webster-Stratton found to be such a powerful incentive, was not something normally provided by Sure Start services, so this was funded from the research grant. Groups ran between 9.30am and midday or between 12.30 and 3pm, so lunch was provided either before or after the group meeting. Group leaders and crèche workers joined parents and children for the meal, something that the workers found very helpful in developing their relationships with the families. It also provided an opportunity to introduce healthy food and many parents saw their children eating food that they would not have expected them to like. Like the Seattle parents in Webster-Stratton's (1998b) Head Start study, our parents gave very positive feedback about the meal, which meant that they did not have to organise a meal at home either immediately before or after the group. For families on limited incomes the meal was a financial bonus, while also providing a social experience for families who were often socially excluded. Sharing a meal also gave their children an opportunity to acquire additional important social skills (Webster-Stratton, 1998b).

So with some help from research funds families were provided with a crèche, transport and meals. This made programme access feasible for these target high-risk families and probably contributed to the high attendance and programme completion rates. From the 86 intervention families who completed post-intervention assessments 71 (83%) attended seven or more of the 12 sessions, with an overall mean attendance of 9.2 sessions (SD 3.2).

4. Ensuring implementation fidelity

Implementation fidelity means ensuring that the chosen programme is delivered in a way that replicates its original delivery and should therefore replicate its successful results. This is a topic whose relevance is being increasingly recognised (Mihalic *et al*, 2002). Whereas in the past the main problem was seen as the failure of service providers to choose evidence-based programmes we now know that, even when an evidence-based programme is chosen, service providers often fail to get the same results due to their failure to replicate the programme accurately or with fidelity. This may be because the programme developer has failed to include all of the information necessary for effective implementation by others, or because of failure of service providers to deliver the entire programme or because it has been 'adapted' in ways that prevent it from achieving the same outcomes. Other factors in service settings, such as lack of resources, suitably skilled staff and time, also make fidelity difficult to achieve. Implementation fidelity has been extensively researched by the Center for Violence Prevention at the University of Colorado, US. Five main components have been identified (Mihalic *et al*, 2002).

1. *Adherence* concerns whether the programme is being delivered as designed, with all the core components, to the appropriate population, with staff trained to the appropriate standard, with the right protocols, techniques and materials and in the prescribed locations or contexts.
2. *Exposure* or treatment 'dose' refers to whether the number of parenting sessions in a course and their frequency and length match the original programme.
3. *Quality of programme delivery* concerns whether the leaders are skilled in using the techniques or methods as well as being enthusiastic and well prepared.
4. *Participant responsiveness* assesses whether participants are actively involved in the programme.
5. *Programme differentiation* refers to whether all of the unique features of the programme are identifiable and present (eg. role-play practice and homework assignments).

Clearly the programme content needs to be delivered in full to ensure fidelity but delivery style is also very important, particularly when the therapist or programme leader is an active ingredient in the programme (Lambert, 1992; Duncan, Hubble & Miller, 1997). Effective programmes work in ways that are compatible with the parents' beliefs and values while collaborating with them and transmitting an attitude of hope without minimising the problem; they encourage clients to focus on present and future possibilities instead of past problems.

Many known active ingredients of effective programmes (Hutchings *et al*, 2004) are incorporated into the IY Parent Programme (Webster-Stratton & Hancock, 1998). In addition, it has all of the tools necessary for effective replication, including a basic leader training programme, ongoing consultation and support and materials for leaders and parents. There are checklists for monitoring both content and process and materials to support the collaborative leader style on which the programme is based. The leader certification/accreditation process involves submitting a full two-hour videotape of a session as well as leader records and parent evaluations in this study. A randomly selected tape from each group in the North Wales study was sent to an accredited IY trainer for assessment and all groups were rated as delivering the programme with fidelity, enabling programme leaders to achieve leader certification. This rigorous leader certification process, a core component of achieving fidelity, is not present in many similar programmes (Mihalic *et al*, 2002).

The first author agreed a contract with the participating Sure Start services. In addition to providing funds for lunches, transport and, where necessary, crèche support, the research funding provided all materials for the group. This included leader session folders and parent handouts, books and magnets for parents for the weekly refrigerator notes, a set of tapes or CDs of the book for any parents with literacy problems, raffle prizes for attendance and homework, a spare set of tapes to loan to parents who missed sessions and a copy of the self-study manual for parents to work on with the videotapes if sessions were missed. This meant that every parent received the same material at each session. Videotapes and cameras were provided to enable video recording of all sessions. To ensure fidelity of delivery the first author, an accredited IY trainer, provided three hours of weekly supervision for group leaders in Bangor (about 100 miles away for the Mid Wales groups). Leaders brought the videotape of the entire two hours of their last session to each session, together with parent home assignments and the principles or ideas that the parents had produced during the session. In return, service managers gave their staff sufficient time for all necessary between-session activities, including preparation for and review of sessions with their co-leader, keeping records of material covered, collecting weekly parent evaluations, making mid-week phone calls to parents and following-up parents who missed sessions. In addition to the two hours per week of contact time and three hours per week of supervision time, approximately 13.25 hours of additional time was spent on these activities per week (approximately 6.5 hours per leader per week), not including travel time or initial meetings with parents.

Group work with high-risk families requires skilled leadership to establish and maintain relationships as the parents can be both challenged and challenging. Leaders felt that their ability to do this in a collaborative manner had been considerably enhanced by the supervision process. They recognised that they had not previously delivered the programme in the evidence-based way that involved both thorough knowledge of the content and skills in collaborative process.

At least one leader in each of the 12 groups achieved the standard needed for accreditation by the end of the programme and in 10 groups it was achieved by both leaders.

5. Evaluating the programme delivery and outcomes

It is important to evaluate outcomes for several reasons. Despite the emphasis in some parts of public services on waiting lists and waiting times, there is a growing interest among service managers in children's services

in knowing about programme effectiveness in order to inform funding decisions. In terms of children with conduct disorder and at risk of later anti-social behaviour it is important to demonstrate the reduction of negative behaviours and an increase in positive behaviours. Evaluation can be by means of basic standardised, validated questionnaires completed before and after an intervention, or it could involve more costly but rigorous methods such as randomised controlled trials (RCTs). RCTs require two 'conditions', with parents randomly allocated to either the intervention condition or a control condition that does not receive the intervention. The two conditions can then be compared before and after intervention to see what, if any, effect the intervention has had. This was the design used to evaluate the IY Basic Parent Programme in North and Mid Wales, producing the first community-based study in the UK to provide a rigorous demonstration of the effectiveness of an evidence-based parenting intervention delivered with fidelity by regular Sure Start staff. The programme was evaluated in 11 Sure Start areas in North and Mid Wales with parents of pre-school children at risk of developing conduct disorder. The 153 participating families were randomised on a 2:1 basis: 104 to intervention and 49 to a waiting-list control condition[13]. Child problem behaviour and parenting skills were assessed via parent self-report and by direct observation in the home. At follow-up, significant improvement in parenting and child problem behaviour was seen on the vast majority of measures for the intervention condition only (Hutchings *et al*, 2007). For the 104 intervention children 82% were over the clinical cut-off of 127 on the ECBI intensity scale at baseline, but this dropped to 42% at follow-up one, and 88% were over the clinical cut-off of 11 on the ECBI problem scale at baseline but this figure dropped to 48% at follow-up (these figures are even better if we just look at the 86 parents who completed assessments at follow-up – 37% and 34% respectively). Furthermore, 61% of the 104 intervention children made a small to very large significant change (as measured by .03 to 1.5 effect sizes)[14] on both scales. Siblings were also assessed using the ECBI and it was found that 52% of siblings made significant improvements (reductions in problem behaviour) on the intensity scale and 49% on the problem scale (51% of siblings were over the cut-off on the intensity scale at baseline, whereas only 35% were at follow-up one). For the problem scale the figures were 53% dropping to 37%. For positive parenting behaviours 83% of the intervention parents made significant increases in the amount of positive parenting behaviours demonstrated in a half-hour observation. Most importantly these behaviour changes were robust and maintained up to the 18-month follow-up (Bywater *et al*, in preparation). In addition, we found that the programme worked equally well across all participating Sure Start areas, regardless of differing crime levels (Hutchings *et al*, 2006); this is an important finding as living in areas of high crime can impact on family and child behavioural problems.

It is also important, and desirable, to evaluate the costs of delivering the intervention and any benefits to society, for example, in a reduction of service. If these high-risk children do not receive a preventive intervention they are likely to cost a great deal to their families, their communities and society at large (Muntz *et al*, 2004; Scott *et al*, 2001b). A bolt-on study to the parent programme evaluation was therefore carried out and cost-effectiveness was evaluated. Findings showed that the parent programme represented good value for money (Edwards *et al*, 2007).

Conclusions

The fact that the IY parent programme was being widely delivered in North and Mid Wales provided the opportunity to seek research funding to undertake a randomised controlled trial of the programme with parents of high-risk children in Sure Start services. Health Foundation funding enabled the University-based research team to collaborate with Sure Start service managers and agree a research project, using strict research criteria, as a replication study of Webster-Stratton's (1998b) Head Start study in Seattle. This was the first high-quality early preventive study with high-risk children in the UK.

The Center for Violence Prevention identifies the involvement of the programme developer as being important and the consultation provided in this instance by Professor Webster-Stratton helped to ensure success. Replication is especially important when the differences between Seattle and Wales are considered. Seattle is a large urban city in the north-west of the United States. It has a multi-ethnic population of about three million people. Wales has a similar population size to Seattle (around 2.9 million people) but the population is distributed very differently and, in North and Mid Wales, is largely rural and predominantly bilingual.

The approach taken in this study focused on a target population of high-risk children similar to those eligible for Head Start services and unlike the prevailing Sure Start philosophy of universal community-based services in high-risk areas. Both this study and the NESS findings in England have contributed to a change in Government thinking. This is evident in Reaching Out: An Action Plan on Social Exclusion, published in September 2006, which recognises the need to target

high-risk children and their families to reduce social exclusion, anti-social behaviour and crime and reduce the costs to society, families and services.

We chose an evidence-based programme, identified a high-risk population and trained people to deliver it in a collaborative way. We ensured that it was delivered with fidelity as it had been when originally researched. By doing this we achieved results that parallel those achieved in Seattle by the programme developer. Governments in England and Wales are now funding greater use of this programme through PAP, Flying Start, Pathfinder and FIPS.

It is important to ensure that the people and agencies involved in the increased use across Britain of the IY programmes with high-risk populations also deliver it effectively with the core components of:

1. Ensuring that they target the right programme and develop an effective strategy for recruiting high-risk families
2. Making the programme accessible to these families via crèches, transport and meals
3. Ensuring that all materials are available and that leaders are trained, supervised and given sufficient time to deliver the programme with fidelity
4. Ensuring that programme supervision is available from someone who has delivered the programme and is well versed and experienced in both the social learning theory content and the collaborative process
5. Ensuring that there is evaluation of effectiveness (using standardised, validated measures).

To achieve good outcomes, authorities need to identify and support a staff member who has a thorough knowledge of social learning theory and collaborative process, experience of delivering the programme and supervision skills. In North Wales this was the first author, a clinical psychologist who also had a good research background. In Powys, in Mid Wales, an educational psychologist has been appointed to lead the development of the IY programmes. The Welsh Assembly Government PAP strategy to develop skills in delivering this programme across Wales recognises that it will take time for all of the 22 authorities in Wales to have accredited leaders who will be able to take a lead in ensuring effective implementation with high-risk families in their localities.

When they were helped to deliver evidence-based programmes with fidelity, Sure Start staff in North and Mid Wales demonstrated that they could deliver effective services to high-risk children and families with good outcomes and at a reasonable cost.

Summary of policy and practice implications

- Parent programmes can be effective in disadvantaged Sure Start areas when:
  - those who need help most are targeted effectively with the use of knowledgeable health visitors
  - parent programmes are implemented with fidelity
  - group leaders are supervised and accredited
  - barriers to attendance are addressed.

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Endnotes

[1] Every Child Matters: Change for Children (2004) is a Government approach with the aim for every child, regardless of their background or circumstances, to have the support they need.

[2] Reaching Out: An Action Plan on Social Exclusion (2006) sets out actions that the Government is taking to improve the life chances of those who suffer, or may suffer in the future, from disadvantage.

[3] The Parenting Action Plan (2005) is published by the Welsh Assembly Government (WAG) and sets out the Assembly's proposals to support mothers, fathers and carers raising children in Wales.

[4] Flying Start is a WAG funded service to support 0–3-year-olds and their families through education and family support, targeting high social exclusion areas.

[5] Sure Start is a UK Government initiative set up to offer family and child services in socially deprived areas.

[6] 18 local authorities in England have been funded by the Department for Education and Skills (DfES) to deliver one of three parenting programmes: Triple P, Incredible Years and Strengthening Families Strengthening Communities.

[7] 50 local authorities in England are funded by the Respect Task Force to take part in the Family Intervention Project (FIP) by delivering a programme from a menu set by the DfES including Triple P, Incredible Years and Strengthening Families, Strengthening Communities.

[8] Cymorth is a WAG organisation that works with providers, partners and policy-makers to improve the lives of people who need support.

[9] The Integrated Strategy for the Early Years is a consultation paper that aims to set out a framework for the effective provision of universal and targeted services for children and their families from pre-birth to age five.

[10] 'At risk' refers to children who are living in families with many risk factors for developing conduct disorder, for example low income, single parent, large families living in socially deprived areas with parents possibly suffering from mental health or criminality problems.

[11] Cochrane Reviews explore the evidence for and against the effectiveness and appropriateness of healthcare interventions (www.cochrane.org)

[12] The ECBI is a parent-completed questionnaire with 36 items asking about number and intensity of problem behaviours displayed by their child.

[13] The control condition parents are referred to as 'waiting-list' control as they are offered the programme/intervention after a typical waiting-list duration, in this case six months.

[14] An effect size is a standard measure of the strength of a treatment effect. Effect sizes of around 0.2 are considered to indicate a small effect, 0.5 medium and 0.8 or above large.

