20

Community-based Support for Parents

Judy Hutchings and Carolyn Webster-Stratton

SUMMARY

Rearing children is one of the hardest jobs facing adults in our society and one for which there is least preparation. Moreover, several aspects of the job of parenting have become more difficult in recent years. Much has been learned about the risk and protective factors associated with different developmental outcomes for children and the important role parents can play in promoting children's social, emotional and academic capacity and competence. Our current understanding is that many parents are not well prepared to do their best for their children.

In this chapter we consider factors that can make parenting more challenging and describe the growing number of interventions, in statutory and voluntary services, that have been developed to support parents and children within their own communities. We describe how working preventively and collaboratively with families within their own communities and building their links with schools can achieve good outcomes for children. Some of the information on practice has been drawn from work in Britain, where the first author is based. There is also a description of the work of the second author who is based in Seattle, USA. The principles, however, readily apply to and are informed by other settings.

The challenge facing parents today is growing. The increase in childhood conduct disorders, now involving up to 20 per cent of all children in Britain and the USA (Rutter et al., 1975), is one example of the problems faced by many parents. Early childhood conduct problems are occurring in increasing numbers and, if unresolved, lead to delinquency and subsequent adult mental health problems and/or violent criminal behaviour. These difficulties are costly to society (Kazdin, 1993; Scott et al., 2001a) and resistant to intervention if they are left untreated for too long. In financial terms these children cost ten times more than other children in regard to their demands on education, social welfare, community and mental health services and the judicial and penal systems (Robbins, 1981).

This growing problem is being tackled by public services in health, education and social welfare and by voluntary agencies, many of whom depend to a significant extent on state funding for many of their activities. The demand for effective programmes to curb and prevent children's disruptive, unruly and antisocial behaviour has never been greater. All developed countries are struggling to deal with the rise in antisocial behaviour, particularly involving substance use and often involving crime. As an example, juvenile arrests for serious violent crimes in the US have increased by 50 per cent in a ten-year period (Cook and Laub, 1998).

Conduct disorders are the most common reason for referral to children's mental health services (Offord et al., 1987) and the most frequent

problem domain in clinical practice (Kazdin, 1990). Even when a service is available, only 10 per cent of these children get access to a specialist service (Hutchings, 1996) and even fewer find their way to one where practice is well developed and evidence based (Scott et al., 2001b). Referred children are not necessarily those most in need of help. Many of the most needy families simply do not seek referral for mental health services or accept help because they perceive these services as stigmatizing and inaccessible.

The search for effective ways to prevent the costly problem of childhood conduct disorders has become a priority in most Western countries. Given the numbers involved, governments recognize that early community-based interventions are the most cost-efficient and effective way to approach this problem. 'Head Start' programmes in the US, and the newer 'Sure Start' programmes in the UK are attempting to do this. Interventions that begin in the early school years are a strategic and long-term attempt to prevent or reduce anti-social and rule-breaking behaviours before they lead to well-established negative reputations, academic failure and escalating problems in adolescence, of which persistent and violent crime are the extremes. Few services, however, succeed in addressing specific issues associated with recruiting parents who, by virtue of their multiple problems, have traditionally been hard to engage.

In the UK, the Sure Start programme, launched in 1999, provides community support for all families with children under the age of 4 years in designated high social-exclusion areas. The Head Start programme in the US, which was established in the 1960s, is shifting its focus from providing early enrichment for 'at risk' 4-year-old children, four hours, four days a week, to providing more comprehensive family support starting in infancy and extending to full day programmes. Unlike Sure Start, however, it is predominantly a means-tested, particularized (not universal) service in designated areas. Both Sure Start and Head Start are important services through which wide-ranging resources are directed to support families whose children are identified as being at risk. Both are currently being developed and researched.

Over the last century there have been huge social changes. Family size has fallen and 50 per cent of new mothers report not having had contact with a small baby before having their own. Many new parents have limited experience of young children, which restricts their knowledge of what to expect of their child and can result in unrealistic expectations. Many new parents no longer live near their families of origin, thus restricting their access to helpful advice and support. When this is coupled with increasing breakdown in couple relationships, single parenthood, unemployment, poverty and social isolation, child-rearing becomes disrupted and parenting more challenging.

We are now aware, more than at any other time in the past, that poverty is an increasingly common experience for large numbers of families, of whom many are single mothers. This is, in part, a result of growth of inequality in income, and loss of jobs in traditional industries resulting in declining unskilled and semi-skilled work. Families with children are over-represented among the poorest households in Western countries. Despite fiscal and other policies, an increasing number depend on means-tested benefits, and on loans and credit, for the money they need to survive. Low-income households are at greatest risk of falling into debt and those with larger families, and lone mothers in particular, are vulnerable both to debt and to the problems of borrowing money to pay off debts. The gap between the living standards of rich and poor households is growing steadily wider in the UK, even under a Labour Government, and the poorest households are not only losing out relatively but perhaps also becoming poorer in absolute terms.

There are increasing concentrations of poor families in specific geographical areas and escape from poverty is becoming increasingly rare. Poverty and unemployment diminish resources to resolve problems in child mental health and welfare through their effects on parents. Neighbourhoods with concentrations of marked vulnerability have child abuse and infant mortality rates many times higher than those found in better off local communities. At a time when the pressures and demands of parenting have become more complex, struggling with other socio-economic difficulties makes parenting yet more difficult.

Other aspects of society's development have contributed to added stresses for parents. For example television, which can be a valuable educational tool for children, also presents problems for parents. Since television shows how the other half live, children can demand things that are advertised on television and some of their peers have, which parents cannot afford. Children may demand to see programmes, because their friends watch them, but the suitability of which parents cannot judge, often until it is too late. Hundreds of studies have now documented the negative effects of aggressive television programmes (Huesmann et al., 2003) and computer programs on children's aggressive behaviours with peers and adults. Today, many children have unsupervised access to television in their own bedrooms. Sometimes television has replaced the need for babysitters and most certainly has reduced family communication, playing time and reading opportunities, as well as increasing exposure to violent programmes.

In fact the average British child spends more time watching television than engaging in activities in the classroom or with their parents.

Not only has television (and computer usage) reduced children's time interacting with peers and parents but convenience foods enable children to eat when, and where, they want. Family mealtimes have disappeared in many homes. Many poorer families no longer have a table at which to eat and the many occasions for family communication and interaction that having a meal entailed have disappeared. Parents frequently find themselves in uncharted territory.

THE HISTORY OF SUPPORT TO FAMILIES IN BRITAIN

In 19th century Britain, concern about child welfare focused primarily on the child. There had been 'Poor Laws' since Elizabethan times, but the Poor Law Amendment Act of 1834 forced unemployed, though able-bodied, people to enter workhouses in order to receive their keep, so that 'idleness' would not be reinforced. Conditions in workhouses were harsh, and husbands, wives and children were separated. Yet, despite the awful conditions, by 1848 there were over 300,000 inmates in workhouses. Those children who entered workhouses were treated in ways that respected neither their rights nor their individuality. At the same time, hundreds of children survived on the streets by begging, stealing or prostitution.

During the second half of the 19th century, recognition of the need for more humane care for children led to the foundation of voluntary children's societies. The philosophy of these philanthropic societies was that children had to be 'rescued' from parents who were failing to meet their needs (LSPCC, cited in Hendrick, 1994). Over a 40-year period Barnardo's (the major children's charity) alone sent almost 20,000 children overseas to Canada, Australia and New Zealand, and other childcare societies did the same. These children mostly entered domestic service or labouring work and this practice continued well into the 20th century.

Although guided by different philosophies, both state and voluntary sectors at that time were operating on the basis that children had to be removed and protected from inadequate parents. Their different solutions ignored the rights of families and failed to consider the possibility that, with support, many parents could care for their children. The idea of removing and protecting children from parents had a long history, going back at least to Plato who, around 300 BC,

recommended that children be raised by the state to avoid inconsistency on the part of (incompetent) parents (Hammer and Turner, 1985).

The 19th century saw some important advances in family health and health care but these were mainly due to public health measures, such as improved sanitation and the prevention of disease related to lack of clean water. The origins of health visiting go back to 1852 and the 'sanitory visitors' employed by the 'Manchester and Salford Sanitary Reform Association' (Owen, 1982). Their role, over many decades up to the Second World War, was mainly concerned with promoting physical health (Clark, 1981). This was a far cry from their current central and increasingly recognized role in supporting families to understand and cope with their young children within their own communities.

After the Second World War, in 1948, with the birth of the welfare state, the Poor Law was finally abolished. Local Authority Children's Departments were established and the rising cost of residential care, and high rates of foster care placement breakdown, led to the provision of the resources necessary to support families and prevent children from being taken out of their homes into care. Bowlby's (1953) views on the importance of mother–child early attachment relationships contributed to this change in thinking and by the mid-1950s the Government was seeking to prevent the admission of children into care through the introduction of comprehensive social welfare legislation. The 1969 Children and Young Person Act required interventions to support families. The responsibility for the prevention and treatment of delinquency fell to the newly formed Social Services Departments (SSDs). In the post-war years, when state-funded services were becoming conscious of the need to support the child within its family, the voluntary bodies were also moving in the same direction and it was from them that much of the innovative work came. Despite good intentions, little preventive work was undertaken by statutory agencies as, mainly due to rising poverty in the 1970s, demand for community services outstripped resources and statutory agencies were forced to put their main effort into child protection from physical and sexual abuse. The death of Maria Colwell in 1973, who had been removed from foster care to be reunited with her birth mother, and the public outcry and damning subsequent enquiry all contributed to this shift.

During the 1980s poverty continued to rise, a record number of people were dependent on supplementary benefit and family breakdown was increasing. Some specialist services to support families with children with behavioural difficulties through parenting interventions, were showing

good outcomes. However, the numbers of children with difficulties were such that it was impossible for specialist services to respond comprehensively or effectively. The problems presented at a rate that could not be met by specialist services, and families living in the poorest parts of the country, mainly in depressed inner cities, with housing and relationship problems and mental ill health, had the worst outcomes. These families were also those for whom preventive services were least available and, when available, least used. Professionals and voluntary bodies alike saw that children in circumstances of 'social exclusion' were at greatest risk of developing physical, behavioural and emotional difficulties. It was clear that effective ways of providing community-based support for families who do not benefit from traditional statutory services was the main challenge facing service providers.

SUPPORT TO PARENTS OF YOUNG CHILDREN

The Sure Start initiative has provided a structure that allows a more comprehensive provision of support to families. This includes work to enhance parental health and mental health, support in dealing with issues such as housing, job training and job finding, the provision of childcare, and resources for parents and families to develop their competence and confidence in their role as parents early in their child's life. In their work in Seattle, the Webster-Stratton Incredible Years programmes, discussed later in more detail, provide meals, childcare and transport for families involved in community-based Head Start parenting programmes, as well as shopping vouchers.

In one local Sure Start area (the Isle of Anglesey), where the first author works, the Sure Start service includes the following:

- a community child-minding scheme
- a 'Home Start' volunteer family support scheme
- preschool support services for families of children identified as having developmental difficulties
- a 'Book Start' project bringing local library services to the community and including a free book as an incentive to join
- an exercise and parenting initiative offering free supervised relaxation and exercise sessions (yoga, swimming and aqua aerobics) for parents with crèche facilities provided
- the funding of playgroups and mother and toddler groups to increase social contact for both mothers and children

- a dedicated Sure Start health visitor within the designated area offering 'sleep' clinics, individual consultations for parents, accident prevention courses and a series of guest speakers on topics relevant to parents
- community classes in computing and information technology
- a community 'Fun Bus' and activity days for children and families where families could also get advice on housing, further education or other problems
- parent survival courses, using the Webster-Stratton Incredible Years Basic Parenting programme

The first author has recently undertaken an evaluation of the Anglesey Sure Start project, mainly through participant satisfaction questionnaires. All aspects of the service have proved very popular with users, and data from the parent survival courses (the Webster-Stratton basic parenting programme) are showing good outcomes for parental mental health and child behaviour.

There are a number of excellent and methodologically sound studies demonstrating the value of support during pregnancy and the first year of life. The Community Mothers programme developed in Dublin (Johnson and Molloy, 1995) supported first-time mothers in disadvantaged and deprived areas. Experienced mothers from the same communities were recruited to support first-time mothers whose children were born during six months in 1989. Programme co-ordinators were responsible for recruiting and supporting the community mothers. These mothers were recruited as having a caring and sensitive nature, reasonable literacy, and an interest in the community. They trained for approximately six hours in their own homes. First-time mothers were randomly allocated to intervention or control groups. Community mothers visited target mothers monthly for the first year of the child's life. The control group received standard support from the public health nurse. Mothers in the intervention group reported a better diet, and more positive and fewer negative feelings. The results are evidence for a model of empowerment as it comes from a programme delivered by mothers from the same communities who shared experiences.

The Social Support and Pregnancy Outcomes study (Oakley et al., 1990) demonstrated the effectiveness of a social support intervention provided by midwives in high-risk pregnancies. Women with a history of low birth-weights were randomly allocated to receive social support in pregnancy in addition to standard antenatal care, while others received only the latter. Social support was given by four research midwives and included 24-hour contact telephone numbers and

home visits to provide a listening service. The babies of intervention group mothers had a higher mean birth-weight and there were fewer very low birth-weight babies in the group. Children in the intervention group were more likely to have received all of their primary inoculations, and were more likely to be read to, to play more cognitive games and to hear more nursery rhymes. The differences between the two groups were maintained, and at seven years, there were fewer behaviour problems among the children and less anxiety among the mothers in the intervention group.

In the Edinburgh Study of Post-natal Depression (Holden et al., 1989), women were screened for depression six weeks after giving birth, and by psychiatric interview, 13 weeks after giving birth. Women identified as depressed were randomly allocated to either eight, weekly, contact sessions by health visitors, who had received a short training in counselling for post-natal depression, or a no-treatment group. Standardized psychiatric interviews were used to identify depression before and after intervention. The majority of the women in the treatment group fully recovered compared with a minority of the controls.

Whilst few studies have looked at parenting support in diverse cultures, the Link worker project (Dance, 1987, cited in Oakley, 1992) targeted Pakistani women with one low birth-weight baby during a subsequent pregnancy. This was a randomized controlled trial study in which intervention mothers were visited three to five times during pregnancy. Intervention mothers had fewer medical problems, higher birth-weight babies, shorter labours, less analgesia and fewer babies with feeding problems.

In a review of programmes for children aged 0–8 years to prevent substance abuse, delinquency and violence in adolescence, Webster-Stratton and Taylor (2001) identify a study by Olds et al. (1986, 1998) as one for which there is the best evidence base. The study evaluated a home-visiting intervention by nurses to mothers in their prenatal months and during the first two years of their child's life afterwards. This study was important both because it was a randomized controlled trial study and because of its 15-year follow-up. Olds et al.'s intensive and comprehensive programme was designed to improve maternal prenatal health, pregnancy outcomes, childcare, children's health and development, and the women's own personal development and participation in the work force. Results indicated that nurse-visited women and children fared better than those assigned to control groups in each of the outcome domains. Home visits during pregnancy resulted in mothers having heavier babies, stopping smoking, and having

fewer pre-term deliveries. The 15-year follow-up showed that intervention mothers had, in contrast to those in the comparison and control groups, fewer verified reports of child abuse or neglect, fewer subsequent births, received less welfare, had fewer maternal problems due to alcohol and drug abuse, and fewer arrests. Children of these mothers had fewer arrests, fewer instances of running away, and lower alcohol consumption.

This programme has been replicated by Kitzman (1997) and others in Memphis with 1139 African-American mothers (primarily poor and unmarried). Results showed that nurse-visited children suffered fewer injuries in the first two years of life. Similar results from nurse visiting interventions were obtained by Larson (1980) in a home-visiting programme in Montreal and by Barnard et al. (1988) in Seattle.

PARENTING SKILLS AND CHILD BEHAVIOUR PROBLEMS

Many children have problem behaviours because their parents lack key parenting skills (Patterson, 1982), use them inconsistently (Patterson and Forgatch, 1989), or fail to use them at the appropriate times (Gardner et al., 1999). Evidence shows that while most children aged 20 months exhibit antisocial behaviours such as tantrums, mainly arising from their lack of communication skills at that age, these are generally replaced with more socially appropriate behaviours within a very short time. However, some children fail to move on and learn to use more socially appropriate behaviour.

Research has repeatedly demonstrated that parenting practices contribute to early antisocial behaviour and later delinquency (Reid, 1993; Campbell, 1995). Inconsistent parental discipline, poor commands, and harsh and inconsistent punishment play a significant role in the development and maintenance of child behaviour problems (Kochanska and Aksan, 1995). When this also includes little positive parental warmth and little involvement with, and poor monitoring of, the child both within and outside the home, the outcome is likely to be problematic for the child.

Patterson (1982), whose early work first described the relationship between parenting and child behaviour, describes a 'coercive family process' that is established when parents are unpredictable in their use of both positive reinforcement for pro-social behaviours and punishment for deviant behaviours.

A wide variety of programmes have been developed to support parents of young children by giving them effective behaviour management

skills through structured training sessions, reading material and attendance at groups. Many of these programmes are designed for 'normal parents' rather than as a crisis intervention. Community-based parenting support is provided in the home, in the community or in school, on a one-to-one or group basis by statutory or voluntary agencies. In Britain, for example, over 600 family centres provide a wide range of support to parents and children.

Voluntary organizations have been important in the promotion of the group approach to parenting education. In the UK, most influential are Parent Network, Exploring Parenthood and Family Caring Trust. Community education programmes have also been developed, for example by the Open University.

In a review of Parenting Programmes in Britain, Celia Smith (1996) identified 38 programmes. Many were relatively small scale and local in delivery, reaching few, sometimes fewer than 100, parents per annum. A few studies were reaching 200–300 parents per year. Parent Network reaches around 2000 parents per year and the Family Caring Trust estimates that at least 20,000 parents per year are reached by its range of programmes. However, provision is patchy and dependent on the interest of particular individuals or organizations. Smith concluded that, in 1996, approximately 4 per cent of parents in Britain were in receipt of a programme. Whilst Sure Start funding will have increased these numbers, still only a small proportion of parents have access to this form of support.

Most parenting programmes have the core principles of helping parents to increase positive child behaviour and at the same time to set clear, consistent and non-violent limits for children. Parent effectiveness training (PET) (Gordon, 1975) was started in 1962 in California and has been influential on both sides of the Atlantic. This is a group-based programme and, in addition to the core behaviour management principles, the programme includes 'active listening' and 'conflict resolution', which is seen as a problem-solving skill. Unfortunately much of the research into PET is unpublished or has methodological difficulties, making it hard to establish the effectiveness of this programme. Systematic Training for Effective Parenting (STEP) (Dinkmeyer, 1979) is based on psychodynamic principles and attempts to create a democratic family atmosphere focused on encouragement, mutual respect, discipline that is consistent with behaviour, time limits and choices. This, like PET, emphasizes reflective listening and the use of natural and logical consequences. This programme has also been developed into a teacher programme but unfortunately,

as with PET, systematic research has been sparse.

Other programmes include: How to Talk So Kids Will Listen (Faber and Mazlish, 1980), a self-administered course for use by groups of 6–12 parents; Responsive Parenting which has individual or group programmes; and Canter and Canter's (1985) Assertive Discipline, to help parents and teachers to engage children in more appropriate behaviour.

One of the most impressive programmes is the Triple P – Positive Parenting Programme – developed by Sanders in Australia (Sanders, 1999). This is one of the better evidence-based programmes and is a multilayered intervention which includes both universal and targeted approaches (see chapter 21). The Mellow Parenting programme developed in Britain has good reported outcomes and is described in chapter 3.

There are strengths and limitations to each of these programmes, the significant overriding limitation being the relatively limited amount of reliable evidence of effectiveness and durability for many of them. The Webster-Stratton Incredible Years programmes, discussed later in this chapter are probably the best evidence-based interventions in this field.

SUPPORT FOR PARENTS OF ADOLESCENTS

Support for parents of teenagers has received much less attention than for parents of younger children, yet this is an issue of considerable importance to most societies. In Britain, the Government has tried to make parents accountable for their youngsters' misdemeanours and crimes through the Parenting Orders, part of the Crime and Disorder Act 1998. It has also established a Connexions programme, with similarities to Sure Start, to reach teenagers.

Many of the services that currently exist for adolescents are therapeutic in nature and occur after the child is in trouble. There is very little evidence of effective strategies for this work. Patterson et al. (1993) at the Oregon Social Learning Centre have undertaken some of the best-evaluated parenting programmes with parents of children of a variety of ages. However, their success rates for children under the age of 10 years are much higher (75 per cent success) as compared with only 25 per cent with adolescents. Those interventions for adolescents with a good evidence base are achieved by removing the youngsters from their families (Chamberlain, 1990).

It is not surprising that interventions for conduct disorders (CD) are of limited effect when

offered in adolescence, when delinquent and aggressive behaviours have persisted for many years, and when secondary risk factors such as academic failure, school drop-out, and affiliation to deviant peer groups have developed (Ruma et al., 1996; Werry, 1997). In fact, interventions targeting adolescents with CD can result in worsening of symptoms through exposure to delinquent peers (Dishion et al., 1999). There have been a number of demonstration projects for treatment of conduct disordered adolescents through specialized residential treatment and foster placements. However, these are costly, because they require skilled and intensive human input and are no real solution to such a widespread problem that have their origins in early childhood.

The increased treatment resistance in older CD children and young people (Webster-Stratton, 1991; Reid, 1993) results in part from delinquent behaviours becoming embedded in a broader array of rewarding systems, including those at the family, school, peer group, neighbourhood, and community levels (Lynam et al., 2000). Thus, the payoff or contingencies in all of these systems must be altered for interventions to become effective for adolescents – an endeavour that requires the co-ordination and expertise of myriad service providers and explains why the outcomes from such endeavours are so poor (Henggeler et al., 1998).

A number of programmes have versions for the parents of adolescents, including PET and STEP. A verson of the Triple P programme for parents of teenagers is being evaluated by Sanders in Australia. The Family Caring Trust has a programme designed for the parents of teenagers; it is a flexible self-help programme run by a range of community organizations including schools and churches. Parent Network courses are for (parents of) children of all ages. They provide an opportunity for parents to talk to each other about the problems they are experiencing. Parents who have received 150 hours of training over six months lead the groups, as experienced fellow parents.

Parent Time (Cohen and Irwin, 1983) is a programme for parents of adolescents who are not experiencing serious difficulties. Results suggest that it gives parents an enhanced capacity to listen, to set limits and to confide in other parents. Parents Who Care (Hawkins and Catalano, 1996) is a book and video presentation with instructions and exercises for parents and families, with guidance on how to involve adolescents in family decision-making. Family Systems Programmes are offered as both group and individual family-based units to empower families 'from within' to direct, monitor and change. Growing up Fast (Gavacci, 1995) was designed to help the whole family to recognize their strengths and set

appropriate goals for themselves to bring the young person through adolescence to maturity. The programme recognizes that the young person is an active agent in the process.

A study providing adolescent-focused newsletters (Bogenschneider and Stone, 1997) demonstrated that, following receipt of a series of three newsletters, parents had a higher level of monitoring compared with the control group and were more responsive to their children, engaging in more intimate discussion with them about adolescent risk behaviours. A number of voluntary agencies have telephone helplines for adolescents themselves. 'Parent line', for example, is a government-funded, national helpline for parents seeking advice with their children, of all ages. Relate has developed a Relate Teen Service for adolescents experiencing difficulties as a result of parental separation.

Unfortunately few of these services have demonstrated effective outcomes in scientifically rigorous ways. Most have the benefit of face validity and some, such as Parentline, are extensively used. However, there is no evidence that these services reach those parents who, by virtue of the range and severity of their problems, are in the most urgent need of help.

BEHAVIOURAL APPROACHES TO SUPPORT CHILDREN WITH BEHAVIOURAL DIFFICULTIES

Among all the programmes for children with behavioural difficulties, the 'social-cognitive' and behavioural parenting approaches have been most extensively researched over the last 30 years and their therapeutic effectiveness is well established.

Behavioural parent training approaches have many elements in common. Treatment is based on 'social learning theory' and utilizes the concepts of modelling, positive reinforcement, time out and contingency contracting (Kazdin, 1993). The aim is to increase positive behaviours through a variety of rewards, whilst reducing unwanted behaviours through response cost or other strategies, resulting in their disappearance and 'extinction'. A most influential parent training programme was developed by Patterson and colleagues (Patterson et al., 1975; Patterson, 1982). This is based on extensively researched models of parent–child interactions and designed to alter the pattern of exchanges between parent and child so that pro-social and co-operative, rather than coercive and disruptive, behaviour is directly reinforced and supported within the family.

Some programmes include work to enhance the parent–child relationship, with a focus on play and other relationship-enhancing activities which has been shown to be an essential component (Taylor and Biglan, 1998).

A parenting programme that combines a focus on relationship-building with cognitive, affective and behavioural components was developed by the second author initially for treating young children with diagnosed oppositional disorder or conduct disorder. This programmme is described in more detail below, but extensive evaluation indicates that the short- and long-term success of treatment has demonstrated significant improvements in child behaviours and improved child adjustment for at least two-thirds of treated children. It has also proved acceptable to the service users. An important by-product of this particular programme appears to be a significant improvement in parental mental health, particularly depression, and improved anger-management skills following parent training. This and other evidence has led to recognition at UK government level that parenting programmes enhance both child and maternal mental health.

Parenting programmes have been delivered in a variety of formats including television programmes, DIY programmes with videotapes, individual consultations and in groups. Local circumstances, such as rurality and the nature of the target group, dictate what is feasible. Many studies show direct evidence that changes in parent behaviour, the target of the intervention, are associated with changes in child behaviour.

Despite the success of behavioural and social learning theory based approaches with the parents of CD children, some studies report parent drop-out of up to 40 per cent and some children do not continue to show clinically significant responses over time. Long-term follow-up studies show that 30–40 per cent of parents who have received parent training continue to have children with behaviour problems in the clinical range (Patterson, 1982; Webster-Stratton, 1985). Furthermore, those with the most difficult social circumstances are less likely to engage in these programmes, and if they do, are more likely to drop out (Dumas and Wahler, 1983). Despite these limitations, parenting programmes are by far the most effective forms of intervention at the present time.

A number of the factors influence treatment outcome. Early intervention and longer duration of treatment are both associated with positive outcomes. Success declines with increasing child age; the older the child at the start of treatment, the poorer the outcome. Where a family is experiencing extreme socio-economic disadvantage or if the mother is depressed, in conflict with her huuband/partner, is a single parent or is socially isolated with respect to her family and her community, some parent training programmes have proved to be ineffective in resolving difficulties with the child. Many programmes find that recruitment rates for parent training from low-income families with children with conduct problems are low. Even when recruited, these multi-stressed parents are the most likely to drop out of treatment and later to relapse, to fail to make clinically significant improvements following treatment, or to maintain treatment effects over time (Wahler et al., 1993). Parent training programmes have to address these issues and evidence from studies by the second author shows how this can be done (e.g. Webster-Stratton et al., 2001a).

The effectiveness of parent training is dependent on the acceptability of the service provided to parents since it affects their willingness to follow advice and to adhere to agreed child management strategies and techniques. Therapist behaviours that are perceived as 'directive' appear to increase the likelihood of parental resistance and lack of co-operation. Non-directive trainers, on the other hand, engaging in such behaviours as 'facilitating' and 'supporting', appear reliably to decrease client non-compliance.

The second author (Webster-Stratton, 1998a) points out that families who fail to engage with services may have been seen to workers to be

> unmotivated, resistant, unreliable, disengaged, chaotic, in denial, disorganized, uncaring, dysfunctional, and unlikely candidates for this kind of treatment – in short, unreachable.

She goes on to remind us that

> However these families might equally describe many of the programmes as 'unreachable', too far away from home, too expensive, insensitive, unrealistic, inflexible in terms of timing and content, hard to understand and/or blaming or critical of parents' lifestyle (Webster-Stratton, 1998a).

The 'calculus' used by these parents is no different from those of the more compliant. It is likely that the costs to these clients of receiving treatment outweigh any possible benefits, even though they want to do what is best for their children. It seems possible, she contends, that this population has been 'unreachable' not because of their own characteristics but mainly because of the characteristics of the interventions that they have been offered.

Child Interventions

Because of the difficulties in engaging the parents of many high-risk children, a number of child programmes have been developed and

researched in recent years. Some programmes focus specifically on social skills deficits such as friendship and/or play skills, whereas others have relied more on cognitive–behavioural methods to teach child problem-solving, self-control and positive 'self-talk'. Few of these programmes have involved parents, many have not targeted conduct problem children, few have used observational measures of change, and more difficult children seem to benefit less from these programmes.

School-based Interventions

Efforts to involve parents in school programmes are not new and attempts to create a link between home and schools have been in operation in the UK through parent–teacher associations for many years. However, they have been mainly successful with middle-class parents and parents of children who are already 'doing well in school'. Linking the Interests of Families and Teachers (LIFT), an Oregon Social Learning Centre project, showed the benefits of offering a parent training programme in the school and of strategies to make teachers more accessible to parents (Reid, 1993). Despite some programmes that are successful in linking parents and teachers, they are, for the most part, independent agents of children's socialization.

Engaging parents is the first priority. Parents spend the greatest amount of time with their children and have generally the greatest influence. The research literature suggests that parenting programmes offered as a preventive measure, before children are diagnosed as having conduct disorder, are more cost-effective, more pervasive in impact, and less stigmatizing. Community-based interventions must have the support of, and from, parents at their heart. Universal programmes, provided in the community, are more likely to engender a collaborative approach to the practice of positive parenting and to build strong and supportive parent communities and partnerships with schools.

THE 'INCREDIBLE YEARS' PROGRAMMES

While not all risk factors for childhood emotional and behavioural difficulties are easily amenable to intervention, some such as poor parenting skills, social isolation, lack of support networks for parents, and lack of school involvement are. If these risk factors can be modified, parents can build up protective strategies that may help buffer some of the adverse effects of poverty and other adversity and their accompanying stressors. Growing recognition of the failure of treatment programmes with older children, coupled with the recognition of the growing numbers of children with problems, has led to the provision of community-based parenting programmes focused on parents of younger children.

Based on her work with referred children, the second author developed a model that suggested the benefit of intervening at the parent, child and school level, and a series of programmes named 'The Incredible Years'. These programmes are described in some detail because of the strong, replicated evidence base.

The Incredible Years programmes include parents, children and teachers (see Figure 20.1) and have been developed and researched over the last 20 years, in a number of randomized controlled group studies as well as in replications by independent researchers. Her programmes have been identified, using strict criteria, as a 'Blueprint Programme' (Webster-Stratton et al., 2001b) for the prevention of violence and, using similar criteria, by the US Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2000). Additionally, in a recent report from the American Psychological Association, the Incredible Years series was identified as one of only two effective treatments for conduct disorder. There are three interlocking programmes for parents, children and teachers, all of which have been used both as therapeutic interventions and in high-risk Head Start communities. All three programmes, parent, child and teacher, use manuals, and protocol adherence is stressed. Leaders are trained in a collaborative problem-solving style in which the specific goals, issues and life circumstances of each group member are used in group discussions. The curriculum of each programme is, therefore, placed in context in relation to particular families, classrooms, and characteristics of the group. This is a culturally sensitive approach that has proven effective for children.

Since developing these programmes as treatment programmes for referred children, community-based preventive parent, child and teacher interventions in high-risk communities have been evaluated, demonstrating that these are strongly evidence-based community programmes. Whilst the parenting component is regarded as important in improving parent–child relationships, programmes to help parents improve their relationship with their child's education providers and help schools to promote children's social competence are also emphasized.

The Parenting Programme

Addressing the issue of how to engage high-risk families and enable them to 'take ownership' of

THE INCREDIBLE YEARS PARENT, CHILD, AND TEACHER PROGRAMS		
Population & Intended use	**Minimum "Core" Program**	**Recommended Supplemental Programs For Special Populations**
For use as Prevention Programs for Selective Population (i.e., high-risk populations without overt behavior or conduct problems) Settings: Pre-school, Daycare, Head Start schools Public Health Centers	BASIC (12 to 14, two-hour weekly sessions)	• ADVANCE Parent Programs for Highly stressed families • SCHOOL Parent Program for Children (Kindergarten to Grade 3) • CHILD Program if child's problems are pervasive at home and at school • TEACHER Classroom Management Program if teachers have high numbers of students with behavior problems or if teachers lack these skills
For use as Treatment Programs for Indicated Populations (i.e., children exhibiting behavior problems or diagnosed conduct disorders) Settings: Mental Health Centers Pediatric Clinics, HMOs	BASIC and ADVANCE (22 to 24, two-hour weekly sessions)	• SCHOOL Program for parents if child has academic problems • CHILD Program if child's problems are pervasive at home and at school • TEACHER Program if child's problems are pervasive at home and at school

Figure 20.1 *The Incredible Years Programmes and their use with selective populations (From Webster-Stratton et al., 2001b).*

the central programme ideas is of critical importance. Many early parent training programmes relied largely on verbal methods such as didactic lectures, brochures, and group discussions. These methods have been shown to be generally ineffective in producing behavioural changes in parents (Chilman, 1973). In addition, such methods are not optimal for parents whose level of literacy, educational or general intellectual ability is limited. 'Performance training' methods such as live modelling, role rehearsal, and individual video feedback have, on the other hand, proved effective in producing behavioural changes in parents and children (O'Dell, 1985; Hutchings et al., 2004). However, implementation is time-consuming and costly, making such programmes impractical for large-scale use. Furthermore, they cannot directly address other risk factors, such as social isolation, or improving home school links.

The 'Incredible Years' training programmes are all based on videotape modelling and have proved to be both practicable and cost-effective. Parents watch video clips of parents and children and practice interacting with their children in ways that promote pro-social behaviours and/or decrease inappropriate behaviours. This flexible modelling approach results in better generalization of the training content and, therefore, better long-term maintenance, which is a better method of learning for less verbally sophisticated parents.

The method also has the advantage not only of low individual training cost when used in groups, but of potential for mass dissemination.

The model is used for working with families, children and teachers actively and collaboratively. In a collaborative relationship, the facilitator does not set him/herself up as an 'expert', dispensing advice to parents about how they should parent more effectively. The collaborative model (Webster-Stratton and Herbert, 1994) implies a reciprocal relationship based on utilizing equally the facilitator's and the parent's knowledge, strengths and perspectives. It is non-judgemental and non-hierarchical. The provision of transport, daycare, meals and flexible course times are built in to take account of families' circumstances and enable them to participate.

The partnership between parents and group facilitators gives back dignity, respect and self control to parents who, because of their particular situation, may have low self-confidence and intense feelings of guilt and self-blame (Baydar et al., 2003). A collaborative approach is more likely to increase parents' confidence and perceived self-efficacy than 'top-down' and 'expert' therapeutic approaches. Parents with high self-efficacy will tend to persist at tasks until they succeed. Also, people who have determined their own priorities and goals are more likely to persist in the face of difficulties. This model is likely to

increase parents' engagement in the intervention, and evidence suggests that the collaborative process has the advantage of reducing drop-out rates and increasing motivation and commitment.

For low-income single mothers, who are often socially isolated with little support and few friends, parent groups can become an 'empowering' environment, decreasing their insularity and giving them new sources of support. The programme helps groups to become support systems by assigning everyone a 'buddy' in the second session. Buddies are asked to call each other during the week to share how the homework assignment is going. This assignment is carried out every few weeks with a different buddy. Parents are initially hesitant about making these calls but, as they experience the support they receive from these telephone conversations, they continue to make calls to one another. By utilizing powerful group processes, the programme is cost-effective and addresses an important risk factor for children with conduct problems, namely, the family's isolation and stigmatization. The parent groups provide support which can become a model for parent support networks.

The 'Basic' parenting programme is designed for parents of children aged 2–8 years and aims to promote modelling effects for parents by creating positive feelings about the videotape models. The videotapes show parents and children of differing ages, cultures, socio-economic backgrounds and temperaments, so that parents perceive at least some of the models as similar to themselves and their children, and therefore accept the tapes as relevant. Videotapes show parent models in natural situations with their children 'doing it wrong' and 'doing it right', to illustrate how one can learn from one's mistakes. This approach emphasizes a coping and interactive model of learning (Webster-Stratton and Herbert, 1994). Parents view a videotape vignette of a parent 'doing it wrong' and then discuss and role play how the parent might have handled the interaction more effectively. This enhances parents' confidence in their own ideas and their ability to analyse different situations with their children and select an appropriate parenting strategy. In this respect, the training differs from most other parent training programmes in which the therapist is 'the expert' and provides the analysis and recommending a particular strategy. The collaborative context is designed to ensure that the intervention is sensitive to individual cultural differences and personal values. The programme is 'tailored' to each family's individual needs and goals (identified in the first session) as well as to each child's personality and behaviour problems. This is theoretically a complex task, but in practice an adequate working approximation can be developed.

The first two segments of the 'Basic' programme focus on teaching parents to play with their children, building interactive and reinforcement skills. The third and fourth segments teach parents a specific set of non-violent discipline techniques including commands, time out and ignoring (Forehand and McMahon, 1981), as well as logical and natural consequences, and the importance of monitoring their child. The fourth segment also shows parents how to teach their children problem-solving skills (Shure, 1994).

There are two other parenting programmes. The 'Advance' programme emphasizes adult interpersonal skills, such as effective communication skills, anger management, problem-solving between adults, and ways to give and get support. The 'Supporting Your Child's Education' programme emphasizes parenting approaches that promote children's academic skills, including fostering reading skills, setting up predictable homework routines, and building collaborative relationships with teachers.

The process of disseminating this work has been carefully planned. Basic parent group leader training is a three-day workshop to familiarize potential group leaders with the programme content and to introduce them, through experience, to the collaborative approach. There is also a certification process for leaders through which they gain feedback to enable them to ensure that they are delivering the evidence-based programme. This is important, because it maximizes the quality of the performance of the group facilitator. Certified leaders, implementing the full programme, achieve results similar to those in the published literature. The certification requirements are clearly specified. Few, if any, other programmes are supported as well to give new leaders confidence that they are delivering an evidence-based programme.

The parenting programmes have been shown to be effective in significantly improving parental attitudes and parent–child interactions, along with reducing parents' reliance on violent and critical disciplinary approaches and reducing child conduct problems (Webster-Stratton et al., 2001a). These results have been replicated by independent investigators in mental health clinics with families of children with conduct problems (Spaccareli et al., 1992; Taylor et al., 1998; Scott, 2001b). The Scott study was conducted in real life in an applied setting, where the therapists were typical personnel of the centre.

Two prevention programmes have been researched in high-risk Head Start communities designed to address the problems of early starter

'at risk' children through a parent training. These have demonstrated that parent training is a highly useful intervention for promoting increased positive parent–child interactions (Webster-Stratton, 1998b; Office of Juvenile Justice and Delinquency Prevention, 2000).

The programme is effective in recruiting families from circumstances in which other studies have shown little success. In a recent analysis of the Head Start studies over 75 per cent of mothers attended more than 75 per cent of the sessions offered. Additionally, those parents with mental health difficulties (depression, anger, substance abuse and a history of having been abused as children) had good programme attendance and were actively engaged in the homework. They also showed significant improvements in their parenting interactions relative to controls and did as well as mothers without mental health problems (Webster-Stratton, 1998b).

Data from two Head Start samples were combined in order to compare the effectiveness of intervention according to ethnic group, with analyses differentiating between Caucasian, African-American, Asian-American and Hispanic participants (Reid et al., 2001). Results indicated that significant changes occurred regardless of the ethnicity of the family, and all ethnic groups had high 'consumer' satisfaction for the programme. However, some differences emerged when scores on the consumer satisfaction survey were rank-ordered, with Caucasian mothers consistently rating the programme somewhat more critically than the other three groups. In terms of attendance, Asian mothers had the highest rates and Caucasian parents attended significantly fewer sessions than Hispanic and African-American parents. The significance and generalizability of these findings is not immediately apparent.

The findings from these Head Start studies have been replicated by independent investigators as prevention programmes with different populations, including with Hispanic (Miller and Rojas-Flores, 1999) and low-income African-American families (Gross et al., 1999) in different cities. Studies using the basic programme have shown that parent training is highly promising as an effective therapeutic method for producing significant behaviour change in children within high-risk, socio-economically disadvantaged populations. These findings provide support for the view that parenting practices play a key role in children's social and emotional development. However, the long-term data suggests that, to improve the potency of this intervention, it is imperative to address child skill deficits and collaboration with teachers to promote more sustained effects across the home and school setting.

The Teacher Programme

On entering school, disruptive children quickly become socially excluded and may elicit the same negative patterns of response from teachers that they experienced at home. For high-risk children to benefit from intervention programmes, healthy bonds or 'supportive networks' are necessary between teachers and parents, and children and teachers. Family–school networks are of benefit to children due to parents' increased expectations, interest in, and support for their child's social and academic performance and create a consistent socialization process across home and school settings.

Effective classroom management reduces disruptive behaviour and enhances social and academic competence (Walker et al., 1995; Brophy, 1996). Well-trained teachers help aggressive, disruptive and uncooperative children to develop the appropriate social behaviour that is a prerequisite for success in school.

The IY teacher programme was developed to teach effective classroom management skills (Webster-Stratton, 1999). It is a six-day group-based training. It targets teachers' use of effective classroom management strategies for dealing with misbehaviour, promoting positive relationships with difficult students, strengthening social skills and strengthening teachers' positive communication with parents. The programme emphasizes the importance of positive home telephone calls, regular meetings with parents, home visits, and successful parent conferences. It uses the same collaborative process skills that were developed for the parenting programme, with vignettes, role play and homework assignments.

The parent and the teacher training curriculum have been evaluated with Head Start teachers and mothers. Following the programme, experimental mothers had significantly lower negative parenting and significantly higher positive parenting scores than control mothers. Parent–teacher 'bonding' was significantly higher for experimental mothers. Experimental children showed significantly fewer conduct problems at school than control children. Children of mothers who attended six or more intervention sessions showed significantly fewer conduct problems at home than control children. Children who were the 'highest risk' at baseline (high rates of non-compliant and aggressive behaviour) showed clinically more significant reductions in these behaviours than high-risk control children. After training, experimental teachers showed significantly better classroom management skills than control teachers. One year later the experimental effects were maintained for parents who attended more than six of the group sessions. The clinically significant

reductions in behaviour problems for the highest risk experimental children were also maintained.

The Child Programme

Despite these improved outcomes achieved by combining the parent and teacher programmes, it was deemed necessary to improve further on the success rate by developing, in addition, a curriculum for the children in their early years in the classroom. This was done by adapting the 'Dinosaur School' programme (Webster-Stratton and Reiad, 2003), originally developed as a small group programme for referred children, into a programme for early school years, delivered to the whole classroom.

The Dinosaur School curriculum (Webster-Stratton and Reid, in press) is guided by child risk factor research and aims to enhance children's appropriate classroom behaviour (such as a quiet hand up, listening to teacher). It also promotes social skills, positive peer interactions (for example, waiting, taking turns, asking to enter a group and complimenting), empathy skills and emotional language to help children develop appropriate conflict management skills and reduce conduct problems. The programme is designed to dovetail with the parent and teacher training programmes. The curriculum can be used by a therapist as a 'pull out' small group programme for treating children with conduct problems. These small group sessions are offered once a week for two hours for 18–20 sessions (usually when parents are in parent groups). In addition, the curriculum can be used as a classroom-wide prevention programme offered by teachers of children aged 3–8 years. It is offered to all children in 15–30 minutes 'circle time' discussions followed by small group practice activities, two to three times a week over the school year.

The Dinosaur School programme uses child sized puppets, Wally and Molly, who share their difficulties and successes with the children. Dina Dinosaur is the principal of Dinosaur School and comes out to review progress. The programme promotes child problem-solving through children becoming problem-solving detectives. As with the parent and teacher programmes, it uses vignettes to promote identity with other children, role play to give practice of new skills, and homework assignments.

A recent evaluation by the second author has compared different combinations of training including parent, teacher and child programmes with a waiting list control group for referred children (Webster-Stratton and Hammond, 1997). Outcomes from this study indicate that classroom observation of teachers who received

the teacher training showed trained teachers to have better classroom atmospheres and to be less harsh and critical and more nurturing. In short, when the teacher training component was added to either the parent or child programmes the effects on children's behaviour were significantly enhanced. The combined training for parent, teacher and child showed more effects across settings on multiple variables (parent and teacher report and observations at home and in school).

This study is currently being repeated as an early intervention initiative in Head Start. There are already many issues to be resolved regarding the use of this programme across larger geographical areas, persuading professionals to adopt it in preference to either home-grown or other off-the-shelf programmes and the insertion of such a programme for a large enough group of children in schools which are typically the least resourced and most stressed. There are also issues of cultural compatibility. For these reasons, it may be worthwhile describing the application of this programme in a different country and quite a different (though not extremely so) culture.

WORK IN WALES

The first author has worked with children and families in Wales for over 25 years. She has researched outcomes of a standard and structured, intensive practice-based behavioural programme for children with severe behavioural problems (Hutchings et al., 2002). The intensive programme utilized video feedback to parents of their own interactions with children and repeated practice of new management skills (parents doing things rather than being given advice). Four-year follow-up (Hutchings et al., 2004) has shown that only the gains made by the intensive treatment group have been maintained. These findings demonstrate that video feedback and coaching help parents but are costly and require highly skilled personnel, thus making the intervention available to very few children and families. This led to the development of a practice-based training programme for health visitors (nurses with statutory duties for health care of young children), which has been researched and demonstrated evidence of positive outcomes for health visitors, parents and children (Lane and Hutchings, 2002). This is now an accredited Masters level module within the University of Wales.

For the last five years the first author's main focus has been on developing the use of the Webster-Stratton Incredible Years programmes in Wales. The programmes have been delivered

both for referred children and as preventive interventions. More than one hundred professional staff across Wales have undertaken the three-day basic parent group leader training course and are running the parenting programme in a range of services. A recent survey found them to be very satisfied with the training and highly motivated to run the programme. Running the IY parenting programmes is challenging, as modelling respect for, and acceptance of, group members by leaders is highly skilled. In addition, providing facilities to make groups accessible requires resources that are rarely provided within services.

The three-day parent group leader training is a thorough introduction to the programme but, even with this training, it takes considerable skill to run the programmes as designed. The programme content is clearly defined and the materials explicitly presented. However, experience suggests that a thorough grounding in social learning theory is an important prerequisite to successful group leadership, as are collaborative leader skills.

A high level of skill and organization is needed to deliver the programmes. The first two parent groups run by the first author had a drop-out rate of almost 50 per cent. It would be easy to dismiss this as not untypical of parents of children referred with such problems. However, all of these parents are experiencing difficulties with a child and need help and support. Many of the programme components are difficult for busy clinicians to achieve but improvements in attendance and homework compliance are achieved by following programme requirements, such as weekly telephone calls to all group members, and rigorously following up absentee parents on the same day. Also, where possible, make-up sessions are provided for parents who miss sessions.

As leaders have become more skilled, we maintain higher levels of attendance, with the majority attending over 75 per cent of sessions, as well as almost 100 per cent homework compliance. Homework compliance is a good predictor of successful delivery of the programme and homework results were initially poor. The strategies for encouraging compliance with homework activities need to be used systematically, including parent completion of the weekly self-monitoring checklist, which helps them to set homework goals and to evaluate their own performance.

Initially too little time was allowed for discussion of homework for the coming week. Since greater emphasis has been given to the importance of homework, compliance has significantly improved and, while barriers are discussed with parents who fail to complete homework, attention

focuses primarily on those parents who have completed homework.

The settings in which services are delivered in North Wales are very different from those in Seattle. The rural bilingual (Welsh and English) communities pose difficulties in terms of gathering together groups of people, even within services such as Sure Start, who are delivering community-based support to scattered populations.

The small group therapeutic Dinosaur School and the Classroom Dina programmes have been run in a number of NHS and Education Service settings across Wales.

A recent development has been the establishment of the classroom-based Dinosaur School programme in Gwynedd, North West Wales in reception classes with rising 5-year-old children. At the same time, their parents are offered the basic parenting programme to encourage them to support their children at the difficult transition point at which they enter school. This has involved collaboration across agencies and commitments at management level to facilitate the maintenance of these activities. The teachers delivering this programme undertook a shortened version of the teacher training programme, learning the basic classroom management skills on which the school programme is based. The success of this programme in its first year (2001/02) led to its expansion into a further six schools in 2002/03 and a further four schools in 2003/04. The plan is to deliver the Classroom Dina programme throughout the first three years of children's schooling. In 2002/03 the six-day teacher classroom management programme was introduced in North West Wales and run for two groups of 12 teachers. This was highly valued by the teachers and is being run again in 2003/04.

The IY programmes in Wales have been promoted through the university based 'Child Behaviour Project', through which basic training in the delivery of all the programmes and some advanced consultation has been organized. The project provides a focus for staff to learn together to deliver these evidence-based programmes. An IY Support Group has been established and meets every three months to help less experienced leaders to deal with common problems and pair up with more experienced leaders to run their first group. As the project has now devoted itself entirely to promoting the IY programmes, it has just (September 2003) become The Centre for Promoting the Incredible Years Programmes in Wales.

The co-ordination of training and the provision of research resources has enabled some evaluation of outcomes. Positive outcomes have been reported from parent, child, and teacher

programmes, in terms of parent and teacher satisfaction and reported improvements in child behaviour. This enables positive feedback to be given to agency managers about the programmes, which helps to ensure the future availability of resources for the programme.

CONCLUSION

Early childhood conduct problems are occurring in large numbers and, if unresolved, lead to delinquency and subsequent costly adult mental health problems and/or criminal behaviour. The search for effective ways to prevent this violence has become a national priority. There is a need to get services to high-risk families in their own communities during children's early years. The way in which services are delivered influences whether families accept, ignore or reject what is available. Parents and children need to be active participants in health care. Services have to pay attention to parents' life styles, and needs and services must be modified to meet these needs so that parents can be contacted and engaged.

The history of work to support families within their own communities is short and it has occurred in the context of rapidly changing society and one in which the challenges of parenting have grown significantly. At the start of the 21st century British government policy is making the 'community' the focus of health care through the establishment of Local Health Groups. These will have responsibility for commissioning statutory services at a local level, with representatives of other agencies. Sure Start services, supporting families 'at risk' and other innovative work from voluntary groups, parent support groups and media resources all have a contribution to supporting parents at a community level. Successful implementation of support to parents in their own communities requires workable methods, and available trained and appropriately supervised staff. The Sure Start programme will only reach some of the families of children at risk and we need a strategy that will meet the needs of all children and families. Health visitors, in Britain, are well placed to work with other agencies to engage all families in a collaborative way during the preschool years but they need both training and for this work to be given sufficient priority in their schedule.

There are serious gaps in research. Few investigators have used randomized controlled studies. This is particularly important when programmes are prescribed by the Courts, as they can be in Britain under the provisions of the Children Act 1989 and the Crime and Disorder Act 1998.

Under these acts, Parenting Orders can require parents of young people in trouble to attend parenting classes.

While many programmes are available for children at risk of developing conduct disorder, few address the problem with parents, children and teachers together and have evidence-based validation from well-designed trials. We need to engage parents in high-risk communities whilst their children are still young and to build partnerships between parents and schools using evidence-based interventions.

The work of the second author has been a major influence on services delivering parenting programmes in the UK, and is currently being implemented and researched in both treatment and preventive settings (Scott et al., 2001). The community programmes incorporate interventions with parents, teachers and children (Webster-Stratton et al., 2001b). The Incredible Years parenting programme has demonstrated how to engage many high-risk families and enable most to assimilate the ideas. In the 'early intervention' setting when they are offered to communities and combined with the child and teacher programmes, they are perceived as non-stigmatizing and offer one of the best available models for supporting parents and enhancing children's social and emotional competence. Parents of high-risk children can be engaged when services recognize their needs and provide for them, for example providing childcare, transportation and meals.

Such community-based programmes can reduce factors that place children at risk for conduct disorders. However, to be most effective they need to encompass various levels of society – the children and their peers, the school, the family and wider society. Both sense and evidence suggest that the earlier that difficulties are tackled, the better they will be ameliorated Programmes are likely to be most effective if delivered early in the child's life and include the parent, the child and the school. The evidence from the Incredible Years early intervention programmes in Head Start centres is demonstrating just this and beginning to be replicated in Britain where a significant number of Sure Start services are incorporating them into their range of services to support families.

Effective parenting programmes require skilled group leaders with knowledge of social learning theory and practical parenting skills as well as effective collaborative communication skills. The task is to engage parents as problem solvers through a collaborative approach that recognizes the strengths and knowledge of the participants as a valuable contribution to the shared problem-solving task of rearing children

in a complex modern world (Webster-Stratton and Hammond, 1994).

Parenting is one of the factors associated with problematic child outcomes and programmes need to address this, as well as other parental physical and emotional health issues and the other by-products of social exclusion. Governments on both sides of the Atlantic are recognizing the urgent need to implement evidence-based support to families within their own communities.

REFERENCES

Barnard, K.E., Magyaru, D., Summer, G., Booth, C.L. Mitchell, S.K. and Spieker, S. (1988) Prevention of parenting alterations for women with low social support. *Psychiatry*, **51**, 248–53.

Baydar, N., Reid, J.B. and Webster-Stratton, C. (2003) Who benefits from school-based preventive parent training programs? The role of mother mental health factors and program engagement. *Child Development*, **74**, 433–53.

Bogenschneider, K. and Stone, M. (1997) Delivering parent education to low and high risk parents of adolescents via age-paced newsletters. *Family Relations*, **46**, 123–34.

Bowlby, J. (1953) *Child Care and the Growth of Love*. Harmondsworth: Penguin.

Brophy, J.E. (1996) *Teaching Problem Students*. New York, NY: Guilford Press.

Campbell, S.B. (1995) Behaviour problems in pre-school children: a review of recent research. *Journal of Child Psychology and Psychiatry*, **36**, 113–49.

Canter, L. and Canter, M. (1985) *Assertive Discipline for Parents*. New York: Harper and Row.

Chamberlain, P. (1990) Comparative evaluation of specialized foster care for seriously delinquent youths: a first step. *Community Alternatives: International Journal of Family Care*, **2**, 21–36.

Chilman, A. (1973) Programs for disadvantaged parents. In Caldwell, B.U. and Riccuiti, W.N. (eds) *Review of Child Development and Research*, Vol. 3. Chicago: University of Chicago Press.

Clark, J. (1981) *What Do Health Visitors Do? A Review of the Research 1960–1980*. London: Royal College of Nursing.

Cohen, M. and Irwin, C.E. (1983) Parent-time: psycho-educational groups for parents of adolescents. *Health and Social Work*, **8**, 196–202.

Cook, P.J. and Laub, J.H. (1998) The unprecedented epidemic in youth violence. In Tonry, M. and Moore, M.H. (eds) *Crime and Justice: A Review of Research, Vol. 24*. Chicago: University of Chicago Press, pp. 27–64.

Dinkmeyer, D.C. (1979) A comprehensive and systematic approach to parent education. *Journal of Family Therapy*, **7**(2), 46–50.

Dishion, T.J., McCord, J. and Poulin, F. (1999) When interventions harm: peer groups and problem behavior. *American Psychologist*, **54**, 755–64.

Dumas, J.E. and Wahler, R.G. (1983) Predictors of treatment outcome in behavioural parent training. *Journal of Consulting and Clinical Psychology*, **52**, 117–34.

Faber, A. and Mazlish, E. (1980) *How to Talk So Kids Will Listen so Kids Will Talk*. New York: Avon.

Forehand, R.L. and McMahon, R.J. (1981) *Helping the Non-compliant Child: A Clinicians Guide to Parent Training*. New York, NY: Guilford Press.

Gardner, F.E.M., Sonuga-Barke, E.J.S. and Sayal, K. (1999) Parents anticipating misbehaviour: an observational study of strategies parents use to prevent conflict with behaviour problem children. *Journal of Child Psychology and Psychiatry*, **40**(8), 1185–96.

Gavacci, S.M. (1995) The growing up FAST: families and adolescents surviving and thriving program. *Journal of Adolescence*, **18**, 31–47.

Gordon, T. (1975) *Parent Effectiveness Training*. New York: New American Library.

Gross, D., Fogg, L., Webster-Stratton, C. and Grady, J. (1999) Parent training with low-income multi-ethnic parents of toddlers. Paper presented at the Society for Research in Child Development, Albuquerque, NM.

Hammer, T.J. and Turner, P.H. (1985) *Parenting in Contemporary Society*, 2nd edition. NJ: Prentice Hall.

Hawkins, J.D. and Catalano, R.F. (1996) *Parents Who Care: A Guide for Families With Teens*. Washington: Developmental Research and Programs.

Hendrick, H. (1994) *Child Welfare, England 1872–1989.*, London: Routledge.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D. and Cunningham, P.B. (1998) *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford Press.

Holden J.M., Sagovskiy, J.R. and Cox, J.L. (1989) Counseling in a general practice setting: a controlled study of health visitor intervention in the treatment of postnatal depression. *British Medical Journal*, **298**(6668), 223–6.

Huesmann, L.R., Moise-Titus, J., Podolski, C. and Eron, L.D. (2003) Longitudinal relations between children's exposure to TV violence and their aggressive and violent behavior in young adulthood: 1977–1992. *Developmental Psychology*, **39**, 201–21.

Hutchings, J. (1996) The personal and parental characteristics of pre-school children referred to a child and family mental health service and their relation to treatment outcome. Unpublished D.Clin.Psy. Thesis, University of Wales, Bangor.

Hutchings, J., Appleton, P., Smith, M., Lane, E. and Nash, S. (2002) Evaluation of two treatments for children with severe behaviour problems: child behaviour and maternal mental health outcomes. *Behavioural and Cognitive Psychotherapy*, **30**, 279–95.

Hutchings, J., Lane, E. and Kelly, J. (2004) Comparison of two treatments for children with severely disruptive behaviours: a four-year follow-up. *Journal of Behavioural and Cognitive Psychotherapy* (in press).

Johnson, Z. and Molloy, B. (1995) The community mothers programme – empowerment of mothers by mothers. *Children and Society*, **9**(2), 73–83.

Kazdin, A.E. (1990) Premature termination from treatment of children referred for antisocial behaviour.

Journal of Child Psychology and Psychiatry, **31**, 415–25.

Kazdin, A.E. (1993) Treatment of conduct disorder: progress and directions in psychotherapy research. *Development and Psychopathology*, **5**, 277–310.

Kitzman, H. (1997) Effect on prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries and repeated childbearing: a randomised controlled trial. *Journal of the American Medical Association*, **278**, 644–52.

Kochanska, G. and Aksan, N. (1995) Mother–child mutually positive affect, the quality of child compliance to requests and prohibitions, and maternal control as correlates of early internalization. *Child Development*, **66**, 236–54.

Lane, E. and Hutchings, J. (2002) Evaluation of a course in behavioural analysis for health visitors: the benefits for health visitors and the families with whom they worked. *British Journal of Nursing*, **11**(10), 702–14.

Larson, C.P. (1980) Efficacy of pre-natal and post-partum home visits on child health and development. *Pediatrics*, **66**, 191–7.

Lynam, D.R., Caspi, A., Moffitt, T.E., Wikström, P.H., Loeber, R. and Novak, S. (2000) The interaction between impulsivity and neighborhood context on offending: the effects of impulsivity are stronger in poorer neighborhoods. *Journal of Abnormal Psychology*, **109**, 563–74.

Miller, L.S. and Rojas-Flores, L. (1999) *Preventing Conduct Problems in Urban, Latino Preschoolers through Parent Training: A Pilot Study*. New York, NY: New York University Child Study Center.

Oakley A. (1992) *Social Support and Motherhood*. Oxford: Blackwell.

Oakley, A., Rajan, L. and Grant, A. (1990) Social support and pregnancy outcome. *British Journal of Obstetrics and Gynaecology*, **79**, 155–61.

O'Dell, S.L. (1985) Progress in parent training. In Hersen, M., Eisler, R.M. and Miller, P.M. (eds) *Progress in Behavior Modification*. New York: Academic Press, **19**, 57–107.

Office of Juvenile Justice and Delinquency Prevention (2000) *The Incredible Years Training Series*. Washington, D.C: Office of Juvenile Justice and Delinquency Prevention.

Offord, D.R., Boyle, M.C. and Szatmari, P. (1987) Ontario child health study: II, six month prevalence of disorder and rates of service utilization. *Archives of General Psychiatry*, **44**, 832–6.

Olds, D.L. (1986), Preventing child abuse and neglect: a randomized trial of nurse home visitation. *Pediatrics*, **78**, 65–78.

Olds, D.L. (1998) Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized trial. *Journal of the American Medical Association*, **280**, 1238–44.

Owen, G.M. (1982) Health visiting. In Allen, P. and Jolley, M. (eds) *Nursing, Midwifery and Health Visiting Since 1900*. London: Faber and Faber.

Patterson, G.R. (1982) *Coercive Family Process*. Eugene, OR: Castalia.

Patterson, G.R. and Forgatch, M.S. (1989) *Parent and Adolescents Living Together, Part 2: Family Problem Solving*. Eugene, OR: Castalia Publishing.

Patterson, G.R., Reid, J.B., Jones, R.R. and Conger, R.E. (1975) *A Social Learning Approach to Family Intervention: Families with Aggressive Children*, Vol. 1. Eugene, OR: Castalia.

Patterson, G.R., Dishion, T.J. and Chamberlain, P. (1993) Outcomes and methodological issues relating to the treatment of antisocial children. In Giles, T.R. (ed.) *Effective Psychotherapy: A Handbook of Comparative Research*. New York: Plenum Press, pp. 43–88.

Reid, J.B. (1993) Prevention of conduct disorder before and after school entry: relating interventions to developmental findings, *Development and Psychopathology*, **5**, 243–62.

Reid, M.J., Webster-Stratton, C. and Beauchaine, T.P. (2001) Parent training in Head Start: a comparison of program response among African American, Asian American, Caucasian and Hispanic Mothers. *Prevention Science*, **2**(4), 209–27.

Robbins, L.N. (1981) Epidemiological approaches to natural history research: antisocial disorders in children. *Journal of the American Academy of Child Psychiatry*, **126**, 493–509.

Ruma, P.R., Burke, R.V. and Thompson, R.W. (1996) Group parent training: is it effective for children of all ages? *Behavior Therapy*, **27**, 159–69.

Rutter, M., Cox, A., Tupling, C., Berger, M. and Yule, W. (1975) Attainment and adjustment in two geographical areas, 1: The prevalence of child psychiatric disorder. *British Journal of Psychiatry*, **126**, 493–509.

Sanders, M.R. (1999), Triple P-Positive Parenting Program: towards an empirically validated multi-level parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Journal of Clinical Child and Family Psychology Review*, **2**(2), 71–89.

Scott, S. (2001) Parent training programmes. In Rutter, M. and Taylor, E. (eds) *Child & Adolescent Psychiatry*, 4th edition. Oxford: Blackwell Science.

Scott, S., Knapp, M., Henderson, J. and Maughan, B. (2001a) Financial costs of social exclusion: follow-up study of children into adulthood. *British Medical Journal*, **323**(7306), 191–3.

Scott, S., Spender, Q., Doolan, M., Jacobs, B. and Aspland, H.C. (2001b). Multicentre controlled trial of parenting groups for childhood antisocial behavior in clinical practice. *British Medical Journal*, **323**, 194–203.

Shure, M. (1994) *I Can Problem Solve (ICPS): An Interpersonal Cognitive Problem-Solving Program for Children*. Champagn, IL: Research Press.

Smith, C. (1996) *Developing Parenting Programmes*. London: National Children's Bureau.

Spaccareli, S., Cotler, S. and Penman, D. (1992) Problem-solving skills training as a supplement to behavioural

parent training. *Cognitive Therapy and Research*, **16**, 1–18.

Taylor, T.K. and Biglan, A. (1998). Behavioural family interventions for improving child-rearing: a review for clinicians and policy makers. *Clinical Child and Family Psychology Review*, **1**, 41–60.

Taylor, T.K., Schmidt, F., Pepler, D. and Hodgins, H. (1998) A comparison of eclectic treatment with Webster-Stratton's parent and children series in a mental health center: a randomized controlled trial. *Behaviour Therapy*, **29**, 221–40.

Wahler, R.G., Cartor, P.G., Fleischman, J. and Lambert, W. (1993) The Impact of synthesis teaching and parent training with mothers of conduct-disordered children. *Journal of Abnormal Child Psychology*, **21**, 425–40.

Walker, H.M., Colvin, G. and Ramsey, E. (1995) *Antisocial Behavior in School: Strategies and Best Practices*. Pacific Grove, CA: Brooks/Cole.

Webster-Stratton, C. (1985) Comparisons of behaviour transactions between conduct disordered children and their mothers in the clinic and at home. *Journal of Abnormal Child Psychology*, **13**(2), 169–84.

Webster-Stratton, C. (1991) Annotation: strategies for helping families with conduct disordered children. *Journal of Child Psychology and Psychiatry*, **32**(7), 1047–62.

Webster-Stratton, C. (1998a) Parent training with low-income families: promoting parental engagement through a collaborative approach. In Lutzker, J.R. (ed.) *Handbook of Child Abuse Research and Treatment*. New York, NY: Plenum Press, pp. 183–210.

Webster-Stratton, C. (1998b) Preventing conduct problems in Head Start children: strengthening parent competencies, *Journal of Consulting and Clinical Psychology*, **66**, 715–30.

Webster-Stratton, C. (1999) *How to Promote Children's Social and Emotional Competence*. London: Sage Publications.

Webster-Stratton, C. and Hammond, M. (1997) Treating children with early-onset conduct problems: a comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, **65**(1), 93–109.

Webster-Stratton, C. and Herbert, M. (1994) *Troubled Families – Problem Children, Working with Parents: A Collaborative Process*. Chichester: John Wiley.

Webster-Stratton, C. and Reid, M.J. (2003) Treating conduct problems and strengthening social emotional competence in young children (ages 4–8 years): The Dina Dinosaur treatment program. *Journal of Emotional and Behavioral Disorders*, **11**, 130–43.

Webster-Stratton, C. and Reid, M.J. (in press) Strengthening social and emotional competence in young children—the foundation for early school readiness and success: Incredible Years Classroom Social Skills and Problem Solving Curriculum. *Journal of Infants and Young Children*.

Webster-Stratton, C. and Taylor, T. (2001) Nipping early risk factors in the bud: preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (ages 0–8 years). *Prevention Science*, **2**(3), 165–92.

Webster-Stratton, C., Reid, M.J. and Hammond, M. (2001a) Preventing conduct problems, promoting social competence: a parent and teacher training partnership in Head Start. *Journal of Clinical Child Psychology*, **30**, 283–302.

Webster-Stratton, C., Mihelic, C., Fagan, A., Arnold, D., Taylor, T. and Tingley, C. (2001b) *Blueprints For Violence Prevention, Book 11: The Incredible Years: Parent, Teacher and Child Training Series*. Golden, CO: Venture Publishing.

Werry, J.S. (1997), Severe conduct disorder – some key issues. *Canadian Journal of Psychiatry*, **42**, 577–83.