What Works in Parenting Support?
A Review of the International Evidence

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Policy Research Bureau

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Foreword and acknowledgements

In early 2003, the Family Policy Unit (FmPU) of the Home Office commissioned the independent Policy Research Bureau (PRB) to carry out a review of the evaluation literature and evidence on effective practice – 'what works' – in interventions to support parenting. Following the machinery of government changes in June 2003, the review was completed working to what became the Families Division in the Department for Education and Skills.

In the last twenty years, the literature in this field has grown from a trickle to a flood: our search of formally published and peer-reviewed documents alone (ie, not including a vast 'grey' literature of evaluation reports and practice summaries) revealed several thousands of potentially relevant papers and books. Our brief was to sort systematically through this huge literature, chart the key findings in a standardised form, and distil out the overarching messages in a succinct and accessible way - all to be achieved within a little over six months. Not surprisingly, we have found this to be a challenging, if very rewarding, task. We are grateful to a number of colleague organisations within the UK parenting support field who helped us locate some of the less visible research literature, including the Parenting Education and Support Forum and many service providers too numerous to list here. A number of expert reviewers provided valuable comments on the draft report to a tight timetable, including Dr Jane Barlow (University of Warwick), Professor Charles Desforges (Exeter University), Hetty Einzig and colleagues (Parenting Education and Support Forum), Dr Ann Hagell (Policy Research Bureau), Clem Henricson (National Family and Parenting Institute), Dr Margaret Lynch (Guys Hospital), Mary McLeod (National Family and Parenting Institute), and Dr Debi Roker (Trust for the Study of Adolescence). Two anonymous reviewers also peer reviewed the final report, and we are grateful for their helpful and thorough comments.

We are also grateful for the support of (and enjoyed our stimulating discussions with) the steering group for the project, including Clare Roskill, of the Family Policy Unit and then Families Division; Robin Woodland of the Family Policy Unit (to June 2003); Ann Barber (to April 2003) and Sara Trikha, both of Research and Statistics in the Home Office; and from July 2003, Tara Cooke and Shiraleen Thomas from DfES, Analytic Services. Lastly, we also thank colleagues at PRB who helped with the project, including Deborah Katz, Rebekah Nichols, and Ilan Katz.

This is a dynamic and fast-growing area of research and practice, and up to the point of publication of this report we were still locating new sources and spotting gaps in our coverage. This review should therefore be regarded as the start of a discussion

as much as the final word, and will undoubtedly need updating sooner than we might have thought!

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Policy Research Bureau
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Executive summary

Introduction

This is a summary of a review of the international (English language) evidence regarding the effectiveness of parenting support programmes, carried out by the independent Policy Research Bureau on behalf of the DfES. In the light of research evidence from recent decades linking various aspects of parenting with outcomes for children, many programmes have sprung up aimed at helping parents to enhance their ability to parent, in the hope that outcomes for children may ultimately improve. At the same time, a body of literature documenting the scientific evaluation of parent support programmes has also accumulated, assessing its effectiveness. The current study set out to review this growing body of literature. The task involved collating, grading, sorting and summarising parenting support evaluation literature (both published and unpublished) in order to delineate what is known about 'what works' both in the UK and elsewhere, and to distil key messages for policy makers regarding practice, research and overarching national policy.

Aims of the review

The aim of this review was to address a gap in the current literature. Although a number of reviews of parenting support programmes already exist, they tend to fall into one of two types. Many rigorous 'systematic reviews' set such scientifically stringent criteria for studies to be included for review that only a tiny proportion of the available literature is drawn upon. Alternatively, broader and more inclusive reviews exist but are often somewhat unscientific in their selection of material included. Moreover, only a handful consider findings from both qualitative and quantitative investigations, and relatively few consider the implications of their findings for policy and evaluation research as well as practice.

We therefore aimed to produce a review crossing these boundaries and covering a wide range of services that go under the banner of 'parenting support', combining scientific rigour with practice and policy relevance and accessibility. Programmes were sorted into four categories: 'what works', 'what is promising', 'what does not work', and those in which effectiveness is still 'not known'. We also aimed to identify gaps in the evidence base and to distil the key messages for research, policy and practice. The evidence was drawn from the international evaluation literature, and included both quantitative and qualitative evaluations in order to provide a fully rounded picture of effectiveness in terms not only of significant outcomes, but also in relation to programme implementation and delivery.

Key terms and methods of the review

When selecting evaluation literature for inclusion, *parents* were taken to include all those who provide significant care for children in a home or family context, including biological parents, step-parents, foster parents, adoptive parents, grandparents or other relatives. We took *parenting support* to include any intervention for parents or carers aimed at reducing risks and/or promoting protective factors for their children, in relation to their social, physical and emotional well-being. Our focus throughout, with minor exceptions, was on programmes of *mainstream* relevance, i.e. interventions aimed at common problems of relatively low severity or relatively high frequency.   Both *universal* services (those open to anyone irrespective of their levels of need) and *targeted* services (those offered only to specific groups or populations, in response to a specific assessed need) were included. We included evaluations of interventions aimed at *primary* levels of prevention (intervening to prevent the onset of problems), and at *secondary* levels of prevention (intervening with high risk groups or where problems have begun but are not yet strongly entrenched) but rarely included those at tertiary levels of prevention and treatment (when problems are already strongly present and require active treatment).

A main report was produced, summarising the literature in a number of broadly-grouped areas of outcome for children, parents, and families. For each outcome area, a combination of individual evaluation studies and pre-existing reviews was used to provide a summary of key messages. In addition, descriptive profiles of many of the programmes were also provided. The main report was accompanied by a 'grid' (or chart) which can be downloaded from the Policy Research Bureau's website (www.prb.org.uk), providing details of a selection of individual parenting support interventions and their evaluations, and giving ratings of the scientific robustness of the evaluations as well as the effectiveness of the programmes. The eventual selection of evaluation studies and research reviews that formed the basis of the review was made from over two thousand potentially relevant journals, books and reports, both published and 'grey'. To be included, interventions had to involve parents or parents with their children (from birth to nineteen years), rather than children alone. It could target outcomes for parents in their own right as well as for children, but only to the extent that the existing literature clearly demonstrated that these parent-level outcomes have a strong and reasonably direct link with outcomes for children. Qualitative as well as quantitative evaluations were included, but had to be of sufficient methodological robustness in either case to merit inclusion. Generally, quantitative studies that used pre- and post-intervention assessments were included, often with a comparative or controlled design (ie, where people receiving an intervention are compared with those not receiving it). However, because of the large number of areas where no studies of this standard were

unearthed, studies with weaker methods but judged to be of some merit were occasionally included, though conclusions are more tentative in these cases.

The selected literature was sorted according to the area of *actual* outcome that was reported by the study (rather than the study's *intended* outcomes), for children, parents and families. Each of these three broad outcome areas were then subdivided into narrower outcomes. Within these categories the literature was further sorted into: 'what works', 'what is promising', 'what does not work' and 'what is unknown', based on the presence of significant results showing support for programmes from a methodologically robust evaluation.

Key Findings: messages about practice, research and national policy

The key findings of the review are summarised below. Because the review was written for policy-makers involved both in commissioning services and research about them, all of the messages extracted are relevant for policy but in relation to three broad themes: messages about practice; messages about research; and messages for national policy in family support.

Below we summarise our **conclusions for policy about 'what works' in practice**:

- Both early intervention <u>and</u> later intervention: early interventions report better and more durable outcomes for children; but late intervention is better than none and may help parents deal with parenting under stress
- Interventions with a strong theory-base and clearly articulated model of the predicted mechanism of change: services need to know both where they want to go, and how they propose to get there
- Interventions that have measurable, concrete objectives as well as overarching aims
- Universal interventions (aimed at primary prevention amongst whole communities) for parenting problems and needs at the less severe end of the spectrum of common parenting difficulties - though some types of universal services require more evaluation to determine their effectiveness
- Targeted interventions (aimed at specific populations or individuals deemed to be at risk for parenting difficulties) to tackle more complex types of parenting difficulties
- Interventions that pay close attention to implementation factors for 'getting', 'keeping' and 'engaging' parents (in practical, relational, cultural/contextual, strategic and structural domains; see Section Four of the main report)
- Services that allow multiple routes in for families (variety of referral routes)
- Interventions using more than one method of delivery (ie, multi-component interventions)

- Group work, where the issues involved are suitable to be addressed in a 'public' format, and where parents can benefit from the social aspect of working in groups of peers
- Individual work, where problems are severe or entrenched or parents are not ready/able to work in a group, often including an element of Home Visiting as part of a multi component service, providing one-to-one, tailored support
- Interventions that have manualised programmes where the core programme (ie, what is delivered) is carefully structured and controlled to maintain 'programme integrity'
- Interventions delivered by appropriately trained and skilled staff, backed up by good management and support
- Interventions of longer duration, with follow-up/booster sessions, for problems of greater severity or for higher risk groups of parents
- Short, low level interventions for delivering factual information and fact-based advice to parents, increasing knowledge of child development and encouraging change in 'simple' behaviours
- Behavioural interventions that focus on specific parenting skills and practical 'take-home tips' for changing more complex parenting behaviours and impacting on child behaviours
- 'Cognitive' interventions for changing beliefs, attitudes and self-perceptions about parenting
- Interventions that work in parallel (though not necessarily at the same time) with parents, families and children

There were also a number of messages for policy with regard to **what is still not known about 'what works' on the basis of current research**:

- How effective (as opposed to merely 'promising') UK parenting interventions are, which cannot be determined without more robustly scientific research methods than are currently the norm
- The extent to which interventions developed and shown to be effective in other countries such as the US can 'translate' to the very different UK context
- What 'doesn't work' (because of a bias against reporting negative or equivocal research findings)
- The specific characteristics of participants and programmes that contribute to success for programmes that show promise or are effective - i.e. not just 'what works', but 'for whom under what circumstances'
- Whether positive changes in parenting and child behaviours associated with parent support interventions can be sustained over the long term
- How changes in parents' knowledge and attitudes can be translated into changes at the behavioural level

- How to retain and engage families in 'high risk' groups in parenting support interventions more successfully, and how to ensure better outcomes for these groups more consistently
- What aspects of resilience and which protective factors in parenting moderate the outcomes of parenting support for both parents and children
- What aspects of parenting support interventions are most effective when working with fathers and how programmes may need to be better designed to meet their needs
- What aspects of parenting support interventions are most effective with black and Asian parents and how programmes may need to be better designed to meet their needs
- How children themselves perceive the effectiveness of parenting support programmes
- The optimal duration for different types of interventions to achieve the best outcomes
- The characteristics of home visiting that contribute to its success, i.e. training levels of staff, frequency and duration of visits, and content of the session
- Whether and to what extent parenting support interventions in the UK are cost-effective
- The relative efficacy of group versus one-to-one intervention in the medium to longer term

There were also **messages for policy about the research base more generally**:

- There is a need to commission more rigorous and robust research designs that can really tell us 'what works', including randomised controlled trials ('RCTs') wherever possible, and certainly more comparative and quasi-experimental designs; and also including better quality qualitative research
- There is a need to build capacity in this field, including funding 'developmental' studies that advance methodologies in this field
- Continued commitment to wide dissemination of research findings is essential, but not only of 'good' results that suggest effective practice. Negative and inconclusive results may also contain important learning. Commissioning a review of 'what doesn't work' in a number of areas might be enlightening
- Especially but not only at local level, there is a need for commissioners of research to be better trained in research methods so that they are able to assess and promote good design and execution in evaluation research

Finally, an important group of key findings concerned **messages for national policy from the evaluation literature:**

- Parenting support benefits families, and this review has clearly shown the potential benefits that may be realised through continuing investment in this type of social intervention
- Many parents need support at some point in their parenting career and efforts to 'normalise' access to support as a universal right seem likely to generate strong benefits. The message that it is not unusual to need support from time to time needs to be conveyed in policy rhetoric, to help increase rates of access, especially at critical points for early intervention
- There needs to be a consistent message about supporting parents delivered across the board, reflecting the wider ecological context of parenting, from the provision of individual programmes to the implementation of national policies. The broad thrust of current policy in the UK appears to be in tune with this, but the impact of new policy initiatives needs to be monitored constantly to ensure that policy in one area does not inadvertently pull against policy in another.
- Across the board, in order to better support parents, policy needs to embody an evidence-based model of parenting linked to good outcomes for children, (e.g. encouraging authoritative, non-punitive parenting rather than harsh parenting; promoting and enabling fathers' involvement in childcare)
- Results show time and time again that it is difficult for stressed families to benefit from parenting programmes when they face multiple disadvantages, and thus policies that reduce everyday stresses in the lives of families (including poverty, unemployment, poor health, housing and education) will support parents in caring for their children
- We need to recognise that there will always be a minority of parents who cannot or will not benefit from parenting support services. This does not mean a service is 'all bad', or that anyone is necessarily to blame. The media should be helped to understand this better
- It is questionable whether punishing those who fail to benefit from parenting support with draconian sanctions is consistent with promoting better outcomes for their children
- It will be vital for the future of this field that government invests in building capacity and skills in the social care workforce and related professions that provide parenting support. Supporting families without compromising their autonomy is a demanding and delicate job, and highly skilled and appropriately trained staff will get better results.

Concluding remarks

Research indicates that there are many families in the community who could benefit from parenting support in one form or another, although attracting parents and engaging them with programmes remains a challenge. Unfortunately, in the UK the

burgeoning number of parenting support programmes in recent years has not been matched by a rise in the number of high quality quantitative and qualitative studies carried out to evaluate them. Consequently the evaluation literature only provides us with a partial picture of 'what works', and only partial understanding of why some programmes work better than others. Nevertheless, clear messages have emerged, showing that provision of parenting programmes still represents an important pathway to helping parents, especially when combined with local and national policies that address the broader contextual issues that affect parents' and children's lives.

1. **Introduction**

The policy context

It now seems a long time since the Children Act (1989) set down in explicit terms a definition of parental responsibility that emphasised the duty of care placed on parents to ensure their children's moral, physical and emotional well being, and obliged Local Authorities to promote the upbringing of children 'in need'[1] by their families through provision of such services as might be required to achieve this (Section 17:iii). Though the 'best interests of the child' were set at the heart of this critical piece of legislation, the role of families and parents in promoting good outcomes for children was given clear prominence, alongside an emphasis on the importance of services in assisting and supporting parents in this task.

Though in the UK we now take this principle very much for granted when thinking about the way family support services ought to be delivered, the Children Act (1989) in many ways re-defined the practice landscape for the social care field in terms of services to children and families. Care in the family – and preferably in their own birth family - for all except the most vulnerable was emphasised as the preferred option for bringing up children, and service planners were required to focus not just on children at the extreme end of the continuum of risk (e.g. abused and neglected children in need of active protection) but on the wider community of families and children 'in need'. A 'refocusing' of resources to include a stronger emphasis on prevention and early intervention reflected three key developments in the thinking of policy makers: one, the increasing scientific evidence-base that was showing that children's probability of developing poorly could be predicted at an early age (e.g Robins, 1979) and that we were beginning to be much clearer about the risk factors involved and therefore the targets of intervention; two, that there could therefore be substantial benefits to society as well as to families and individuals of 'getting in early' to provide services (e.g. Little and Mount, 1999); and three, that many families who were in need were not being reached by services (Department of Health, 1995; Ghate and Hazel, 2002).

Since then, and especially since the Labour government came into office in 1997, there has been a burgeoning interest in (and a massive increase in spending on) family support interventions in the UK. In just a few years, family support has come to enjoy a central position in the national policy and practice picture, driven strongly by two Green Papers[2]: *Supporting Families* (1998; led by the Home Office), and *Every*

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[1] That is, families and children who would be likely to suffer impairment if they did not receive services (Little and Mount 1999).

[2] Government papers produced for the purpose of consultation on significant policy and service developments.

*Child Matte*rs (2003; led by the Cabinet Office, reporting to the Chief Secretary at the Treasury)[3], with its follow up, *Every Child Matters: next steps* (2004; DfES). The first (amongst other things) focused attention on the particular role of parenting in the development and prevention of offending and antisocial behaviour by young people, and marked the beginning of a period of intense policy focus on the interface between outcomes for children and inputs by parents, including an increasing recognition of the importance of the role of fathers and the need to extend family support services to men as well as women. In its wake came the introduction of Parenting Orders, a controversial new disposal introduced under the Crime and Disorder Act (1998) and first rolled out in 2000, mandating parents of young offenders and persistent truants to receive parenting education and support provided by local multi-agency youth offending teams. Under the provisions of the Anti-social Behaviour Act (2003), the government extended this principle more widely in the form of voluntary parenting contracts, introduced residential parenting support for some, and extended various provisions to include parents of persistent truants.

Every Child Matters also placed supporting parents and carers at the top of a list of four key areas for development, the others being early intervention and effective protection, accountability and integration of children's services, and workforce reform. Following in the wake of major national concern about children falling through the child protection net after the death of eight year old Victoria Climbié, it proposed a wide range of potentially far-reaching changes and reforms designed to lead to better integration of children's services. These included the establishment of multi-agency Children's Trusts, the introduction of better information sharing systems for keeping track of children 'in the system' (previously known as Identification, Referral and Tracking – IRT, subsequently renamed Information Sharing and Assessment), and a number of new posts for both central and local government (including the creation of a Minister for Children, Young People and Families heading up a new directorate of children and families based at the Department for Education and Skills, and bringing together sections of departments concerned with services for families that were previously housed and managed separately). *Every Child Matters: next steps* detailed how the proposals outlined in *Every Child Matters* were to be implemented, including the introduction of a Children Bill, placing statutory duties on key agencies to work in partnership towards common goals, accompanied by a £20 million package of support to localities to enable them to take the Green Paper agenda forward.

At the service delivery level, a mapping exercise of family support services in the UK by the National Family and Parenting Institute estimated that 40% of all services had been set up in the previous five years (Henricson, Katz, Mesie, Sandison and

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[3] Paul Boateng, who acted as the sponsor minister

Tunstill, 2001). Though a substantial proportion of these services are provided by the voluntary sector, central government has been driving this expansion, using vehicles such as *Sure Start,* one of the first and most expensive in a series of national area-based initiatives delivering support services for parents across the country at a cost of around half a billion pounds` in its first five years. It provides a wide range of services to families including early education, childcare, health and family support as well as advice on benefits and employment opportunities. Since its launch in 1998, *Sure Start* has gone from strength to strength, in pursuit of the government's objective to halve child poverty by 2010 and eliminate it by 2020. Its next phase includes extending its services to include 'Sure Start Children's Centres' offering pre-school child and family support services in the 20% poorest wards of the country.   In 2000 the Children's Fund was announced and now has a budget of £450 million over six years, providing a range of services aimed at children aged 5-13 years. Most recently of all, a new Parenting Fund is providing a total of £25m over three years for the set up and delivery of interventions aimed specifically at parent support and education in the voluntary and community sector.

In summary, compared to the situation pre-1997 there can now be said to be a reasonably well established 'parenting support industry' within the UK. Indeed, an outsider tracking the thrust of policy and practice development over recent years might be forgiven for concluding that we as a nation had decided that almost any social ill - poverty, social exclusion, crime and anti-social behaviour, poor educational attainment, poor mental and emotional heath - could be remedied by improving parenting skills. A recent survey of parents registered at three G.P practices in England showed that around a fifth of parents had attended a parenting programme, and more than half expressed an interest in doing so if offered (Patterson, Mockford, Barlow, Pyper and Stewart-Brown, 2002). Though it is clear that there is still much work to do, and further investment is required to sustain and take forward the gains made in recent years in this area of service provision, the once oft-stated dictum that '*parenting is the greatest single preserve of the amateur*' (Toffler, 1970, quoted in Dembo, Switzer and Lauritzen, 1985) may now be less true than it has been at any time previously.

The need for the review

Yet – and it is a big yet – despite intense policy interest in the field, a now considerable body of practice expertise, numerous literature and 'systematic' reviews, and a growing research tradition of impact evaluation, many new services that are developed bear only a distant relationship to practice that is of scientifically proven efficacy and rely instead on what we might call 'practice wisdom'. Partly, this reflects a healthy diversity and creativity in the field, as well as the fact that it is often easier to get funding to develop a new, innovative intervention than it is to replicate a tried and tested model. Partly it reflects local services' sense that only

they 'know' their community, and a desire to build services tailored to specific local needs and concerns. Partly it is because what is 'proven' remains, for many, a bit of a mystery.   There is still a sense that we don't yet quite know 'what works' – or that if we do know, we haven't successfully articulated it in a concise and digestible way. As the trawl through the available literature that we undertook for this review showed, there is a wide range of information in existence, from detailed accounts of evaluations of individual studies and programmes, to 'systematic'[4] reviews of the literature in a defined area, to meta-analyses[5], to essays and literature reviews on 'what works', to short summaries of key elements of effective practice aimed at service providers.

A number of reviews of 'what works' of one kind or another exist in this field already (e.g. Smith 1996; Barlow 1997; Lloyd, 1999; Statham 2000; Barlow and Parsons, 2002; Coren and Barlow, 2002; Woolfenden, Williams and Peat, 2002; Desforges and Abouchaar, 2003). As a rule, however, these past reviews differ from the current review in two main ways. First, a number are confined to particular types of parenting support, or to the exploration of a particular category of outcome, such as children's emotional and behavioural problems or parental mental health. Second, they either approach the task from a deliberately inclusive but sometimes rather unscientific angle, or they take a very focused, systematic and exclusive approach. In our view, there are few accessible reviews that cross these boundaries and aim to give coverage to the broad range of services that go under the banner of 'parenting support' in a way that can marry academic rigour with practice and policy relevance and accessibility.

Perhaps it is the sheer volume of material, and its diversity and selectivity that is part of the problem. Researchers who have been working and writing in the field for some time may sometimes feel puzzled when yet another policy maker states 'we

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[4] A 'systematic review' in this context is a technical term describing a highly rigorous method of sifting research findings from a range of studies and extracting or 'boiling down' their findings to arrive at conclusions based on studies included on the basis of very tightly defined criteria. In general, systematic reviews result in the jettisoning of large parts of the research base for failing to meet these criteria. When these methods are applied in social research (as opposed to clinical research, from which this method derives), where research rarely lives up to the gold standards of quantitative clinical research, findings tend to be based on only a tiny proportion of the studies that were originally identified as relevant. Examples of the ratios of number of studies *included* (ie that fulfil scientific selection criteria) relative to number of studies authors *initially identified* in their searches on the topic range from 1:10 (Smith 1996), through 1:14 (Barlow 1999) to 1:121 (Woolfenden et al, 2002).
[5] A 'meta-analysis' is also a technical term for a type of review that re-analyses data aggregated across a number of different studies, using rigorous criteria to select studies to be included. The synthesised conclusions are usually presented in statistical terms, expressed in terms of an 'effect size', a standardised statistic that allows us, amongst other things, to assess the magnitude of one intervention's overall impact when compared to others. Effect sizes can range from 0 to 1, and a small effect size (.2) indicates not much impact and big one (.8) means a very marked impact (Cedar and Levant 1990; Cohen 1977).

need to know what works', but the fact is that funders faced with sorting through and prioritising a wide range of applications for grants need more to guide them than the often arcane conclusions of weighty academic reviews, hedged around with caveats and mysterious mathematical signifiers such as effect sizes. Busy policy makers and service planners don't have the time to read the individual studies that have contributed to the reviews. They don't have time to read long discursive documents weighing the subtleties and complexities of the field. Moreover, there are some big blank patches in our picture of what works, and (to extend the metaphor) remarkably little fine brush work to give texture below the surface of that big picture. Beyond 'what works', can we say what works *for whom*, or *under what particular circumstances*? It is a question that is still not easily answered.

Aims and objectives of the review – what the review is, and is not

Our aim then, then, in this review, was to collect and rigorously sort the international evaluation literature in the field of parenting support, extract its key findings, and distil these into a concise, accessible 'state of the art' document. In respect of each key aspect of parenting support intervention that we explored, we were asked to delineate what was known under four headings: what definitively works; what looks promising; what is unknown; and what definitively doesn't work. In addition, we were asked to reflect on what are the gaps in the evidence base, and the implications of this for policy, practice and research. In doing this, we were asked to produce two outputs: one, a table or 'grid' showing a selection of the key research studies in the field broken down into various components (descriptive information and results; available online); and two, an accessible commentary on the story the research tells us, combined with illustrative profiles of key programmes (i.e. this report). The commentaries are organised according to groups of outcomes for children and parents. The commentaries and grid are related but not interchangeable; the commentaries can be viewed as our assessment of the broad 'balance of evidence' in a particular field, whereas the grid tabulates an illustrative selection of the actual evidence. The grid gives some of the fine detail of the individual studies that were judged to be (a) of reasonable quality and (b) illustrative of key findings that informed the review as a whole, while the written commentaries are very much the 'big picture'. They provide overviews of each broad outcome area, wherever possible drawing on pre-existing research reviews in areas where a reasonably strong consensus about what is effective has already emerged in that field, and on sets of individual studies where the picture is less clear (or where reviews are few or patchy in their coverage). In our pursuit of this big picture, it is inevitable that some of the important caveats have been glossed over from time to time. We were asked to complete the review of this vast field in a short time and to make it as concrete in its conclusions as possible. In trying to be clear, we hope however that we have not sacrificed too much of the subtlety and texture that characterises this huge literature. In Section Two (Methods) further detail is given

about how the commentaries and grid were constructed and how they relate to one another.

It is also important to be clear that this review is not a 'systematic' review in the technical sense of that term. Those who specialise in the study of the specific outcome areas we have covered as sub-sections of the whole review will undoubtedly spot gaps. Though we have tried to capture as much as possible of what is currently known about the outcome areas we were asked to address, we do not claim to have conducted an exhaustive survey of each outcome area. Time did not permit this. This is why we do not follow the convention of systematic reviews of providing detailed commentaries about the precise numbers of studies found, the number excluded, and those included. Rather, we were asked to apply rigorous research skills to the task of taking an overview, and then to apply our professional judgement to answer the question: what is effective? Wherever possible we have avoided equivocation. Where it seemed to us that *on balance* there is a consensus in the literature, we have allowed ourselves to tend towards the definitive rather than the cautious in our conclusions. This is not to say we have intentionally stretched the evidence further than it can go, but where we feel there is reasonable clarity, we have said so. The bullet-pointed summary boxes at the end of each commentary exemplify this approach. However, we remind readers that our judgements are offered in the context of, and as a contribution to, an ongoing professional debate about what works: we do not claim to deliver up the gospel in this field. This is a fast developing area of practice, and in common with others researching in this field, we recognise that all our conclusions may need to be revisited in the fullness of time.

Lastly, it was apparent throughout the process of sorting the evidence on outcomes that behind any discussion of impact lurks the issue of how interventions are implemented. Implementation (or 'process') issues are of paramount importance in the field, and many a well-designed service has fallen at the first hurdle of getting parents through the doors in the first place. There is much practice wisdom now (and a considerable body of literature) about 'how to' deliver services to families, yet relatively little hard evidence that would pass muster, scientifically speaking, to back up the assertions made by the many writers in this field. We have thus gathered together a summary of process factors about which there appears to be the greatest degree of consensus, backed up wherever possible with robust research evidence, and this can be found after the outcome commentaries, in Section Four.

Key terms and definitions

Parents and parenting

In this review, we use the term 'parents' to include all those who provide significant care for children in a home or family context. Most often this means biological

parents, but it can include other important groups of carers, such as step-parents, and foster or adoptive parents or grandparents. 'Parent' is of course a gender-neutral term, the use of which frequently obscures the fact that the parenting done by women may differ in a range of ways from that done by men. In the review we try to distinguish where relevant and possible between mothers and fathers, but it has to be said this is an uphill task given that so much of the research on parenting is in fact based on the study of mothering (i.e., based on samples of women), but does not necessarily make this explicit at the outset. It is still the case that relatively few studies discuss or analyse fathers as a specific group.

What do we mean by 'parenting'? It is important to be clear about the definition of this term before we can understand what we mean by parenting support. In the most recent edition of the *Handbook of Parenting* (a weighty tome that runs to over 2,000 pages in five volumes), parenting is defined thus:

> *'Put succinctly, parents create people. It is the entrusted and abiding task of parents to prepare their offspring for the physical, psychosocial and economic conditions in which they will eventually fare, and it is hoped, flourish…. Parents are the "final common pathway" to children's development and stature, adjustment and success.'*
> (Bornstein, 2002; Preface, page ix)

This is an inspiring definition, though it tells us relatively little about what parents actually do in concrete terms, or how parents themselves would define what constitutes parenting. In fact, the list of things that 'parenting' encompasses is probably endless in its diversity. Only a few core features seem more or less universal across social groups and social contexts (though there are always exceptions). Most conceptions of parenting encompass the provision of care directed both at children's physical needs as well as their emotional and social needs, describing the parenting role both in terms of nurturance and socialisation. Another commonality is that most parenting takes place in the context of family groups; yet another is that women tend to be assumed to be the 'primary caregivers', with men's role less often investigated, unacknowledged or unclear. It is also striking that across cultures, most parents are universally described as caring deeply about 'doing a good job' of being a parent, and in most writing about parenting, there seems to be consensus that parenting is one of the most difficult jobs that exists (and is getting harder). Beyond this, diversity is the dominant feature. Once we realise this, it also becomes clear that we must be prepared to find many different views of what makes for 'good parenting', and it is this plurality that can create difficulties for the policy maker or service planner trying to isolate the most important elements of parenting support.

Absolutely critical in helping to make sense of this diversity and in developing what has now become a recognised field of parenting studies has been the influence of

Bronfenbrenner's concept of the 'ecological perspective' on human development (Bronfenbrenner, 1977; 1979; Belsky, 1980). As its name would suggest, the ecological model takes a systems perspective, and provides a framework for understanding how factors that impinge on parents and children nest together within a hierarchy of four levels; socio-cultural ('macro system'), community ('exo system'), family ('micro system') and individual ('ontogenic')[6]. These levels also describe a pathway of influence moving from the distal (social and community factors) to the more proximal (family and individual factors), reminding us that parenting does not take place in a vacuum, but within a complex web of interacting, interdependent factors, and that we cannot understand factors associated with one level of the model without also exploring those at other levels. Building upon this model, other writers have also reminded us that parents and children influence each other in an ecological and 'bi-directional' way (Belsky and Vondra, 1989), and that we cannot understand parents without also understanding children.   Both of these perspectives – ecology and bi-directionality - are critical when we try to devise and assess the success of 'parenting support' interventions. It is easy to lose sight of them amongst the growing weight of research findings, but they help enormously in understanding why interventions do and not appear to 'work' in improving outcomes for families.

Parenting support

'Parenting support' is a wide term covering many different things. Other terms that are often used interchangeably (and in combination) but often connote slightly different things include 'family support', 'parent education', and 'parent training'. As will be evident from the foregoing discussion, what may be supportive to one parent may not be supportive to the next, and when working with parents and children, the complex nature of family ecology makes supporting parenting a challenging business. As Garbarino and Bedard (2001) have expressed it: "*Parents face different opportunities and risks in rearing their children because of parental and child mental and physical make-up and because of the social environment they inhabit as a family*". Put simply, within any society parents are starting off from different places, and will encounter different sets of circumstances that will help or hinder them as they progress through the parenting life course. In recognition of this, implicit in the rhetoric of policy and planning for parenting support one can often detect a concern with levelling this uneven playing field, and equipping parents who are struggling in some aspect or other of child care with the tools to function more like our societal ideal of what a 'good parent' is.

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[6] From *ontogenesis*: the origin and development of an individual (Concise Oxford Dictionary: Ninth Edition)

Yet often, the overarching aims of parenting support initiatives are at odds with the reality of what actually happens in a parenting support service. At an operational level, most services address aspects of parenting support that exist at the proximal levels of the ecological model – family and individual factors (and especially individual factors) – rather than factors that are more distal and are located at the social, cultural or community levels, where the roots of disadvantage often lie. Few services are able to tackle directly the background to many parenting problems – poverty, lack of community integration, degraded physical environments, inadequate education, poor housing. Most concentrate instead on what Bronfenbrenner called micro-system and ontogenic factors: how parents interact with their child, how much they know about child development, how they view themselves as caregivers and people, their relationships with their partners. So, although in the practice literature there is much discourse about 'holistic' services, it is probably unrealistic to expect any intervention to be able to offer a truly 'ecologically comprehensive' package. The best that most services can do is be aware of the ecology of parenting and child development, have a clear idea of the particular level(s) of the system at which their own service is targeted, and be prepared to refer families to other agencies for assistance with aspects of the ecology of parenting that their own service cannot help with. Indeed, it might almost be said that the term 'multi agency working' was invented for parenting support: certainly, there can be few areas of health and social care in which the imperative for multi-agency working is quite so strong.

Support for parents comes from a variety of sources, often broadly grouped into *informal* (from family, friends and neighbours, arising from parents' own pre-existing 'natural' networks), *semi-formal* (often provided through community-based organisations, and generally by the voluntary sector), and *formal* support (organised services, often needs-led, and provided by the statutory sector alone or in partnership with the voluntary sector; Ghate and Hazel 2002). In this review, we have <u>not</u> included research on informal support, except insofar as organised services have attempted to impact upon parents' own natural networks as an explicit objective. Thus, we have focussed only on the kinds of support to parents that can be described as 'intervention' – that is, *things done to, or with* parents, not simply experiences that they may have, however supportive they may be. Of course, this misses out a critical (possibly the most critical) element of parenting support, and we should not forget that formal interventions can only ever be seem as one aspect of the complex matrix from which most parents draw support over the course of a parenting 'career'.

We use the term 'intervention' throughout this report, interchangeably with 'service' and sometimes 'programme' to cover a wealth of different activities. For the purpose of this review, parenting support was taken to involve interventions aimed at parents, or parents <u>and</u> children, but those focusing on children alone were

excluded. 'Children' included those in the age range of birth to 19 years (with exclusively pre-natal interventions excluded). [For a glossary of some of the key terms used in the commentaries and in the grid, see the 'Methods' (Section Two)].

Gardner (2003) identifies two significant aspects of parenting support '*prevention* of damage and *promotion* of strengths', highlighting a strong trend in both practice and research to steer away from a purely 'deficit' model that focuses on problems, weaknesses and risk factors in parenting, and to ensure that strengths and protective factors that promote resilience are also considered. Our operational definition, underpinning the selection of material for the review, follows this trend:

> **Parenting support** *is any intervention for parents aimed at reducing risks and promoting protective factors for their children, in relation to their social, physical and emotional well-being.*

However, what this definition lacks, perhaps, is the missing piece of the jigsaw that completes the picture of what 'support' is. It may seem intuitively obvious, but nevertheless is sometimes overlooked, that it is not sufficient just to 'aim' to support parents if we want to influence outcomes for children. Parents must themselves *feel* supported by the help or services they are offered. The services offered must seem appropriate to their own self-identified needs, and not merely reflect political or professional agendas for what it is felt parents ought to do or be, however much care has gone into their design and delivery. Services must reflect back to parents the expertise they have in their own lives and in the lives of their children. Without this, parenting support services are unlikely to show evidence of effectiveness; indeed, they may even make things worse by undermining already fragile families and teaching parents to avoid so-called 'helping' agencies (Ghate and Hazel 2002). By the same token, of course, the fact that parents 'feel supported' by a service does not of itself constitute sufficient evidence of effectiveness: parents may feel subjectively 'satisfied' with a service they have received (and indeed, have taken something positive from it), but this does not mean that outcomes for children will necessarily improve. On the whole, almost all evaluations report that "most parents felt satisfied with the service they received"; yet relatively few interventions can demonstrate strong evidence of actual impact beyond this. The message here is that both elements are required before we can say we have delivered an *effective* service as well as an *acceptable* one.

Outcomes

By 'outcome' we mean something that is thought to have come about *as a result of* something else. The term implies a direction of influence (a causal relationship), which in turn implies a temporal relationship (a sequential element). When we talk of outcomes for parents or children, this can refer to any aspect of psychological, social or physical functioning that is considered 'plastic' (malleable) enough to be

influenced by the environment or ecological system within which an individual lives. By the same token, outcomes are things that can be influenced (at least in theory) by manipulating elements of the ecological system in which that individual is embedded – for example, by offering a service that in some way improves that person's environment, or that enhances the individual's ability to withstand the stress of a less than optimal environment. Thus, in evaluation research the term 'outcome' can be used to cover a vast range of things, including states of mind, attitudes, beliefs or bodies of knowledge; behaviours, skills and competencies; states of health or well being; relationships, community engagement and social functioning; the ability or willingness to access services, and so on. The tradition is to judge the effectiveness of an intervention by the extent to which certain undesirable or negative 'outcomes' (factors) appear to have diminished as a result of exposure to that intervention; or conversely (and less frequently), the extent to which desirable or positive factors have increased. Of course, this sets the bar high, scientifically speaking, since as will be evident from the selective list above, two other characteristics of outcomes present especial challenges both for services and those that would evaluate them: one, in general they are things that typically develop slowly and incrementally over a period or time; and two, they are subject to an almost infinite complexity of influences. Given that services (and evaluations) tend to work on limited time frames relative to the developmental trajectory of many of the outcomes we are interested in influencing, and given that it is almost never possible to address (or measure) all of the possible mediating factors that bear on outcomes, most evaluation work falls well short of a standard of proof of effectiveness that might pass muster in court of law. For this reason some writers prefer to avoid the term 'outcome' altogether, feeling that it implies a degree of scientific certitude that we simply cannot have outside laboratory based research (e.g. Gershoff, 2002). Unfortunately the available alternative terms ('factors', 'constructs', etc) tend to be rather unwieldy and so like the majority of writers, we use the term 'outcome' in this review even when the elements of causality and temporality that the term implies are less than conclusively demonstrated in the literature we are reviewing.

It will be noticed from the definition of parenting support given above that we have stressed the linkage between *support* to parents and *outcomes for their children*. Perhaps this sounds obvious, but one area of potential confusion (and a point for debate) in this field is the extent to which we should be interested in exploring outcomes for parents as carers of children, or those for parents as people in their own right, aside from their child care role. It is generally assumed that unless parents are functional as people, they are unlikely to be functional as care-givers. For that reason, some interventions that are concerned with general adult functioning (e.g. adult literacy programmes, adult mental health) have been described as parenting support because the users of that programme happen to be parents. Of course, most would agree that from the point of view of optimal child

development, it is better to have a parent that can read than a parent who can't, or parent who is contented rather than one who is depressed. However, once we go down this route we can quickly find ourselves a very long way from the territory that this review was intended to map. Almost anything that is 'good for people' can be construed as 'supportive to parenting'. Thus, in this review we have concentrated on outcomes for parents only to the extent that the existing literature clearly demonstrates these parent-level outcomes to have a strong and reasonably direct link with outcomes for children.[7] The relationship between the outcomes at different levels and for different family members may be proximal (close) or distal (more distant) but they can all be located within a process model mapping the relationship between parent factors and child development. To this extent, our selection of literature from which to draw has been theoretically-driven. Of course, in viewing the list it is important to bear in mind that what is deemed a desirable outcome (for parents or for children) is culture, context and time dependent. Desirable outcomes for children are nearly always defined by how adults want children to be rather than by how children inherently are, and indeed in some of the literature a very 'un child-centred' tone can be detected. Similarly it seems that little attention has been paid to how children want their parents to be, in the sense of capturing the child's perspective on what constitutes 'good parenting'. Sometimes we may need to remind ourselves that the quality of children's lives as they are lived 'in the moment' may be just as important as sculpting them into the adults we hope they may become. Moreover, as in all areas, ideas about parenting and childrearing are subject to fashion, and, as can be detected in the current preoccupation in the UK with services aimed at preventing the development of antisocial behaviour in children, they are also shaped by the political priorities of the government of the day. Our review naturally reflects these biases. If the selection of outcome areas on which we focused seems at all idiosyncratic, it should be remembered that the review is a bespoke one, commissioned by policy makers to answer questions of specific current interest to them, and the report reflects this.

What is 'evidence'?

Although we provide a detailed explanation in our 'methods' section as to the literature that we took into account in coming to conclusions about what works, it is also useful to consider more generally the nature and quality of the available evidence in the field of parenting support research. The commonly agreed 'gold standard' methodology used for assessing the effectiveness of interventions is the randomised controlled trial (RCT) developed in the context of clinical medicine, the results of which are typically used in meta-analysis and systematic reviews. Reliance on RCTs and meta-analyses for assessing effectiveness presents considerable problems for a review of parenting support, as very few evaluation

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[7] The list of outcomes on which the review focuses can be found in Section Two, Methods.

studies adopt the RCT design (especially outside the United States). In reality, particularly in the UK, many community-based evaluations of parenting support rely on simple pre- and post-intervention testing of the target population, as few can afford the luxury of a matched comparison group, or alternatively are not practically able to implement such a design due to ethical reservations about 'denial of service' on the part of providers (Ghate, 2001), or because of funding and time constraints. In this field, we are often therefore reliant on other ways of understanding effectiveness.

In addition, there has been a strong tradition of using qualitative methods to evaluate services in the UK, for which RCT methods are rarely appropriate or feasible. As a result, many studies in the UK literature cannot directly answer the question of 'what works' interpreted against strictly 'scientific' criteria. Nevertheless, many of these studies have much to contribute to understanding of the factors that influence the success of a programme (Newman and Roberts, 1999). In particular, studies focussing on process issues involved in the setting up and running of projects provide a critical backdrop to appreciation of the effectiveness of programmes. It is important to establish, for example, whether an apparently unsuccessful intervention is the result of a lack of effective implementation rather than a lack of effective intervention per se (Policy Research Bureau and Trust for the Study of Adolescence, 2002). Factors such as an inability to engage parents from particular groups in the population, lack of flexibility in responding to culturally diverse needs, or clients' finding interventions unacceptable may be the undoing of an otherwise promising intervention. Research by Barnes and Freude-Lagevardi (2002) and our own work (Ghate and Hazel 2002) suggests that participants' perceptions or beliefs form some of the most important factors determining the success of a programme – factors that are often overlooked by practitioners and policy makers in their search for the definitive teaching models or techniques that constitute successful programmes. Thus full assessment of the effectiveness of a programme involves a combination of complimentary evidence drawn from the analysis of process issues as well as measures of outcome, and we have included discussion of both types of data in the report and grid. (For further discussion of what constitutes evidence, see Corrie, 2003, for example.)

Thus, whilst in this review we have attempted to distinguish the scientifically rigorous studies and give them their due weight in the conclusions, we have also tried hard to draw in 'softer' material from studies and writing on process factors and the experiences of participants, as well as what we term 'practice wisdom' – the observations and opinions of experienced practitioners (or those who work with them) informed by years of work on the front line of this field. This approach very much reflects the state of the literature, which could be conceptualised as having reached a half-way house on the way to 'science'. Although there is quite a lot of material, there is very little that meets the usual 'systematic review' criteria, and it is

important not throw the baby out with the bath water by abandoning everything that does not yet meet the criteria for rigorous science. However, in so doing, we have tried to distinguish what is and is not robust with sufficient clarity to allow the reader to understand what is known, and what is suggested or promising but not known. We might also add that the sometimes weak standard of evidence of effectiveness that is accepted in this field by funders and policy makers does it no favours. Given the present level of public expenditure on parenting support programmes in the UK, some might say it is time that funders started demanding more both from researchers and service providers in terms of rigorous evaluation designs and monitoring systems that meet the standards of basic science[8].

The structure of the report and associated documents

The **report** begins with a section on the methods used in the study. There then follows a series of commentaries, organised by outcomes for children, for parents, and for families. Each commentary is concluded by a summary box, briefly detailing key conclusions in respect of what is known about the characteristics of successful interventions, what is known about the characteristics of unsuccessful interventions, and what requires future research. After the outcome commentaries there follows a section on process and implementation issues. We conclude the main part of the report with our discussion and main conclusions. We have provided a glossary as a guide to some of the common terms used throughout the report. **Appendix I** of the report contains a series of 'programme profiles' – descriptions of 'named' or well-known parenting support interventions in the United States, Australia, Canada and the UK. **Appendix II** of the report gives details of the types of information that have been provided in relation to the most important studies in each outcome area. This should be read with reference to the online **grid**, where details of the individual evaluations and programmes themselves can be found (accessible at the Policy Research Bureau's website: www.prb.org.uk). A list of all studies in the grid or referenced in the report can be found in the **bibliography**.

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[8] Indeed, even in the US some do say this; see for example Chaffin (2004).

2. Methodology

Searching the literature

The review was based on English-medium evaluation literature, both published and unpublished. *Published literature* was searched using the following electronic databases:

- International Bibliography of the Social Sciences
- The Cochrane Library (Central Register of Controlled Trials, Database of Systematic Reviews, Health Technology Assessment Database, NHS Economic Evaluation Database)
- ERIC
- MEDLINE
- PsycINFO
- Sociological abstracts
- Social Science Citation Index

Search terms used for extracting abstracts included: "parent* support", "parent* education", "parent* training", "parent* evaluation", and "parent* intervention". Additional searches were carried out using a combination of these terms with terms relating to specific topics and populations of special interest, such as parents in prison, teenage parents, etc. A hand search of some of the key journals was also carried out to enhance coverage of the relevant literature.

Searches generated lists of several hundred potentially relevant journals and books. Abstracts were then checked for relevance, based on the inclusion and exclusion criteria set out in detail below. Full articles, chapters and books were then obtained and reviewed for inclusion. A second reviewer checked the selections made by the first reviewer, and any disagreements were checked with a third reviewer.

Unpublished literature was accessed by making contact with leading organisations and individuals in the field of parent and family support, including service providers and researchers. Internet searches were also carried out using general search engines (e.g. Google, Lycos, Webcrawler) as well as more subject specific ones (e.g. Social Science Information Gateway, electronic Library for Social Care – eLSC).

Overall we estimate that around 2,000 pieces of evaluation literature were considered for coverage in this report, including reviews as well as individual evaluations. Of these, 88 individual evaluations were finally selected for inclusion in the online grid that should be accessed in conjunction with the report. Over 50

reviews were also consulted. See below (Inclusion Criteria) for the basis on which selections were made.

Selection of studies

Though a range of sources have been drawn on in compiling the report, the key selection criteria for the bulk of the report and for the grid was that work should describe an *evaluated* intervention or group of interventions. Following from this, the criteria developed for selection of material for inclusion in the review were influenced by three main parameters concerning, first, relevance to the U.K. policy and practice field, second, methodological robustness, and third, the time scale for the review. These are discussed in more detail below.

Relevance to UK policy and practice

Of primary concern was the relevance of the review for the work of the Family Policy Unit. At the time this research overview was commissioned, the Unit was in the Home Office. In June 2003 the Unit was transferred to the Department of Education and Skills as part of a machinery of government change. It has now become part of the Families Division, which has become part of Sure Start. This overview research reflects some of the prime concerns at the time when this publication was commissioned, with some change in emphasis as it neared publication in DfES.

At the request of the Unit as it then was, the selection of material for inclusion aimed to provide coverage of parenting support interventions that might be described as 'mainstream' in focus. That is, we tended to focus on interventions dealing with relatively common outcomes, and those that target problems or disorders within the 'mild and frequent' spectrum of difficulties that parents face rather than those dealing with rarer, more serious types of problems that would fall into the 'clinical' range. This said, we have, however, also included some interventions working with specific parent populations or on specific aspects of child behaviour such as anti-social behaviour, that reflected particular policy interests for the Family Policy Unit while it was in the Home Office

Methodological robustness

Methodological rigour was also of importance, but we recognised that there were research 'gaps' in which few sufficiently rigorous evaluations had been carried out. Under such circumstances we chose to include less robust studies as well as the more rigorous ones, but have commented on their methodological weaknesses where applicable. (Methodological rigour is discussed in more detail under 'inclusion criteria' below.) Because we wanted to highlight what is *not* known in this

field as well as what *is* known, wherever enlightening (and wherever we could find them), studies were also included when they provided negative findings or null outcomes to inform a 'gap analysis'.

Time scale for the review

The short timetable for the project inevitably influenced the way we used reviews in forming commentaries. (For example, the bulk of the literature searching and writing up was carried out between March and June 2003, to meet the funders' timetable.) Pre-existing research reviews were routinely taken into consideration in drawing up commentaries and the reader is referred to these reviews where appropriate. In a limited number of specific areas where there was an extensive volume of research literature and numerous existing reviews (e.g. in relation to ADHD and conduct disorder), we judged it appropriate to provide a commentary based purely on a synthesis of reviews. In other cases, 'Exemplar' individual studies were included that typified the conclusions drawn, selected on the basis of their methodological robustness and comprehensiveness.

These considerations led to a more idiosyncratic inclusion of literature than would normally form part of a formal Systematic Review, but resulted in a more 'bespoke' review, more closely tailored to the practical needs of the Family Policy Unit.

Inclusion criteria: Individual studies

Target population

As described in the introduction, studies that involved parents, or parents and children were included, but those focusing on children alone were excluded. 'Children' included those in the age range of birth to 19 years, and interventions that were exclusively pre-natal were excluded. The term 'parents' was taken to include: carers, foster parents, adoptive parents, step parents, and grandparents. Interventions aimed exclusively at improving adult couple relationships were excluded.

To be included, studies had to have what was regarded as 'mainstream' relevance, i.e. they focused on interventions aimed at parents dealing with common problems or disorders of relatively low severity in terms of a spectrum ranging from 'mild and frequently found' to 'severe and rarely found'. (Examples of types of studies excluded as a result of this criterion are described below under 'exclusions'.) Put another way, we tended to focus strongly on interventions aimed at *primary* levels of prevention (ie, intervening to prevent problems arising in the first place), and on *secondary* levels of prevention (intervening with high risk groups or where problems have begun but are not yet strongly entrenched) and rarely on *tertiary* levels of

prevention and treatment (when problems are already strongly present and require active treatment). For example, we included interventions aimed at primary prevention of child abuse amongst whole communities, but excluded interventions aimed at specific families at high risk of or suspected/known to have abused a child. The only exception to this occurred in relation to child emotional and behavioural outcomes (section 3.1a), where studies relating to antisocial behaviour of 'clinical' severity were reviewed.

Evaluations of interventions aimed at specific groups of parents of particular policy or practice interest were also included, wherever possible. These special interest groups were identified in conjunction with the Steering Group at the Family Policy Unit. The special populations covered in this report include fathers; ethnically diverse parents; teenage parents; parents of teenagers; and parents in prison. In the case of other special populations of policy interest, we found no evaluation studies of sufficient scientific merit to include. These special groups therefore are not covered by this review: children in transitions; children and parents with disabilities; asylum seekers and refugees; travellers; gifted children.

Intervention type

In terms of the breadth and intensity of the interventions included, the review encompassed a range of services from universal to targeted (see 'glossary' at the end of the report for definition of these and other key terms), and from preventative through to therapeutic, (though as said earlier, with a greater emphasis placed on preventative interventions). The interventions took a variety of forms, ranging from skills training, education, peer support, home visiting, counselling and discussion (on a one to one or group basis) and family therapy. Interventions ranged in intensity from low-level and low-cost to extremely intensive and high-cost. Most involved some kind of face-to-face contact between service workers and parents. Information-based interventions not involving face-to-face contact with users (e.g. newsletters, telephone help-lines) were included where we could find good evaluations – which was not often.

The providers of the service could be from any of a number of sectors or contexts, including but not restricted to: health services; social services; education services; leisure services; youth justice and criminal justice. They came from both voluntary and statutory sectors.

Evaluation methodology

Quantitative studies
In terms of methodological criteria, quantitative studies were included on the basis of their rating on the Scientific Maryland Scale (SMS; Farrington, Gottfreson,

Sherman, and Welsh, 2002). This scale ranks evaluation studies on a five-point scale according to several criteria: the number of measurement time points in the study; the use or absence of a control sample; and the presence or absence of randomisation to experimental conditions (i.e., whether participants are randomly allocated to an intervention ('treatment') or control ('no-treatment' or 'other-treatment') group. The scale points are attributed to studies as follows:

- **Level 1.** Includes studies reporting outcome measures with an intervention group assessed at one point in time only;
- **Level 2**. Includes pre- and post- intervention measures (i.e. measures at two points in time), but with no control group.
- **Level 3**. Pre- and post-intervention measures and also treatment and control group.
- **Level 4.** Pre- and post-intervention measures and treatment and control group, and analysis also controls for (takes into account) other factors that influence outcome.
- **Level 5.** Randomised controlled trial (RCT) i.e. pre- and post-intervention measures and treatment and control group, with participants randomised to treatment and control group.

Many other reviews have employed very stringent inclusion criteria resulting in inclusion of RCTs alone (i.e. studies at level 5 on the SMS rating, e.g. Barlow 1999; Woolfenden et al, 2002). However, since few studies in this field reach these dizzy heights of scientific rigour, this strategy usually leads to a high rate of rejection of studies from the review, and reviews carried out on this basis tend to give only partial pictures of what is actually happening 'in the field' at the practice level. Most commonly, the strategy also means we learn little about process and implementation factors, as studies that have something useful to say about factors that influence the success of the implementation of the programme but that do not provide robust outcome data are overlooked (Newman and Roberts, 1999).

Therefore, in this review in general we took the decision to apply a cut-off point for inclusion of *three or above* on the SMS; i.e. studies rated between levels three and five on SMS were included. However, even using these more relaxed inclusion criteria for the review, there were still some areas of the literature in which evaluations of this ranking were sparse or even non-existent. Many service evaluations, particularly in the UK, fall well short of ideal standards of scientific rigour (see Ghate, 2001, for a discussion of the methodological limitations of the UK research base). To take account of this, in order to ensure we had not entirely missed out examples of interventions that were relevant for UK policy and practice development, we also included studies of lower rating when the only studies rated three or above on the SMS in a particular area of the literature were entirely non-UK based (typically North American). To have done otherwise would have led to the

review reflecting an overwhelmingly North American literature to the exclusion of UK studies. The inclusion of studies rated at level two or below on the SMS was, however, still subject to our professional judgement of the quality of the study from our perspective as experienced researchers.

To operationalise this, we devised an additional rating system that took into account a number of other aspects of the evaluation that in our view influence the quality of a study but that are not captured by the SMS. We named the rating system the Global Assessment of Evaluation Quality (*GAEQ*). The GAEQ was not so much a tool for rating studies on specific dimensions of rigour as a way of judging whether adequate account of any limitations in the design had been taken account of in the conclusions. Dimensions of this additional, more subjective, scale therefore included:

1. the quality of the data collection tools (e.g., were tools standardised or validated/pre-tested or piloted in any way, and were they developed to measure clearly articulated constructs)
2. the sample representativeness (taking into account, for example, whether response rates were reported and whether the sample included adequate numbers of people in the population groups for which conclusions were drawn)
3. the sample size (e.g. were the numbers of cases included sufficient for the type of analysis conducted, and was the extent to which the sample adequately represented the population of interest considered when drawing conclusions)
4. the appropriateness of analytic methods used (e.g. did analysis meet appropriate standards of rigour, were the tests used appropriate, and was basic technical detail provided about methods of analysis);
5. whether programme integrity[9] had been considered when drawing conclusions;
6. whether the evaluators were independent of those delivering the service.

Using a simple yes/no rating on each dimension, the GAEQ could be scored from zero to six with higher scores reflecting a better quality evaluation.

Qualitative studies
Qualitative studies were also included in the review where they were available and of good quality, and were used especially to shed light on the effectiveness of interventions in terms of service implementation and delivery. As with quantitative research, qualitative research varies enormously in its quality. However, the blanket

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[9] 'Programme integrity' refers to whether evaluators had been able to account for variation in the content or intensity of the service that had been delivered to different users.

dismissal of all qualitative research as anecdotal and unscientific that used to be common is now thankfully (and rightfully) rare, and there is increasing recognition of the elements of 'quality in qualitative research'.

At the time we carried out the sorting and analysis of studies and research reviews for this report, there were no widely used published scales like the SMS for 'rating' qualitative studies in a standardised way[10]. We decided therefore to apply a version of the GAEQ to qualitative studies to arrive at a similar process of 'quality control' as for the quantitative studies we retrieved. Therefore, as with quantitative studies, a decision regarding whether to include individual qualitative studies or not was reached on the basis of our judgement of the quality of the study in terms of the factors listed above, excluding point five concerning programme integrity[11]. Hence GAEQ ratings for qualitative studies could range from zero to five, with higher ratings again reflecting a better quality evaluation. Full details of the GAEQ are provided in Appendix II, along with a description of the other characteristics of the evaluations and the interventions that are reported in the online grid.

Inclusion criteria: Research review articles

Research review articles and reports from the last twenty years of evaluation science played an important role in guiding the development of the outcome commentaries. In many respects, inclusion criteria for existing research review articles that we sourced were similar to those outlined above for individual studies. For example, we selected on the basis of mainstream relevance, as well as with regard to the type of interventions covered in the review. However, although reviews (like individual study reports) can vary in quality, there is no universally accepted standard for grading the quality of reviews such as the SMS. Thus we selected reviews for inclusion on the basis of our own professional judgement of quality including clarity, adherence to rigorous and objective methods (eg systematic review or meta-analytic methods, or other properly articulated processes), whether they had been published in a respectable peer-reviewed journal, whether they emanated from a respected institution or expert team, and whether they were independent of the service providers. The reviews drawn upon in the text of this report are indicated in

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[10] However, recently a rigorously researched and comprehensive framework for assessing quality in qualitative evaluation has been published by the Government Chief Social Researcher's Office and the Cabinet Office of the British government (Spencer, Ritchie, Lewis and Dillon 2003). This is likely to be much more time-consuming to use than equivalent tools for judging quantitative research due to the large number of dimensions included, but its application should help to advance the field considerably.

[11] This point was felt to be more applicable to quantitative than qualitative investigation, as it was attempting to assess the evaluation's account of the quantifiable aspects of the intervention 'dosage' in relation to outcomes.

the bibliography, but are not (for obvious reasons) entered into the grid of individual studies.

Exclusion criteria

A number of exclusion criteria were generated in order to focus the content of the review, and to limit its potentially very broad scope given the relatively short timescale involved. For both reviews and individual studies, the exclusion criteria were as follows:

- Reviews that pre-dated 1985, unless a seminal work
- Individual evaluation studies that pre-dated 1990
- Studies/reviews whose focus was too specialised i.e. where the target difficulty or disorder was on the severe or rare end of the spectrum of disorder or problems. For example, studies/reviews of the following were excluded:
    - Child abuse and neglect *except* where intervention was concerned with primary prevention, given the 'mainstream' parenting focus of the review
    - Severe mental health problems (e.g. psychoses)
    - Severe learning difficulties and other severe intellectual problems
    - Severely developmentally delayed children
    - Autism spectrum disorders
    - 'High conflict' (extremely violent families/or involving domestic violence)
    - Severely/chronically drug-involved or alcoholic/'recovering' parents
    - Severely substance-misusing young people or parents
    - Interventions that mainly involve pharmacological aspects of 'parenting support' (e.g. medication for ADHD)
    - Divorcing or separating parents, which though potentially within the remit of our work had already been well covered in the UK by previous reviews (e.g. Hawthorne, Jessop, Pryor, and Richards, 2003)
    - Physical health and disability, due to the large medical/clinical literature.

Sorting and grouping the literature

Both the commentaries and the grid use *outcomes for children, outcomes for parents, and outcomes for families* as a key organising principle. (It will be remembered that outcomes for parents are only included where there is a reasonable consensus in the existing literature that these have a direct and proximal relationship with outcomes for children. Also, interventions targeting children alone were <u>not</u> included.) Outcomes considered in relation to these three broad categories are set out below (1-3). Each category is subdivided into smaller sections (a, b, c, etc.), with examples of the sorts of topics included under each section. These groupings concern the *actual outcome as measured within the evaluation* rather than the *intended outcome of the*

intervention, as these can be quite different in practice. Where studies reported on multiple outcomes it was necessary to select a main outcome by which to categorise the findings. This may have resulted in what to some may seem a rather arbitrary categorisation of literature. However, we considered several ways in which we could sort the vast body of literature that we have covered in this report, and no single method was entirely satisfactory. There could have been other ways to arrange the evidence, but our decision to arrange outcomes as we have was influenced by our thoughts about the way in which this report was likely to be used. We envisaged readers having topic specific areas of interest that they could most easily access in terms of the list of outcomes described in the box below. Outcomes that are listed in the online grid are also coded according to this list.

Outcome categories

1. **Child-focused outcomes**

a. **Emotional and behavioural development** - including externalising disorders (e.g. conduct problems, antisocial behaviour, offending, attention deficit and hyperactivity disorder, oppositional disorders), internalising disorders (e.g. depression, anxiety) and sleep difficulties; primary prevention of substance misuse (alcohol/drugs/smoking).
b. **Educational development** - including school readiness, early literacy and numeracy skills (such as vocabulary use), and educational competence in school years (such as reading and numeracy).

2. **Parent-focused outcomes**

a. **Skills (behavioural aspects of parenting)** - including supervision, monitoring, negotiation, boundary setting, communication and negotiation.
b. **Attitudes and feelings/coping/confidence (attitudes to parenting)** - including personal views about coping as a parent rather than observable skills; and parenting stress.
c. **Knowledge/understanding of child development (cognitive aspects of parenting)** – including knowledge of factual aspects of child care
d. **Emotional/mental health** - including prevention of depression, enhancing well-being and self-esteem, and reducing psychological distress.
e. **Social networks** - parents' social isolation or connectedness; access to networks and services.

3. **Parent-child focused outcomes**

a. **Parent-child relationships** - including qualities of relationships such as warmth, attachment; general parent-child interaction and communication; communication with non-target child or other family members; and primary prevention of child abuse and neglect.

Deciding 'what works'

Interventions were categorised in relation to their effectiveness according to the available evidence, bearing in mind the quality of the evaluations. Four categories were used: works; promising; does not work; and unknown. They were defined as follows:

- **What works:** programs must have at least one level three to five SMS-rated evaluation showing statistical significant results <u>and</u> the preponderance of all available evidence must indicate effectiveness.
- **What doesn't work:** programs must have at least one level three to five level evaluation with statistical significance tests showing ineffectiveness, and the preponderance of evidence must support the same conclusion.
- **What is promising:** where level of certainty is too low to support generalisable conclusions, but where there is some empirical basis for suggesting effectiveness and it is reasonable to predict that further (better) research could support such conclusions.
- **What is unknown:** any program not classified in one of the three above categories.

These categories were adapted from Farrington et al (2002), in the context of evaluation of what works in crime prevention. In the original formulation of these categories, more than one level three to five SMS-rated study with significant results was required to categorise a study in the 'works' category. For the present review, however, we found that there were generally fewer replications of successful interventions in the parenting support field than is perhaps common in criminological research, and we have made our categorisations less stringent as a result. Hence in our review an intervention can be described as 'working' on the basis of just one methodologically robust evaluation (i.e. one level three to five SMS-rated evaluation).

Synthesis of the literature

Synthesis of the literature resulted in three components of the report, each fulfilling different functions. The first component of the review is the 'outcome' commentaries that form the main body of this report. The second component is the online grid that accompanies this report, while the third component is the 'Programme Profiles' section of this report that appears in Appendix 1. The way in which these components were constructed and can be used is described below.

Outcome commentaries

As described earlier, in drawing up the commentaries and their conclusions we made use of previously conducted research reviews as well as individual evaluation studies. Due to the short time frame, it was decided that a pragmatic approach should be taken to achieving a balance between a reliance on reviews versus individual studies. Therefore, for outcome areas that have been relatively robustly researched already, such as children's antisocial behaviour, we tended to rely more heavily on reviews to draw conclusions rather than try to synthesise the vast numbers of individual evaluation studies that have been carried out in this area. There seemed little point, after all, in repeating the review exercise carried out by others when clear messages had already emerged. In other areas that have been relatively under-researched, however, we relied more on our own distillation of individual evaluation studies to draw up our conclusions. This was true of outcome areas such as preventative parental mental health programmes. Therefore, the balance of reviews and primary research studies used differs from one outcome commentary to the next, and this is noted in the introduction of each of the commentaries.

The online grid

The pragmatic approach described above was also reflected in our choice of what to enter into the online grid. In areas that were heavily researched we have tended to provide detail of 'exemplar' studies that typify a number of individual intervention studies of robust methodology, while in under-researched areas we give details of all the available evaluation studies with at least satisfactory methodology. What constituted a 'satisfactory' methodology was for the most part taken to be studies that had an SMS rating of three or above, as described previously. However, in cases where there were no U.K. studies of this methodological status, we had to be more flexible about our inclusion criteria, and therefore entered studies into the grid that fell below this standard, but which we nevertheless believed had some merit.

While the outcome commentaries within this report provide a broad overview of what works in individual areas of parenting support, the grid provides the reader with the fine detail of a range of individual evaluations and interventions. Because the grid tabulates the detail of studies providing evidence of effectiveness or lack of it, whereas the commentaries synthesise the balance of evidence across the range of research evidence, it should not be expected that the grid will necessarily always support perfectly the broad conclusions outlined in the commentaries. Some interventions (or parts of interventions) in any given 'genre' will inevitably fail where others succeed, and occasionally studies will reveal that this has happened in some cases, even where on the whole, the results have been encouraging. The grid is not however intended to be a comprehensive list of all studies of any given

intervention, and should not be taken as such. We intended that the grid and report should be read together to satisfy the need for some illustrative, close-up detail of the major interventions, their target populations and outcomes, in combination with main messages about the broader context of parenting support within which they occur.

The grid also provides information about the methodological soundness of individual evaluation studies. For example, the SMS and GAEQ ratings within the grid, as well as the sheer number of studies reported within each outcome area demonstrate whether a particular topic area has been robustly investigated or not. The grid also categorises programmes into 'works', 'promising', 'does not work', and 'not known', based on the rating system described earlier. It therefore provides some of the basis from which we have drawn our conclusions about what works, and shows, for example, the balance of UK versus North America studies, and the distribution of large scale versus small scale evaluations. Full details of the categories of information provided in the grid are provided in Appendix II.

Programme profiles

Readers who require more information about individual programmes beyond the detail provided in the grid, will find a selection of programmes described in the 'Programme Profiles' shown in Appendix 1. The programme profiles give a more discursive, detailed picture of the nature of the interventions, their generalisability and their effectiveness. The programme profiles give coverage of many well-known or else well-researched U.K. and non-U.K. programmes. We have chosen not to include contact details such as website addresses for individual programmes or researchers for these programmes or evaluation studies because of the speed with which such information becomes out of date. Again, the profiles were not intended to be a comprehensive directory of all intervention activity in this field, and should not be approached with this expectation.

Commentary 3.1a
Child outcomes: Emotional and behavioural development

Introduction

Most of the literature concerning the way in which parents can be supported in changing emotional and behavioural outcomes for their children focuses on their role in reducing non-compliant or antisocial behaviour. This encompasses a broad range of behaviours, variously labelled according to severity, context and the age of the child as oppositional disorder, conduct disorder, delinquency and offending (commonly referred to as 'externalising' disorders in the psychological literature, as contrasted with 'internalising' disorders such as depression). The focus in this body of literature is very much about reduction of these overt 'negative' behaviours rather than reporting on enhancement of children's prosocial behaviour, such as helping, sharing, comforting or giving. Hence in much of the discussion that follows, **prevention of antisocial behaviour** (or its precursors, including Attention Deficit and Hyperactive Disorder - **ADHD**) forms the main focus. In addition we have included a review of interventions in relation to **prevention of substance misuse,** involving alcohol and drug abuse. **Other childhood difficulties** such as internalising disorders and sleep problems are also discussed where robust evidence can be found.

Of course, problems with externalising behaviours such as antisocial behaviour by young people are both visible to and costly for the wider community beyond the family, and it is not surprising that both policy makers and service providers have tended to concentrate preventive resources in this area. However, there is an increasing body of evidence suggesting that the incidence of internalising disorders such as depression is also common and rising amongst young people (Frombonne, 1995; Meltzer, Gatward, Goodman and Ford, 2000). Evidence shows that though the costs of these kinds of problems may not be so visible to society, they may be equally high in the long term. For example, people who experience depression in childhood and adolescence are more likely to experience depression in adulthood (Bifulco, Brown, Moran, Ball and Campbell, 1998), and their depression is more likely to involve recurrent or chronic episodes (Brown and Moran, 1994). Given that depression is far more common among women than men, this means that many depressed girls are at risk for becoming depressed mothers, with a resulting impact on the next generation. Recent figures from the Office for National Statistics, for example, show that mother's mental health was the only factor found to be significantly independently associated with the persistence of emotional disorders among children, after taking account of sociodemographic and household characteristics (Meltzer, Gatwood, Corbin, Goodman, and Ford, 2003; see also Ghate and Hazel 2002, who found poor parental and child mental health to be strongly

associated with one another). A follow-up at age 33 years of the cohort of children who were part of the National Child Development Study (NCDS) that began in 1958 across Great Britain found that children whose parents had been in poor mental health were more likely to have later psychological functioning problems and a tendency towards depression as they reached early adulthood (Buchanan and Ten Brinke, 1997). Hence tackling internalising disorders such as depression in children and young people may bring lasting impact in the form of better mental health and associated functioning for future generations.

A wide range of interventions conceptualise parents as a key agent in bringing about change in the antisocial behaviour of their children. Parenting practices in particular often form the target for interventions because of the associations between harsh, inconsistent parental discipline, poor monitoring and supervision, and emotional and behaviour problems in children (e.g. Loeber and Dishion, 1983). Therefore, several of the interventions discussed in this section are also of relevance to Commentary 3.2a in this report, covering parenting skills. The studies reported below are however ones in which outcomes have been described in relation to changes in child behaviour, rather than changes in parenting practice. A considerable amount has been established about 'what works', (although not often 'why it works') in relation to parenting programmes affecting antisocial behaviour. Given this fact, as well as the burgeoning literature in this area and our timescale for the review, the commentary below draws together conclusions from a number of recent reviews of research in this area, rather than being reliant on a synthesis of the many individual studies that could potentially be included. However, individual studies are referred to when they are exemplars (in the sense of representing a number of similar studies as well as being methodologically robust) or where they report on a well-known or well-established programme.

Antisocial behaviour and its precursors

Typical populations and programmes

There is great heterogeneity in terms of the nature and content of interventions for parents that target children's antisocial behaviour. Some are based on group work with parents, while others involve working with individual families. Some focus on parent behavioural training (teaching parents specific 'child management' skills, in some cases using videos modelling scenarios that illustrate typical child-parent interactions and prompt discussion about optimal parenting skills[12]) while others take a relational approach to addressing problems (i.e. one that focuses on relationships between parents and children), and some involve elements of both. The nature of the intervention may vary as a function of the age of the child, the severity

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[12] See also commentary 3.2a

of the behavioural problem, the family context, and the context in which the service is being delivered (e.g. home, community or clinical setting). The child's age, for example, can influence the focus of programmes, with positive interaction patterns between mother and child often forming the focus for work with pre-school children, 'contingent' discipline and reinforcement[13] forming the focus with primary school-age children, and supervision and monitoring skills forming the focus for parents of adolescents (Patterson, Dishion and Chamberlain, 1993). In the discussion of studies provided below, an overview is provided in terms of interventions that target preschool children, followed by a discussion of those that focus on older children (school-age and adolescent).

Effectiveness for younger children

The pre-school years have been described as a critical time developmentally for the prevention of conduct disorder (Richardson & Joughin, 2002). However, most of the literature in this area focuses on interventions with school age-children and adolescents, and describes interventions aimed at reducing behavioural problems that are already well established. There are noticeably fewer studies that focus on the primary prevention of externalising behaviour, which is surprising given the research evidence suggesting that there may be very early indicators of later disorder (Robins, 1979).

A review by Sampers, Anderson, Hartung and Scambler (2001) observes that most of parent training programmes aimed at parents of very young, pre-school children have been developed as downward extensions of programs specifically developed for school-age children. They suggest that greater consideration be given to the influence of developmental or maturational changes (such as cognitive ability) when tailoring parenting programmes to younger age groups. Sampers et al (2001) describe Eyberg and colleagues' Parent Child Interaction Training (PCIT) programme (Eyberg and Boggs, 1998) as appropriately designed for younger children, but only 'promising' as yet, given the current lack of sufficient empirical support. They conclude however that Webster-Stratton's Incredible Years' group-based discussion and 'video-modelling' programme is not only appropriately designed for use with toddlers and preschool children, but has been demonstrated empirically to improve children's behaviour, and furthermore is cost-effective. (The latter is described in the programme profiles that appear in Appendix 1.)

A recent review by Richardson and Joughin (2002) also concludes that behavioural parenting programmes such as Webster-Stratton's are effective in reducing conduct problems in young children. While both individual and group-based programmes

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[13] i.e., teaching parents to take a proportionate and consistent approach to setting boundaries and enforcing rule, and helping them to learn to encourage and reward desirable behaviours as well as discouraging undesirable ones.

are effective, there is some evidence to suggest that group-based programmes may be more cost effective than individual clinic-based training (Cunningham, Bremner and Boyle, 1995), as well as providing parents with peer support. The review also highlights the need for programmes of much longer duration (beyond the typical 10 to 20 weeks) when children's behaviour problems are of greater severity. However, this raises the issue of how to help parents improve their commitment to a potentially demanding programme, and how to make programmes more accessible. (See Section Four on process and implementation issues later in the report.)

Additional interventions have been included alongside parent training to increase the effectiveness of parent programmes for parents of pre-school children. For example, tackling concurrent family problems such as marital conflict and parental depression in addition to child behaviour problems has resulted in improved child outcomes, as shown by research using the enhanced Triple P programme (Sanders, 2000), details of which are given in Appendix 1.

In addition to behavioural training programmes, home visitation programs targeting high risk families have also been found to be effective in reducing antisocial outcomes for children. Most involve a multi-dimensional approach. The Elmira Prenatal/Early Infancy Project (PEIP; Olds et al, 1997), for example, provided parent education and enhanced family support and access to services via nurse home visits for the first two years of the child's life. Outcomes included reduced neglect and abuse, and fewer arrests of children by the age of 15 years. With notable exceptions, such as the study above, information about the extent to which the results of parenting programmes with young children are maintained over-time is limited, and further large-scale enquiries with long-term follow up data are required (Barlow and Parsons, 2002).

Effectiveness for school-age children

While interest continues to grow in early prevention of conduct problems, there will always be parents who require longer-term support or later support in dealing with their children's behaviour as their children progress beyond preschool years through later childhood to adolescence. A UK programme aimed at parents of disruptive young school children is the SPOKEs programme (Supporting parents on kids' education, described in Appendix 1), reported by Scott and Sylva (2003). It combines parent training based on the 'Incredible Years' Webster-Stratton programme in conjunction with a parent-led literacy scheme for children entering reception and year one of primary school. It has been shown to be effective in reducing antisocial behaviour and improving reading ability, and attributes its success to several factors including: use of a strong theory-based parenting programme, using a collaborative approach where partnership with parents to identify their needs and concerns is stressed, combining a literacy element to increase attractiveness, pitching the

programme as being universally relevant rather than for 'failing' parents, establishing close partnership with the schools in which the scheme was based, and good supervision of group leaders.

For children with more severe or enduring difficulties, there are several comprehensive reviews of the many interventions available for school-age children and adolescents (e.g. Farrington and Welsh, 1999; Serketich and Dumas, 1996; Woolfenden et al, 2003). Various reviews conclude that both Multi Systemic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, and Cunningham, 1998) and Multi-dimensional Treatment Foster Care (MTFC, Chamberlain and Reid, 1998) are effective in treating juvenile offenders in the United States, although published data about its effectiveness in the UK context is not yet available. Both programmes are high-intensity and costly to deliver, involving carefully monitored and controlled 'wraparound' services to young people and their families that tackle many different problems and issues simultaneously. MST is fully manualised and adherence by practitioners to the delivery protocol is considered of prime importance and is rigorously monitored and enforced. Outcomes include reduced time spent by young people in institutions and reduced arrest rate. (Both of these programmes are described in Appendix 1.) Parenting training is just one of several components within these programmes, alongside for example, child skill-building or family therapy. A review by Borduin, Heiblum, Jones and Grabe (2000) concludes that the characteristics of MST that may be particularly effective in bringing about changes in behaviour are the comprehensive nature of the treatment, which tackles several causal factors at once; the intensity and flexibility of the programme in terms of meeting the needs of the individual child and family, and the natural and multiple environments that it deals with (ie, families are not taken out of their communities but worked with in the situations in which they live), involving home, school, etc.

Another multi-component US programme that has been effective in producing reduced conduct problems and improved educational and social outcomes for adolescents is 'Fast Track'. This is a preventative intervention, targeting high risk school-age children, based on the developmental theories and longitudinal research surrounding early onset conduct problems. It addresses risk factors in several areas (including the classroom, school, individual child and family risk factors) and includes a universal component delivered in classrooms in combination with selective components (parent groups, child social skills training, parent-child sharing time, home visiting, child peer pairing and academic tutoring). Recent evaluations involving randomised controlled trials report effectiveness in a number of areas (for parents and children), increases in emotional and social coping skills, reading skills, peer relations, better school grades and fewer behavioural difficulties (Bierman et al, 1999). Fast Track has been the inspiration behind the UK programme 'On Track', the outcomes of which are currently being investigated.

There are many factors that may be contributing to these programmes' effectiveness. Yet we have a long way to go before we can clarify what the precise components that lead to success factors are. We do not know, for example, enough about variables such as the characteristics of children, parents, treatment providers, treatment content, format or duration, all of which are likely to make a difference. In terms of parents' characteristics, for example, behavioural parent training for children's conduct problems has been shown to be less effective and/or has led to higher drop out among participants with pre-existing depressive symptomatology or marital discord, and amongst single parents and the socially isolated. Better understanding of the interactions between the characteristics of service users and the programmes themselves could lead to more flexible tailoring of programmes to the needs of the individual.

In general, working with both parents and children in parallel in preventative interventions seems to be a criterion of success in this area, with one review noting that "*mobilising adult caregiving is a critical …intervention target for even the most severe adolescent delinquent* "(McCord, Dishion and Poulin, 1999). However the same review highlights that care must be exercised with peer group interventions that bring high-risk young people together in groups as these have been known to result in iatrogenic[14] effects. For example, one component of a programme involving adolescent peer group work with antisocial young people, has shown negative results. The Adolescent Transition Program (ATP; Dishion, Patterson, and Kavanagh, 1992) is a parent training programme aimed at prevention of problem behaviours (in high risk 10 to 14 year olds), and has been developed by the Oregon Social Learning Centre. It involves a psychoeducational programme (involving use of videotapes to provide examples of 'family management skills' such as positive reinforcement, monitoring, limit-setting, and relationship skills) run from a community health centre, with separate components for parents and teenagers. It has been shown to reduce parent-child conflict and to reduce aggressive and delinquent behaviour in the short-term (Andrews, Soberman and Dishion, 1995). However, reports on a schools-based version of the teenage component of the programme indicated an escalation of problem behaviour among teenage participants. It seemed that for children participating in the intervention, there was an adverse impact arising from peers influencing one another in a negative way, thereby escalating rather than reducing anti-social behaviour. In contrast, the parent component of the schools-based programme led to a reduction in parent-child conflict, and antisocial behaviour at school (and also early-onset tobacco use).

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[14] i.e. negative effects arising out of the intervention itself

Attention deficit hyperactivity disorder (ADHD)

Typical populations and programmes

Although the focus of the current report is on 'mainstream' parenting support services (ie those addressing parenting issues faced by a substantial proportion of parents) we have included a short section on attention deficit and hyperactivity disorder (ADHD) due to its association with antisocial behaviour in young people, an area of much current policy interest. Given the extensive literature devoted to this topic, what is presented here is a brief summary based on recent research reviews rather than on primary intervention studies.

ADHD in childhood is a known risk factor for antisocial behaviour in adulthood, and early intervention is recommended to prevent the development of entrenched problems that may be difficult to dislodge in later life (Moran and Hagell, 2001). Although ADHD has a neurobiological component (Taylor, 1994), evidence suggests that aside from independently contributing neurobiological factors, one of the main causes of ADHD in children may be the type of parenting they receive, especially when delivered within a chaotic and hostile family environment. As well as being detrimental to child development and associated with poor concentration and poor educational attainment, having a child with ADHD leads to high levels of family and parent stress. Behavioural parent training has therefore been considered as a means of improving outcomes for children with ADHD, as well as easing the stressfulness of the situation for their parents and siblings. However, the majority of the literature concerning interventions in this area involves pharmacological approaches. Although drug treatment is arguably cheaper than training parents, it has undesirable side effects, and may have only short-term effects on symptoms. Thus, in addition to this 'single modality' approach, non-pharmacological approaches or combined interventions have been developed that include a variety of behavioural management techniques for use by teachers and parents (such as social reinforcement for positive behaviour, time out for misbehaviour, etc), as well as social skills, problem solving, and 'self-control training' for the child.

Effectiveness

A review by Purdie, Hattie and Carroll (2002) comments that although there are a small number of studies showing increased child compliance as a result of parent training, families of children with ADHD usually experience a range of difficulties that render parent training alone insufficient to produce significant changes in child behaviour across several contexts (e.g. home and school) as well as over time (e.g. beyond the weeks or months of follow-up). The types of family difficulties encountered typically include maternal stress and depression, parental alcohol abuse, and marital disharmony. Other reviews of the literature in this area also

suggest that single modality treatments are generally less effective than treatments that combine approaches (Frazier and Merrell, 1997; Horn and Ialongo, 1988; McGoey, Eckert, and DuPaul, 2002). Horn and Ialongo (1988), for example, report that the use of psychostimulant drugs in combination with parent training and cognitive-behavioural 'self-control' training for the child may lead to a lower dose of psychostimulants being required. However, a recent randomised controlled trial of preschool children with ADHD challenges these findings, as it reports improvements in ADHD symptoms maintained for up to 15 weeks post-treatment, using parent training alone (Sonuga-Barke, Daley, Thompson, Laver-Bradbury and Weeks, 2001). Hence parent training may be particularly useful in ADHD cases when intervention is applied early.

The research evidence regarding effective treatment of ADHD is typically marred by very small sample sizes as well as lack of long-term follow-up. Hence the multimodality approach, although more promising than the use of parent training alone, still requires further investigation before we can conclusively describe it as 'working' in relation to ADHD.

Substance misuse prevention

Typical populations and programmes

There is now a plethora of prevention programmes designed to affect drug and alcohol use in children and adolescents and aimed wholly or in part at parents. These programmes often have multiple components (e.g. parent, peer and child education), are typically delivered by paraprofessionals, and can vary from as little as five weeks to as much as four years in duration. Interventions included in this commentary are universal in their approach and aim to prevent or reduce alcohol and drug use among young people who are not already seriously abusing substances. Tertiary prevention or treatment programmes are excluded from this section because of the more specialised nature of these interventions and the clinical severity of problems typically characterising the target groups. Drug and alcohol prevention programmes may include components directly related to drug and alcohol prevention (e.g. developing parental 'norms' against drug use, developing child drug refusal skills), and/or skills training components which are indirectly related to drug and alcohol misuse (e.g. parent communication skills training, strengthening child self-esteem). The Strengthening Families programme is a good example of a substance misuse intervention focusing on factors indirectly related to drug and alcohol abuse, which has been successfully adapted for both substance misusing and non-substance misusing families (and is described in more detail in the programme profiles in Appendix 1).

Effectiveness

Evaluations of the effectiveness of substance misuse interventions involving parents
have measured both the impact on children and young people's likelihood and
actual use of drugs and alcohol, and the impact on parents themselves. Many multi-
component prevention programmes (including parent and child education, peer
modelling, family management and parent-child communication skills) have been
shown to be effective in reducing adolescent substance intake, raising knowledge
and awareness of alcohol and drugs, and modifying parental attitudes and norms
towards alcohol and other drugs (e.g. Park, Kosterman, Hawkins, and Haggerty,
2000; Perry, Williams, and Komro, 2002; Rollin, Rubin, Marcil, Ferullo, and Buncher,
1995). Parenting behaviours that prevent or reduce children and young people's
access to drugs and alcohol, especially parental permissiveness regarding substances
(i.e. few rules or lax discipline), have also been targeted by effective drug-prevention
programmes (e.g. Park et al., 2000; Perry et al. 2002; Rollin et al., 1995; Srebnik,
Kovalchick, and Elliot, 2002). DeMarsh and Kumpfer (1985) note that some
programmes have also been shown to impact positively on a range of outcomes
connected only indirectly with substance misuse – including family communication
and interaction, child school behaviour problems, child academic performance, and
parents' approach to parenting in general, and discipline in particular. In DeMarsh
and Kumpfer's (1985) review of parenting programmes, the authors find support for
a 'broad-spectrum' approach to drug and alcohol prevention which focuses on
developing generic life skills (e.g. building self-esteem and communication skills)
rather than just focusing on child and adolescent alcohol and other drug use
prevention. Furthermore, the review finds support for the use of parent training
programmes as well as family-oriented programmes (multiple component
programmes targeting parents as well as children). The recommended programmes
represent a variety of approaches and techniques, and focus on improving parent-
parent or parent-child interactions, developing communication and emotional skills,
or modifying negative or ineffective approaches to parenting and child management.
This recommendation is based on the high number of risk factors for substance
misuse addressed by parent/family-oriented programmes not specifically targeting
drug and alcohol abuse, and evidence of the ineffectiveness of single component,
child-focused alcohol and drug education programmes.

There has, however, been considerable debate in the literature about the use of
'broad-spectrum' or generic parenting programmes for preventing alcohol and
substance misuse specifically. Of the twenty-two parent-focused prevention
programmes reviewed by Elmguist (1995), most focused on developing generic life
skills rather than specific drug-use prevention skills. The underlying assumption
that the acquisition of general life skills (particularly parent-child communication
skills) equips children with the emotional and social skills necessary to refuse

alcohol and other drugs has frequently been challenged, and research evidence is inconsistent on whether or not this is true (Fox, 1991; Elmguist, 1995).

A number of recently implemented primary prevention programmes that often utilise behaviour modification techniques, and focus specifically on alcohol and drug abuse, have generally produced positive results (e.g. Park et al., 2000; Perry et al., 2002; Rollin et al., 1995). However, to draw more definite conclusions about the effectiveness of drug and alcohol abuse prevention programmes, more rigorously evaluated studies (using randomised controlled trials) should be conducted (e.g. Park et al., 2000; Perry et al. 2002; Rollin et al., 1995).

Finally, there is limited support for the effectiveness of current interventions aimed at preventing or reducing cigarette smoking in children and young people, although there is evidence that multi-component preventative interventions (including community, family, parent, and/or child elements) are more effective in reducing smoking prevalence than media campaigns alone (Sowden, Arblaster and Stead, 2003). Anti-smoking interventions typically emphasise community-level, school (peer) level, and child-level, rather than parent/family-level components, and where parents are targeted, the focus is likely to be on strengthening parent-child communication (Sowden et al, 2003).

Other emotional and behavioural outcomes

We do not deal with other disorders at length in this commentary as our interest is in mainstream rather than clinic samples. As we noted earlier, many of the parenting interventions for less common externalising disorders and for most internalising disorders among children are not part of the mainstream picture but are restricted to small and relatively extreme groups seen in the context of clinical work. For information about 'what works' in relation to other emotional and behavioural disorders affecting children, readers are referred to reviews such as Carr (2000) who provides a comprehensive review of interventions for a variety of disorders of clinical severity, and includes evaluation findings in relation to parenting interventions. The review clearly shows that there is a potential role for involvement of parents, through, for example, though family therapy, in the treatment of children with internalising disorders such as anxiety and depression. However, more well-designed controlled trials of family treatments are needed to assess their effectiveness in treating childhood depression and anxiety.

Among emotional and behavioural outcomes that affect a significant proportion of children and their parents, bedtime refusal and night waking have been tackled using parenting interventions. Sleep deprivation in parents of young children has been shown to be associated with depression amongst parents, and with elevated rates of harsh discipline by parents (Ghate et al forthcoming). A review by Mindell

(1999) describes recent empirically supported behavioural treatments for bedtime refusal and night waking in young children. The results of the review indicate that 'extinction' (a technical term for delayed responding rather than immediately responding to a child's cries) and parent education on the prevention of child sleeping problems are the most well established and effective interventions (e.g. Don, McMahon & Rossiter, 2002). According to this review, 'graduated extinction' (ignoring a child's cries as long as possible, limited comforting) and scheduled awakenings (waking the child before s/he typically wakes up) could be considered efficacious treatments, with positive bedtime routines (engaging in calming and positive activities with the child) being a promising intervention (Don et al, 2002). However, the long-term effect of these interventions has not been examined in comparison to alternative approaches such as having the child sleep in the parental bed, for example.

Future research

While we were able to identify a number of programmes that are effective for preventing and treating antisocial behaviour, our understanding of *why* they are effective is still in its infancy. For example, though we know that multi-component programmes show the most promising results, the independent and additive effects of the individual components are not known. We also need to examine the characteristics of participants further to understand why programmes are more effective for some families than others. Greater understanding is required of what constitutes a 'good fit' between the needs of high risk populations and the comprehensiveness of the treatment package (Farrington and Welsh, 1999). Programmes that work both with parents and young people in parallel show greater promise than those that work only with parents or only with young people, though programmes that include a component treating antisocial young people together (i.e., through peer-group work) have been shown in some cases to increase rather than decrease undesirable behaviours and should be approached with caution. Further research is required to understand these effects. The ideal duration of programmes is also not yet certain in all cases; though programmes of 10-12 weeks' duration are common and feature amongst those shown to be effective, longer and more intensive programmes do however seem to be indicated for the more severe and well-established problems. Last, there is also a need for research that involves longer-term follow-up of children, although there are studies that stand out as notable exceptions to this (e.g. Olds et al, 1997).

Summary: Child emotional and behavioural development

Programmes that have worked for early intervention for conduct problems typically involve:
- Behavioural parent training on an individual or group basis (and groups may be more cost-effective than individual clinic-based training)
- Age-appropriate methods taking account of children's developmental stage

Programmes that have worked for older children with conduct problems typically involve:
- Combined mode interventions involving multiple components that tackle several factors alongside parent training
- Programmes of sufficient duration and intensity, that are flexible and tailored to meet the needs of the individual families
- Programmes that are delivered with close attention to programme integrity (ie manualised, with a clear curriculum, and monitored delivery)
- Programmes that are theoretically-based i.e. based on a theory of why parenting changes child behaviour

Programmes that have worked in relation to substance misuse typically involve:
- A universal approach, including parents and their school age children
- Multiple components (child, parent and peer components) rather than child education alone

Programmes that have not worked typically involve:
- Peer group components that aggregate antisocial young people through group work, due to iatrogenic effects (negative effects arising out of the intervention itself)

Future research is needed to address:
- Long-term outcomes of children from parent training programmes, especially pre-school children
- The need for larger scale studies of children with ADHD, again with longer-term follow-up.
- The characteristics of children, families, service providers and of interventions that optimise effectiveness, in order to understand what works for whom, including understanding of the match between family needs and the duration and intensity of the programme.
- Which particular ingredients/combinations of multi-modal packages are responsible for bringing about successful outcomes so that we can understand why particular programmes are successful.
- The need for further evaluations of family-based treatments for internalising disorders using controlled designs.
- The coverage of areas/topics required in preventative alcohol and drugs programmes i.e. whether 'broad spectrum' or alternatively more narrowly focused interventions are best for preventing substance misuse

Commentary 3.1b
Child outcomes: Educational development

Introduction

Children's level of educational ability is an important outcome in its own right, but also has links with other outcomes such as conduct problems (Maughan et al, 1996; Sturge, 1982). The significance of active parental involvement for children's educational achievement and adjustment is now well established; see Desforges and Abouchaar, 2003, for a recent research review. This review concluded that parental involvement has a significant effect on these outcomes even after all other factors (such as social class, maternal education and poverty) have been taken into account. It also concluded that, at least as far as the primary school age level is concerned, differences in parental involvement have a greater effect on achievement than differences associated with schools. As Desforges and Abouchaar state, parental involvement can simply take the form of 'at home good parenting', which influences children's self concept as learners and, thereby, their levels of aspiration. Alternatively, it may be a by-product of a variety of parent training programmes covered throughout this review, or interventions that specifically promote educational competence and home-school links. Included in this section of the report, however, are interventions that directly address educational outcomes for children as their main goal. These outcomes are variously defined depending on the age of the child. For example, programmes that start in pre-school years often focus on increasing **children's readiness for formal education**, as well as early educational skills such as vocabulary use or letter recognition. Programmes that focus on children in the school-age years are more likely to address specific **educational abilities such as reading**. However, consideration is also given to related outcomes that are reported in conjunction with educational outcomes, including **social integration and peer relationships**.

In drawing together the messages to emerge from this outcome area, we have relied on a combination of review papers and primary evaluation studies. The US has a longer history of carrying out rigorous evaluations in this area, particularly in relation to so-called 'two-generation' studies. Hence it has been possible to draw together findings from several US reviews of such programmes. In comparison, research in the UK is less well developed in terms of the number of scientifically rigorous studies available to comment on, with the consequence that few reviews are available. Hence we have been more heavily reliant on the use of individual evaluation studies to distil our conclusions of the UK literature. The studies discussed below are reported in terms of two types of interventions, depending on the breadth of their coverage. The first involves 'two-generational' programmes that involve a broad range of outcomes for children and parents, and the second involves

more narrowly focused schemes that cover specific issues such as school-home links or children's literacy.

Two-generation programmes

Typical interventions and populations

Programmes that aim to influence educational outcomes can vary enormously, ranging from those that aim to tackle fairly narrowly defined outcomes such as children's literacy skills, to those that encompass multiple, family-wide outcomes of which education forms a main theme but not the only one. The latter type of programme includes the 'two generation' interventions that have been adopted as part of various national initiatives across North America since the 1970s. These are preventative programmes, typically targeted at low socioeconomic status families, and which aim to improve a wide range of outcomes for parents and their children. They generally involve two or three components in varying levels of intensity: a child-focused component comprising early childhood education and high quality child-care; a parenting-focused component involving parenting education; and an adult education/employment component involving adult education and training aimed at increasing family self-sufficiency. While a host of family-wide outcomes have been examined in relation to these two-generation programs, the present commentary focuses specifically on educational outcomes for children.

A review by St Pierre, Layzer and Barnes (1998) comments on several of the best known and best tested two generation programmes. It describes the considerable variation in the intensity and duration of these programmes and the content of the individual components. Programmes typically last between one to five years, beginning in the antenatal period or within the first year of the child's life. They involve a combination of service delivery modes and types of support including home visits, high quality day care for pre-school children, centre-attendance for parental workshops and educational sessions, as well as additional contact from professionals such as health and social services.

Effectiveness

The review by St Pierre et al (*op cit*) concludes that there is mixed evidence of the effectiveness of these programmes when short-term outcomes are considered. For child development outcomes in particular there is either a small or no short-term effect reported. For other outcomes, there are 'scattered' effects on parenting assessed in relation to child rearing attitudes and expectations, parenting teaching skills and parent-child interactions; few effects on parents' employment status, depression, self-esteem or use of social support; large short-term effects on parents' attainment of a General Education Development certificate, but not linked to higher

adult literacy; and finally, increased uptake of social and educational services. An evaluation of the Comprehensive Child Development Programme (CCDP) in the U.S., for example, found that no significant impact had been made on cognitive or socio-emotional development outcomes for children at five year follow-up (Goodson, Layzer, St Pierre, Bernstein, and Lopez, 2000). This apparent programme failure has been attributed to shortcomings in implementation and evaluation, such as poor randomisation, low participation rates and utilization of comparative services by the control group (Gilliam,Ripple, Zigler and Leiter, 2000).

On the other hand, an early and well-known example of a two-generational programme that reported positive effects on children's educational and related outcomes is the Perry Preschool ('High/Scope') Project. Begun in the 1960s, its original goal was to provide high quality preschool support to three and four year old low-income African-American children. Through a combination of classroom work with children, group meetings with parents and home visits from teachers spread over two years, the programme managed to impact on several educational outcomes for children, including improvements in intellectual and language tests at preschool age and up to age seven years. At age 14 years, participants scored higher in tests of reading, language and mathematics than non-participants. At age 19 years their general literacy skills were higher than non-participants, while at 27 years, they had higher earnings, higher educational achievements and fewer arrests throughout adolescence and young adulthood (Schweinhart, Barnes and Weikart, 1993). (The Perry Preschool project is described in the branded programmes in Appendix 1.)

A more recently developed programme that also reported positive results was the Houston Parent-Child Developmental Centre Project (H-PCDC; Johnson, 1989), where follow-up data were collected up to eight years after the intervention ended. The programme lasted two years and was aimed at low-income, Mexican-American parents with a one-year old child. The main goal of the programme was to promote school competence in young children, and a secondary aim was to reduce child behaviour problems. It involved a combination of home visits by paraprofessionals, weekend family workshops, plus educational sessions on child care and development and home management. At the end of the intervention, children's I.Q. scores had been raised in comparison to the control sample, and mothers were found to be warmer and more responsive to their children and to be providing a more educationally stimulating environment. Intervention children performed better in achievement tests at primary school age. They were also found to have fewer behaviour problems at preschool age and at primary school age. It therefore appears that educational outcomes for children can be improved by two generational programmes in the long term, in additional to a number of related outcomes such as a reduction in child behavioural problems.

With two generational programmes that involve multiple components, it is unclear which elements of the interventions achieve the greatest impact for what outcome, or indeed, why some succeed where others fail. However, what is clear is that intensity matters. Generally, the greater the level of participation in the programme, the greater the level of benefit. Finding ways of engaging high risk parents is essential, especially given the high degree of commitment of some programmes combined with the difficulties of transportation, language differences and childcare. The Houston PCDC project, for example, involved 550 hours over two years, and drop out rates were high – as much as 50% in some cases - explained by the mobility of the population who move away from the intervention area, and the uptake of work by mothers whose priority is to alleviate family poverty (Johnson, 1989). (See Process and Implementation Issues for further discussion of related findings.)

It is also important to consider the degree of change that is expected as a result of the intervention. In the Early Head Start programmes for example, while cognitive development was higher for participating children in comparison to the control sample children after the intervention, their scores still remained below the national average for their age (DHHS, 2002). However, the change may still have been sufficient to reduce the risk of poor cognitive and school outcomes later on, and may have reduced the need for costly additional educational support services.

Parental involvement and family literacy

Typical populations and programmes

There are a number of schemes that generally aim to enhance home-school links. These tend to involve the use of frequent parent-teacher communication and meetings regarding curriculum and school practices, pupil progress and achievements. Programmes that involve a more specific focus on children's abilities include those that aim to improve educational skills such as literacy and numeracy. 'Family literacy' programmes range from schemes that provide general advice to parents about listening to their children read, to those providing explanations, modelling, monitoring and detailed guidance on parent teaching behaviours. Other family schemes involve separate literacy components for parents and child, in conjunction with joint activities carried out together, and often target disadvantaged families.

Effectiveness

In a recent UK-authored review of parental involvement and pupil achievement and adjustment, Desforges and Abouchaar (2003) conclude that the available evidence shows that parental involvement in their children's education (through increased school-home links) can be raised using such schemes, and does impact on

educational outcomes for children. However, as the authors point out, methodologically rigorous evaluations of outcomes are lacking, although a body of evidence regarding 'good practice' in relation to such schemes has emerged (see Ofsted's '*Family Learning: a survey of current practice*' [2000], for example). This means that it is impossible on the basis of the evidence currently available to understand the specific mechanisms involved.

In terms of schemes that enhance literacy, Toomey (1993) argues that the practice of simply sending books home with children for parents to hear them read is less effective than schemes that provide training to parents in specific skills for helping their child. Parents can be trained in various approaches such as 'Pause Prompt Praise'(PPP) and paired reading, which have been shown to bring about improvements in poor readers' interest in and enthusiasm for reading as well as improving their reading competence. A British study has also shown a beneficial effect when parents rather than peers or older children provide tutoring to children in paired reading schemes (The Kirklees project, Topping and Whitely, 1990, described in the Programme Profiles in Appendix 1).

More recent studies by Brooks and colleagues have examined the impact of the 'Family Literacy' schemes set up by the Basic Skills Agency, originally known as the Adult Literacy and Basic Skills Unit (ALBSU) (Brooks et al, 1997; Brooks, Gorman, Harman, Hutchinson, and Wilkin, 1997; Brooks and Hutchinson, 2000). These schemes involve three integrated components: accredited basic skills instruction for parents, early literacy development for young children, and parent/child sessions encouraging pre-reading, and early reading skills. They share similarities with two-generational programmes described earlier in that they comprise individual components for parents and children as well as joint/shared components. However, their focus is much more specific, targeting literacy and/or numeracy specifically rather than a broader range of child development outcomes. The pilot scheme involved 96 hours spread over 12 weeks, for families with children in the 3 to 6 years age range. Although the evaluation did not involve a control group, comparison of pre and post intervention assessments of parents and children showed improvements in reading and writing for both parents and children which were maintained at two years follow-up. Adaptation of the Family Literacy scheme for use with year seven pupils in secondary schools has not been successful however, and it is recommended that alternative approaches be used to assist low attainers in this age group (Brooks, Harman, Hutchinson, Kendall, and Wilkin, 1999).

An example of an early intervention, UK-based programme aimed at pre-school children and their parents is the Sheffield Raising Early Achievement in Literacy (REAL) project (described in more detail in the programme profiles that appear in Appendix I). The overall aim of the programme was to develop a way of working with parents to promote the literacy development of their preschool age children,

and involved a child-focused and parent-focused component. The adult component involved offering advice and information about access to local adult education services, and also an accredited course in parents' roles in children's early literacy development. The child-focused component offered home visits from teachers, provision of literacy resources, centre-based group activities, special events and postal communication. Preliminary results using a RCT evaluation design show positive results in terms of raising the early literacy skills of the participating children (Hannon and Nutbrown, 2001). Although the scheme achieved high levels of family participation, the uptake of the adult education component was extremely low (10%).

Another example of an early intervention based within the UK is PEEP (Peers Early Education Partnership), which covers children from birth until the time of school entry, and aims to enhance children's educational achievement and literacy in particular. The programme comprises a structured, age-appropriate curriculum for children involving specific target areas such as listening, talking, numeracy and self-esteem. Parents are trained to use specific books, rhymes, songs and activities to support this learning. A recent evaluation of the programme found that after two years, participating children (age three to five years) were found to have significant gains in vocabulary, language comprehension, understanding of books and print, and number concepts, and also had higher self-esteem when compared to matched non-participating children (Evangelou and Sylva, 2003).

Associated outcomes

A number of other outcomes are sometimes reported alongside educational outcomes for children, most typically involving peer relationships, social competence or prosocial behaviour assessed within the school context. Although understanding the key ingredients of programmes that bring about these significant changes is an area requiring further investigation, there are a number of success stories in the literature, where 'packages' of good outcomes of which educational improvements are just one element can be found. A preventative programme for at risk children reported by the Conduct Prevention Research Group (1999) for example, attempted to address school failure, peer rejection and aggressive behaviour using a muliticomponent programme involving parent group sessions, child training and home visits. The programme succeeded in improving children's reading skills, academic achievement, and social coping skills, as well as decreasing aggressive behaviour. Positive outcomes for parents were also reported including more positive school involvement. The recent SPOKEs project in south London (see section 3.1 a), though ultimately aimed at improving child behaviour problems, used child literacy as a non-stigmatising 'hook' to get parents engaged with the programme, and has reported improvements in children's reading abilities alongside positive results on the behaviour variables (Scott and Sylva, 2003).

Future research

There are a number of questions that remain unanswered, particularly in relation to multicomponent programmes, where the difficulty lies in understanding what contributes to their success. In relation to family literacy schemes for example, it is unclear what value is added by the intergenerational teaching component of schemes, since reports suggest that the joint sessions are in fact more difficult to plan and teach than parent-only or child-only sessions (Ofsted, 2000). As Desforges and Abouchaar (2003) point out that identification of the successful components of such schemes has important implications for cost effectiveness, and further evaluation studies are needed in this area. What is clear is that improving parental educational achievement alone does not necessarily lead to improved educational outcomes for children. Some form of direct intervention with children is also needed. A support programme evaluated by Askov, Maclay and Bixler (1992), for example, provided educational input for parents but not children and did not lead to improvements in children's attainment, whereas a programme evaluated by Norwood, Atkinson, Tellez and Saldana (1997) which trained parents to support their children's learning led to enhanced literacy and numeracy for their children. More generally, what is still unknown is the intensity of programmes required to bring about positive effects.

There is also a very limited literature examining educational interventions for ethnically diverse groups of children (whose first language may not be English), or educational schemes that are culturally sensitive. A small scale, promising study of low-income African-American and Latino parents is notable for its attempt to develop a culturally sensitive programme (Norwood et al, 1997). The aim was to help develop the academic readiness of children and to help parents support their children's learning. The programme was able to help foster positive relationships between parents and school personnel as well as improve the children's performance in maths and reading. In the UK, a study by Brooks et al (1999) reported favourably on the adaptation of the Basic Skills Agency 'Family Literacy' scheme (described earlier) for use with ethnically diverse groups. Testing of the adapted programme with a group of predominantly Punjabi and Urdu speaking parents and children showed literacy gains for both children and parents. Further programmes for ethnically diverse groups need to be devised and evaluated.

Summary: Child education

Programmes that have worked typically involve:
- Intensive two-generational programmes involving multiple components
- Training parents in specific techniques and skills to help their children read, as passive 'listening' approaches (e.g sending books home without accompanying parent training) have been shown to be less effective

Programmes that look promising involve:
- Pre-school and primary school aged children and their parents using family literacy schemes (such as 'REAL' project and the Basic Skills Agency's schemes)

Programmes that have not worked typically involve:
- Improving educational attainment for adults alone rather than addressing children's needs directly
- Parent-child literacy schemes aimed at secondary school age children using the Basic Skills Agency model
- Programmes that do not pay close attention to implementation factors affecting engagement and retention of participants

Future research is needed to address:
- How to retain participants in two-generational programmes that require a large commitment to be effective
- The specific characteristics of two-generational programmes that can increase effectiveness, other than programme intensity
- Further development and testing of culturally sensitive programmes and schemes for ethnically diverse groups
- Ways of involving fathers (missing from the literature, in general)
- The need for long term follow-up data
- Schemes that work with secondary school age children

Commentary 3.2a
Parent outcomes: Parenting skills

Introduction

Bolstering existing parenting skills or teaching new ones is a key objective of many parenting support interventions, generally in pursuit of more overarching aims that have to do with improving parent-child relationships, increasing parenting effectiveness, and reducing child behaviour problems. In this section, we define parenting skills as **things that parents *do* to or with children**. That is, we include skills and competencies that may, at least in theory, be learned. They include specific practices or behaviours employed by parents usually with a particular goal in mind – generally to discourage undesirable behaviours by children and/or encourage desirable ones. They are part of but not synonymous with the concept of *parenting style* – a more overarching concept that includes not only what parents do but also the quality of their relationship with their child - how they feel about the child, and how they and the child relate to one another. Effective use of parenting skills is part of the 'authoritative' parenting style (Baumrind 1967; Maccoby and Martin 1983) that has been shown by the literature to be optimal for psychological and social outcomes for children in the developed world. The exercise of effective parenting skills (e.g. setting clear boundaries and maintaining them; praising children for good behaviour and achievements) helps to reduce the frequency of inappropriate or unconstructive responses to children by parents, re-inforce desirable patterns of behaviour and discourage problematic ones in children, and can also indirectly improve the affective (relational) aspects of the parent-child relationship for both parties, for example by helping to reduce the frequency of negative interactions such as conflict, and increasing the frequency of positive interactions that can foster more enjoyable relationships.

Parenting skills training is an aspect of parenting support that is relatively well researched, and there are a considerable number of existing reviews on this topic, ranging from the short and broad-brush to the highly detailed. (Statham, 2000; Assemany and McIntosh, 2002; Dembo et al, 1985). This commentary draws mainly on reviews, therefore, though exemplar studies have been referenced where they add to the overall picture. Note that the organisation of the research evidence over the next four commentaries around the outcome categories of parenting skills (commentary 3.2a), parenting attitudes (3.2b), parenting knowledge (3.2c) and parent mental health (3.2d) is a presentational device on our part that may not necessarily reflect the reality of service delivery (and may be different to the approach taken in previous reviews in this field). We have organised the material in this way in an attempt to bring greater specificity and clarity to our writing, and to help isolate what we know (and do not know) about specific elements of the

parenting support field as a whole. Readers should however bear in mind that recent trends in the design of parenting support services have often been away from the 'single approach' model and towards the development of 'integrative' programmes that may combine two or more approaches, including both behavioural and attitudinal elements (for example).

Typical populations and programmes

Interventions that address parenting skills as a primary outcome have been labelled in a variety of ways, but typically are described as 'behavioural' programmes, 'parent training', 'parent management training', 'parent skills training' and 'behavioural parenting training (BPT)' programmes. There are a number of well-established, manualised programmes that teach parenting skills including Carolyn Webster-Stratton's video-modelling programme; Parent-Child Interaction Therapy (PCIT - Eyberg and Robinson, 1982) ; parts of Tremblay et al's Delinquency Prevention Program (Tremblay et al 1992); and Helping the Non-Compliant Child (Forehand and McMahon, 1981). Parenting skills programmes have been around for a relatively long time (for example, the Living with Children program developed by the Oregon Social Learning Center in the US in the 1970s; Patterson, 1975) and there is now a considerable body of relatively robust evaluation evidence on some of these well known 'brands' of intervention. This commentary should be read alongside the commentary on interventions targeted at outcomes for children's emotional and behavioural difficulties (Section 3.1b), as many of the best-known 'behavioural' interventions were initially developed to assist parents struggling to cope with children presenting problematic (oppositional, non-compliant or disruptive) behaviour in the clinical range (e.g. Webster-Stratton's programme, details of which are described in the programmes profiles in Appendix 1). However, over time these types of programmes have become more common, and are now widely used with parents outside a clinical setting. As noted above, the findings of this commentary are also relevant to those interested in integrative programmes that combine skills-training with other approaches to parent support.

Most behavioural programmes were initially developed for use amongst parents of school-aged children, whose behaviour and attainment was presenting difficulties in the school setting and who were thought to be on the road to delinquency in adolescence. Over time, these programmes have been developed both upwards and downwards in terms of the age of the children targeted, and now include early intervention programmes for pre-school children, and also for parents of older children, including adolescents some of whom are overtly involved in antisocial or offending behaviour. In recent times, substantial impetus to develop parenting skills programmes for parents of teenagers has come from the crime prevention policy field, in the hope that parents can be taught how better to guide and control

wayward adolescents who are a cause for concern to their local communities and beyond.

The interventions typically take the form of a structured course of sessions, and are generally medium term (usually between 6 to 12 weeks in length), though some have been more intensive. Some programmes follow a manual, with a set curriculum to be followed each session. Many include video-modelling and group discussion elements. Most take place out of the home setting, but often in a community venue such as a school or neighbourhood centre. Some in addition incorporate in-home support sessions on a one-to-one basis, either before, during or as follow-up to group-based courses. Three sets of skills are commonly targeted by parenting support interventions, and are included in this review: (1) supervision and monitoring (parental knowledge and influence over children's movements and activities, especially when unattended by adults); (2) boundary setting and discipline (drawing and enforcing standards for children's behaviour, correcting undesirable behaviour and rewarding or reinforcing desirable behaviour); and (3) communication and negotiation (including involving young people in family decision-making).

The focus on these factors is generally theoretically justified, even if this is not explicitly articulated in programme descriptions. Taken together, at a general level these skills are seen as important for good parent-child relationships and interactions and for a good quality of family life in general. More specifically, they are thought to be associated with better outcomes for children as they develop, and there is emerging evidence that positive parent-child relationships may have long-term benefits for both physical health and social and psychological functioning in later adult life. For example, effective supervision and monitoring have been shown by a number of studies to act as protective factor against the development of antisocial behaviour in young people (e.g. Wilson, 1980; Riley and Shaw, 1985). Harsh or erratic discipline has been linked with poor short and long-term outcomes for children, including increased aggression, later antisocial behaviour, and poor mental health (see Ghate, 2001, for a review). There is less evidence for the specific links between parent-child communication and negotiation by parents with children for healthy psycho-social development, but especially as children grow older, this seems to be an important aspect of the socialisation function of parenting, implicated in helping children resist the potentially damaging effects of peer-influence (Fuligini and Eccles, 1993) and in promoting reflective or 'vigilant' decision-making in young people (Brown and Mann, 1990).

Effectiveness

Most reviews are agreed that there is now a relatively extensive body of evidence attesting to the effectiveness of parenting skills programmes and suggesting that boosting specific parenting skills is strongly associated with good outcomes for both parents and for children and young people. In comparison with other types of approaches, though both behavioural *and* non-behavioural intervention models (see commentary 3.2b) typically result in favourable reports of parent benefits (e.g. high user satisfaction with the intervention; self-reports of changed parenting behaviours), behavioural, skills-based programmes are much more successful than non-behavioural models in demonstrating impact at the child behavioural level as well as at the parent level.

At the parent level, parents tend to report high satisfaction with having attended a parenting skills intervention, to express a sense of enhanced well-being or enjoyment of parenting afterwards, and to report they have learned useful things and have implemented changes in the way they interact with their child that has eased pre-existing problems. Qualitative data (e.g. Ghate and Ramella, 2002; Barlow and Stewart-Brown, 2001) suggest that parents respond well to the concrete, 'grounded' nature of these types of interventions, which teach specific skills to use in specific situations and offer practical, take-home tips to participants. Where group-based methods are used, parents who may be anxious about whether they are 'doing it right' also report drawing considerable comfort and enhanced sense of perspective from learning that others face similar situations (or even that others may be worse off than they are!) In the short term, quantitative and qualitative studies show that parents report general enhancement of skills across a range of dimensions – for example, that they are spending more time with children and attending more to (reinforcing) positive behaviours; that they are giving better and more appropriate commands to their children; and that discipline is being implemented in a more consistent and positive way (e.g. less shouting and hitting, more discussion and explanation), as studies entered in the accompanying grid show. However, most studies collate only short-term impact data from parents. Only a relatively few studies have collected follow-up data on parent outcomes, though those that have report sustained improvements in parenting skills for at least one to two years following the programme (Assemany and McIntosh 2002).

However, these programmes also typically report high rates of premature dropout, adding up to somewhere between a quarter and half of those referred according to reviews that have collated information from the (limited number of) studies that report these data (Assemany and McIntosh 2002). Many parents also fail to fully engage with the programme in active ways, and thus cannot reap the full benefits, though again, information on engagement is not uniformly reported in the literature. How the programmes are implemented appears critical to their success,

independently of the content of the course that is delivered (Prinz and Miller 1994). See Section Four (Process and Implementation Issues) for further discussion.

At the child level, Forehand and Kotchick (2002) consider that '*behavioural parent training has emerged as one of the most successful and well-researched interventions to date in the treatment of child and adolescent externalising problem behaviours…with extensive empirical support for its…utility*'. As the findings of studies entered in our grid show, there are now plenty of data to support this view. However, despite the success of these programmes for many families, some parents also continue to report difficulties after the programme, with perhaps up to 40% continuing to report difficulties with children that are still in the 'clinical range' (ie, would be regarded as clinically significant by a child mental health professional) after termination of the programme. Factors that may predict negative treatment outcomes include the socio-economic situation of the family at referral (poorer families do less well); high levels of family 'dysfunction' (problems with relationships, poor parental mental health etc); and the severity of the child's externalising behaviours at the time of referral (children who are already conduct-disordered, overtly offending etc do less well).

Future research

In terms of outcomes for parents, since parenting skills are hard to measure 'in situ' (at home), most studies rely on 'soft' data on parents' own perceptions of changes in their skills than collect independently verified observational data of what parents actually do differently as a result of having taken part in a parenting skills programme. More studies that collect observational and other types of data are therefore required to provide independent evidence of effectiveness before we can be sure whether parents really do behave differently as a result of attending a parenting skills intervention or whether they just *feel* they behave differently. It is striking, for example, that children's views on whether and how their parents have benefited from these types of services are largely absent from the literature, despite the fact that they are intended to be key beneficiaries. Where young people's views are reported, there is reason to think children may be less positive about these interventions than their parents (e.g. Ghate and Ramella, 2002, who found young people were not as strongly convinced that monitoring and supervision had improved after their parents had taken part in skills training as were their parents). More research is therefore required that collects children's perceptions of changes in parenting as a result of participation in these programmes. In terms of research on outcomes for children, in general, due to the history of these kinds of interventions, there are more data relating to interventions for parents of younger children than there are relating to parents of adolescents. Further studies that assess their effectiveness with parents of adolescents are needed, in particular to examine whether parent-only programmes are sufficient to alter child outcomes or whether

child-focused components are also required (the latter seems most likely, given the conclusions reached in Section 3.1b of this report). It is also as yet unclear how well these types of interventions serve different groups in the community, as ideas about good parenting skills may vary by ethnicity, social class and by sex of parent. We also know rather little about whether both care-givers (where there are two) need to be trained simultaneously in order to maximise the potential of these interventions, though anecdotally practitioners report that training only one parent of a couple may actually cause conflict in the household, rather than being entirely beneficial[15]. Lastly, at both the parent and the child level, most studies focus only on the short-term effects of interventions (Tremblay et al, 1992), and further properly controlled longitudinal studies are required to assess lasting effects.

Summary: Parenting skills

Programmes that have worked typically involve:
- High attention to implementation issues to promote attendance and lasting engagement
- Interactive methods of teaching rather than didactic approaches
- Practically-focussed, offering 'take home and try' tips for modifying parents' behaviour

Programmes that have not worked typically involve:
- Low attention to implementation issues
- Focus on parents' attitudes and verbal interaction styles rather than their behaviours
- 'Talk-based' rather than interactive teaching style
- Individual-based work rather than group-based (except for very high risk parents in which case more intensive, tailored intervention may be vital)
- Families with very high levels of pre-existing background difficulties
- Children whose behaviour problems are more severe

Future research is needed to address:
- The relative benefits of group-based versus one-to-one work (practice wisdom and qualitative studies suggest groups may be both cost-effective and have good outcomes, but there is little robust research on one-to-one work outcomes with which to compare this)
- The relative mix of in-home, personally tailored support to group-based, more generic styles of delivery that is most efficacious
- The relative effectiveness of offering programmes to one parent only; both parents; and parents <u>and</u> children
- The optimum duration and intensity of programmes needed to achieve desired outcomes
- The extent to which existing programmes need to be culturally adapted
- Follow up studies of lasting impact on parents and on children, with controlled designs

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[15] Information gathered from local Youth Offending Teams as part of the YJB's Parenting Programme, Ghate and Ramella (2002)

Commentary 3.2b
Parent outcomes: Parenting attitudes and beliefs

Introduction

It is possible to distinguish in the practice and evaluation literature between
interventions (or parts of interventions) aimed at concrete aspects of parenting skills
(so-called 'behavioural' programmes) and those that focus on *parenting attitudes* –
defined as how parents **feel and what they believe about their parenting**: for
example, parents' beliefs about child behaviour and development, their perceptions
of their own competence, their sense of coping, and their general confidence and
enjoyment in parenting. Though these are potential beneficial outcomes of any
parenting support intervention, whatever its type, we focus in this commentary on
approaches that specifically target these outcomes as primary or main objectives.
We have labelled these types of interventions as 'cognitively based' for want of a
better, more inclusive term, because they are focused on stimulating reflection and
self-evaluation of attitudes and beliefs about parenting rather than on practising
specific skills and techniques for managing and interacting with children. However,
it should be noted we do not review the literature on formal cognitive behaviour
therapy ('CBT') or other psychotherapeutic approaches, as these tend to be used
with parents at the more severe, 'clinical' end of the spectrum of family problems,
and were hence outside our remit[16]. As we noted earlier in the report in
Commentary 3.2a, many parenting support interventions these days incorporate
both behavioural and attitudinal elements.   In this section, however, we focus on
isolating the evidence with regard to the latter approach to parenting support as
distinct from any other approaches, insofar as we are able.

Most parents admit to feeling stressed at last some of the time, and sending parents
away feeling better equipped to manage the challenges of parenting is often
regarded as a desirable outcome of a parenting support intervention. The idea of
'parenting stress' is well-established in the literature and indeed one of the most
commonly used measures of impact in this field internationally is the 'Parenting
Stress Inventory' (Abidin 1983). Indeed, many programmes explicitly set themselves
the objective of reducing participants' sense of stress in the parenting role,
independently of whether any actual improvements in the quality of parenting (or
impact upon children) are observed. To the extent that research has shown that
'feeling supported' is a major correlate of (a) how parents rate a service they have
received and (b) their belief that they are coping with parenting, it can be argued
that unless programmes achieve this, they have not succeeded in being effective
from the user's perspective. However, improving attitudes *per se* may not help

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[16] The same applies to Family Therapy, which is not covered in this review

improve the quality of parenting or outcomes for children, and indeed programmes that seek to change parents' beliefs about and attitudes to parenting generally express their objectives in relation to other types of outcomes (e.g. parenting skills; child behaviour) in indirect terms: that parents cannot parent effectively if they feel incompetent, and that the idea that one is 'doing things wrong' can be disempowering and disabling, leading to heightened stress, lowered self-esteem and eventually to depression and other poor mental health outcomes for parents, which may in turn still further reduce their ability to parent effectively. It has also been hypothesised that a low sense of 'self-efficacy' (belief in oneself and one's ability to solve problems) in parenting leads to inconsistent and non-authoritative parenting styles and practices including ineffective discipline, and, as we noted in Commentary 3.2a, there is substantial evidence that these factors are implicated in the path towards poor outcomes for children.

There are a number of reviews of the efficacy of cognitively based approaches, and where possible we have drawn on the review literature for this commentary. However, for some less well-researched variants, exemplar studies are used.

Typical populations and programmes

Because of their specifically cognitive focus, Dembo et al (1985) classify these interventions as about *education* rather than 'training'. Well-known cognitively based interventions that address parenting attitudes and beliefs as a primary outcome include Parent Effectiveness Training[17] (PET [Gordon 1975], based on the work of Carl Rogers), which emphasises democratic relationships within families and a 'no lose' approach to conflict management that minimises the exercise of parental power; Adlerian programmes based on the theories of Adler (1927) that emphasise parents' understanding and comprehension of children's behaviours and thought processes; 'Adlerian-plus' programmes such as STEP (Systematic Training for Effective Parenting; Dinkmeyer and McKay, 1976); and Rational-Emotive Parent Education (REPE; e.g. Joyce, 1995), based on Rational -Emotive Therapy[18]. These programmes rely heavily on verbal and written methods of teaching, usually in a classroom style group-work format and with varying levels of 'teaching' led by a trained facilitator intermixed with less formal discussion and sharing amongst group participants. Indeed, Adlerian programmes, once very popular in the United States, are sometimes described explicitly as 'study groups'. Some programmes (e.g. PET)

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[17] PET is sometimes classified as behavioural programme, but as the programme tends to focus on communication, 'active listening' 'I-messages' (clear communication about thoughts and feelings) and locates the responsibility for behavioural change with the child, we have grouped it with cognitively-based programmes.

[18] REPE focuses on challenging 'irrational' or unhelpful beliefs about parenting, helping parents reduce the emotional stress associated with parenting, and in addition tries to 'identify ways in which parents can foster optimal personality development of children' (Joyce 1995).

involve role-playing exercises and homework assignments, and most focus strongly on communication within the family including 'active listening' and clear communication of personal feelings and emotions. There is usually a fixed number of sessions, over a relatively short to medium time frame (e.g. one session per week for 10 weeks). (Detailed descriptions of STEP and PET are provided in the Programme profiles in Appendix 1).

Effectiveness

In addition to assessing the effectiveness of these types of cognitively based programmes in their own right as a specific 'genre' of parenting programme, a number of reviews have also compared their results with those of behavioural programmes. In both respects, evidence as to the effectiveness of these cognitively based variants of parent training is somewhat mixed, and in addition, several reviews suggest that conclusions about effectiveness are limited by a paucity of well-designed studies that meet rigorous scientific criteria. Thus, some of the lack of evidence for impact of these programmes may at least in part be the result of the poor design of many of the evaluations. Cedar and Levant (1990), who conducted a rigorous meta analysis of 26 published PET studies (having selected these from over 80 potential candidates), concluded that the ability to measure the impact of these types of programmes (and hence to demonstrate high effectiveness) was directly and proportionately associated with the design of the study in question, such that methodologically better studies tended to yield bigger effect sizes (i.e. greater levels of measurable change between pre- and post-test time points).

However, even allowing for possible methodological shortcomings in the evaluation literature, in general, the research indicates with fair clarity that these programmes do have measurable benefits for parents (as measured by parent self-report), but have been less successful in demonstrating good outcomes for children. For example, cognitively based programmes appear to be consistently effective at modifying parents' attitudes, resulting in more liberal attitudes to child rearing (Dembo et al 1985; Mooney 1995; Cedar and Levant 1990), and making them feel less guilty and self-critical about their parenting approach (Greaves 1997; Joyce 1995). Parenting stress is also lowered (Greaves 1997), and some reviews suggest that parent-child interaction frequency is increased. Cedar and Levant's meta analysis of 26 PET programmes (1990) also suggests that the effects of all types can persist 'up to 26 weeks beyond the end of the programme', though in general measures of impact diminished over time (and the number of studies employing follow-up measures was relatively few). Some caveats to this generally positive message with regard to parent benefits can be found in the literature, though. There are some reviews that suggest the programmes work better for parents with older children (for whom the verbal communication methods promoted by these types of intervention may be more suited), than for those with pre-school children. In addition, parents of

children who are displaying especially challenging behaviour or who are conduct-disordered at the start of the interventions report lower impact.

In respect of the impact on children, the picture is less positive. Though some studies show that child self-esteem may be increased (Cedar and Levant 1990), presumably by some reflexive process whereby changes in parents' attitudes and ways of interacting with children make children feel better about themselves, on balance most reviews conclude that these types of programmes have minimal measurable impact on children themselves – at least in the short term. However, the limitations of short-term versus long-term measurement of outcomes may well be germane here: some reviews suggest that these programmes may in fact have an impact upon child behaviour – but that this is likely to be a latent or delayed effect, and only shows up where long-term follow-up measures are used (which is rare; Mooney 1995; Cedar and Levant 1990).

Future research

On the whole then, the general message from the literature is that these various types of cognitively based programmes are effective at changing parents' attitudes and lowering their perceptions of the stress associated with parenting. However, there is much less evidence that child outcomes are affected by these types of interventions, though better designed studies with long-term follow-up measures could perhaps change this conclusion. In particular, as would be expected from the cognitively based format (focused on thinking and talking rather than 'doing'), these programmes do not seem especially appropriate for parents who themselves have high levels of family problems, or whose children are displaying more serious behaviour problems. Therefore, greater exploration is required of alternative formats or approaches that could work effectively with higher risk families to alter parenting attitudes, and ultimately impact on child outcomes. Though there is (limited) evidence to suggest that socio-economic status/social class may also be a factor impinging on the effectiveness of these types of approaches, we need to know more about this, and we also need to know more about how well these cognitively-based approaches work with parents who are not Caucasian or female. Lastly, we still need to assess the extent to which these types of approaches 'add value' within integrative programmes to the more concrete skills-training elements that they sometimes accompany – something that cannot easily be disentangled without carefully monitored and controlled programme delivery and more sophisticatedly designed evaluations that incorporate comparison groups and random allocation to different 'treatment conditions'.

Summary: Parenting attitudes and beliefs

Programmes that have worked typically involve:
- Higher socio-economic class or well-educated parents
- Parents of older children
- Parents of less delinquent children

And, where more than just attitudinal change is the objective:
- Some practical (behavioural) component in addition to cognitively-based methods

Programmes that have not worked typically involve:
- Low socio-economic class parents
- Parents of younger children
- Families with very high levels of background difficulties
- Children whose behaviour problems are more severe
- Time-limited programmes without 'booster' sessions to promote lasting impact

And if more than just attitudinal change is the objective:
- A focus on parents' attitudes and verbal interaction styles alone
- An exclusively discussion-based delivery with no practical component

Future research is needed to address:
- The optimum duration and intensity of programmes needed to achieve desired outcomes
- The extent to which existing programmes need to be adapted culturally
- The extent to which these programmes work for fathers as well as mothers
- The extent to which these programmes can help higher risk families
- Follow up studies of lasting impact on parents and on children, with controlled designs
- The extent to which there is 'added value' from these approaches when used in combination with integrated programmes including skills-training and information-giving

Commentary 3.2c
Parent outcomes: Parenting knowledge

Introduction

In addition to interventions designed to modify parents' behaviours and skill levels or to alter attitudes to parenting such as those types of parenting programmes described in the foregoing commentaries 3.2a and 3.2b, a third category of interventions can be identified in the literature. This third group consists of interventions focussed on improving or extending **parents' understanding and knowledge about child development, child care and child health.** Again, this type of approach may form a distinct part of a wider programme of parent education or support, or it may operate as a discrete intervention in its own right. Though enhancement of parenting knowledge and understanding either by fact-giving or advice may be a by-product of almost any kind of parenting support intervention, in this commentary we focus only on interventions that have this as a specific and clearly identified objective[19].

The hypothesised 'mechanism of change' underpinning these approaches assumes a path from parenting knowledge, to attitude change, to behaviour change, to outcomes for children. Thus, these approaches assume that improving parents' understanding of how children think, grow and develop will enable parents to tailor their own responses and behaviours towards children more appropriately. They may then be better equipped to care for their children's physical needs (for example, protecting them from injury and health problems), or better informed about aspects of children's emotional, psychological and social development. This in turn may help avoid potentially damaging parenting practices that could lead to poor outcomes for children. Studies exploring parents' own views about their needs for support and help with parenting certainly seem to lend support to the case for developing these kinds of interventions. Research amongst parents themselves increasingly shows that many parents both directly and indirectly express a need for both factual information and advice about a diversity of issues that arise in the course of normal family life. For example, over two thirds of parents in a recent nationally representative sample of families living in deprived areas of Britain said they wanted to know more about a range of topics from the pros and cons of how to discipline children, to how to talk to them about sexual development (Ghate and Hazel, 2002). In a recent community study of parents using primary health care in Oxfordshire, over half expressed an interest in attending 'parenting classes'

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[19] Note that interventions offering education and advice to young people to prevent teenage pregnancy are not covered, since although these form a major category of service delivery offered both on a targeted and universal basis these are not strictly 'parenting support' interventions.

(Patterson et al, 2002). Further indications of demand for these kinds of services include the fact that successful (answered) calls to a national 24 hour help line (ParentLine Plus) in the UK are currently running at around 5,000 per month (Boddy, Smith, and Simon, 2004). The commentary that follows draws mainly on individual studies rather than reviews as in many of the previous commentaries. We found no thoroughgoing reviews of this genre of intervention – an interesting gap in the literature base that we feel should be remedied.

Typical populations and programmes

The literature shows that education-based or knowledge-based parenting programmes have been widely offered in many countries both as universal (open access) services and as targeted ones. Frequently they have been targeted at particular need groups - especially adolescent mothers, but also groups such as incarcerated parents, for example - whose understanding and knowledge of child development and child care generally may be lower than population norms (De Lissovoy, 1975; Oates, Davies, Ryan, and Stewart, 1980; Showers and Johnson, 1985). However, many programmes have also been offered on an 'open access' basis, for example information offered to all new parents in a community via newsletters (Riley, Meinhart, Nelson, Salisbury and Winnott, 1991), telephone help lines open to any member of the public, or have been implemented as part of primary health care aimed in the long term at child health outcomes (e.g. breastfeeding promotion programmes)

The structure and intensity of these interventions ranges widely from what are called 'ambient' methods in the advertising and marketing world (posters, leaflets and audio-visual materials in public places), to short (one-off) 'information sessions', telephone help line services and other low-level, flexible and time-limited programmes for groups of parents, to more intensive, formal services offered to groups or single individuals over a standardised time frame and working to a set curriculum. For example, one low-level promising mainstream health promotion intervention for parents in Adelaide, Australia (Cockington 1995) used closed circuit televisions in the waiting rooms of emergency and outpatient departments in general hospitals to deliver information films on child health topics including immunisation, nutrition and accident prevention. At the other end of the extreme, another successful intervention for mothers in the rural mid-west of the United States involved weekly in-home education sessions delivered by a carefully trained Parent Educator over a continuous six month period, following a clearly structured manualised curriculum covering 30 specific topics on child development from safety in the home to child discipline (McDonald Culp, Culp, Blankemeyer and Passmark, 1998). In between are interventions such as the one evaluated by Showers (1991) involving the use of a series of 15 flash cards ('Child Behaviour Management cards') containing simple information and illustrations on appropriate expectations of child

development at different ages and on how to manage 'problem' behaviours that most commonly trigger harsh responses by parents. The cards were supplied to workers running a more general vocational home economics programme for pregnant and parenting adolescents in schools, for use as simple information handouts or as stimulus materials for discussion.

Topics addressed by these kinds of interventions tend to stick to factual information and associated professional advice e.g. immunisation of children prevents disease [point of information], therefore parents should ensure children receive certain types of inoculations at critical stages of development [professional advice] .   They typically include:

- Information about stages of child development, key milestones etc
- Appropriate expectations of child development – e.g. what to expect at what age, and information about cognitive and emotional development in particular
- Communicating with children and how children process and internalise information
- Discipline and boundary-setting and how certain types of parenting practices may impact on child attitudes and behaviours
- Handling 'difficult' behaviour (e.g. crying, picky eating, biting, tantrums, toilet training)
- Child health promotion and how to access services and products such as vaccinations
- Aspects of diet, nutrition and food safety
- Accident prevention and home safety

Additionally, some more specialised programmes are targeted at increasing parents' knowledge of 'special' issues – for example, information on ADHD, substance misuse, and adolescent 'unchaperoned' behaviour.

Effectiveness

The studies that have been well evaluated tell a clear story: namely that factual knowledge and understanding of child development and child care issues can certainly be enhanced in the short to medium term through services of this kind, for parents of all types and ages, and that some 'less complex' parent behaviours may also be influenced. Several recent studies of these kinds of interventions have used a pre- and post-test methodology, measuring knowledge in various domains, sometimes with a control or comparison group. Most show statistically significant gains in knowledge following the intervention, and some in addition show self-reported changes in behaviours.   Both short-term, low level and longer term, more intensive interventions have been reported to show positive results.

In general, though all types of parents have been shown to benefit, the more 'marginalised' the group (adolescents, low socio-economic status groups, recent immigrants etc) the greater the gains. Thus in the Australian hospital-based study cited above, the author compared scores on a child health knowledge test for a group of parents exposed to the information films and a group not exposed. The measurements were taken two months after the exposure to the films. Though overall the difference in scores was small (c.6%), the differences between the scores of those parents with the lowest levels of knowledge, and those who were recent immigrants to Australia (of non-UK origin) was as much as 70%. Given that the average exposure time to the information films was only 10-20 minutes on one occasion only, these results are impressive, and interestingly, even parents whose knowledge of English was poor reported improvements in their understanding of child health issues, despite the fact that the films were delivered in English. In McDonald-Culp et al's study (*op cit*) based on a very intensive home-based intervention offered to both adolescent and non-adolescent mothers, after six months both groups of mothers reported significant improvements in knowledge and understanding on a range of issues. However, adolescent mothers (who started off with lower levels of knowledge) made the greatest gains and narrowed the gap between themselves and other mothers over time. Fulton, Murphy and Anderson (1991) evaluated another intensive four to six month programme for adolescent mothers in the USA that combined professional home visiting on a twice-monthly basis and fortnightly visits by the young mothers to the programme centre, together with flexible access to educational resources of the mother's choosing (videos, leaflets, books). The aim was to enhance mother's knowledge of child development. At the end of the programme, significant gains in knowledge of child development on a standardised measure (and associated drops in a 'child abuse potential' score) were reported.

Few studies were able to take long-term follow-up measures, but several studies show encouraging results at medium-term follow-up (i.e. five to six months after the intervention). Fulton at al (*op cit*) checked for reports for child abuse 10 months after their post-test measurements, and found that none of the mothers who had taken part in the study had been reported, though this was a high-risk group. A study by Srebnik et al (2002), of gains in parents' knowledge about risk-taking amongst adolescents when at unsupervised parties and gatherings also showed promising results at three to six month follow-up. Following a single two-hour information session led by health and crime prevention professionals, parents reported significant changes in their knowledge about substance misuse and their awareness of unsupervised gatherings of young people. However, as in other areas, studies that have monitored changes over time show diminishing effects as time elapses (Showers *op cit*).

Clearly, though changes in knowledge are encouraging, the desired outcomes implicit in these interventions are about translating enhanced knowledge into behaviour change.   Though few studies were able to make robust measures of actual changes in behaviour (and almost all rely on self-report rather than independently verified observations), there are some indications that in at least some areas, interventions like these can change behaviours. For example, a study of the 'Handle with Care' project (a pilot intervention offering food hygiene information and education to low-income mothers in New Jersey, USA, over the course of two structured lessons) showed that in post-tests and at three month follow-up, mothers reported both knowing more about and actually using safer food preparation and handling procedures (Hughes, 2002). In McDonald-Culp et al's study, all mothers improved their score on a 'home safety' checklist, which included questions about whether dangerous materials and items were kept locked out of children's reach, and whether cars had child car seats installed etc. In Cockington's study, relative to the control group the parents exposed to the child health promotion films reported greater frequencies of child immunisation, more active steps in accident prevention and home safety, and more changes in children's diet. In Srebnik et al's study (*op cit*), at follow-up parents reported significant changes in active monitoring of their teenager's whereabouts, increased imposition of family guidelines about acceptable behaviour, increased communication about substance use and misuse with their child, and reduction in their teenager's attendance at or hosting of unsupervised parties. A study of age-paced newsletters sent to parents in Canada (Riley et al, 1991) found that parents reported changes of behaviour in five key dimensions of behaviour with their child and attributed these changes to the newsletters' content. Again, in that study parents in particular 'risk groups' (adolescents, low-income families, etc) reported even greater benefit and behaviour change than other groups of parents in the sample.

On the less encouraging side, though studies report mixed results, it seems that men and boys may benefit less from these kinds of interventions than women. Although few studies include adequate number of males for robust analysis, several report only slight and statistically non-significant gains for males as compared with females. The exceptions to these are studies carried out with men-only samples, where evidence of effectiveness is strong, but these tend to be focused on special groups (e.g. fathers in prison; Wilczak and Markstrom, 1999) who are unlikely to be representative of fathers more generally. Some studies have suggested that where parents are facing particularly difficult situations, they do not make significant gains in knowledge from these kinds of interventions, even though they may report changes affective aspects of parenting such as sense of competence and efficacy, increased parenting satisfaction and less stress (e.g. Odom's 1996 study of mothers of boys with ADHD). Lastly, evaluations of these types of intervention rarely concern themselves with the measurable impact on children, and we found almost no studies that reported robust measurement of this aspect of effectiveness. It remains to be

seen, therefore, if these interventions are able to improve outcomes for children in the longer term.

In summary then, the results from evaluations of knowledge-based interventions seem promising, at least in relation to simple gains in factual knowledge, and simple (though important) behaviour changes such as accident prevention, food hygiene and supervision and monitoring. Gains have been shown to be maintained (albeit at a reduced level) for as much as six months. Interestingly, even relatively low-level interventions using simple technology (e.g. information cards, one-off sessions etc) show promising results, suggesting that these methods could provide very cost-effective routes for parent education. Given that parents themselves perceive a strong need for more accessible information about common child care issues, there seems to be a strong case for expansion of this kind of service to more parents, both in high need and average-need populations.

Future research

There are several issues that remain unresolved in relation to programmes in this area. As with programmes in other areas of parenting, we are still unsure about the duration and intensity of programme required to produce meaningful results. Though men-only programmes have been demonstrated to show successful results (e.g with young fathers in prison), the numbers of male research participants in programmes delivered to mixed groups in the wider community are typically too small for the researchers to be able to draw robust conclusions about the effectiveness of the programme with fathers as compared with mothers. There are some indications that in mixed groups, men and boys may benefit less than women and girls, but this area needs substantially more research in order to be able to determine if this is the case, and if so, why. There is also a lack of data about the long term effects of these kinds of interventions, and about the cost-effectiveness of these approaches. Most importantly, it is unclear whether or how more complex behaviours (e.g. the way children are disciplined) are affected by these types of knowledge-based interventions, or how children themselves are affected, if at all.

Summary: Parenting knowledge

Programmes that have worked typically involve:
- All types of parents, but gains are greatest for low-knowledge, high-risk groups (e.g. adolescent parents, recent immigrants, incarcerated fathers etc)
- Transmission of straightforward factual information using a range of media
- Delivery by 'authoritative' professionals
- Delivery over a range of formats, from low-level and short-term to longer and more intensive
- A focus on concrete issues (e.g. health care; home safety; child development; substance misuse; monitoring and supervision)

Programmes that have not worked typically involve:
- Children with complex or challenging behaviours
- Parents of children with severe behaviour problems or neurobiological conditions (e.g. ADHD)

Future research is needed to address:
- The extent to which gains in knowledge translate into measurable change in both parenting and child behaviours
- Whether promising low-level interventions can achieve the same results more cost-effectively than longer, more intensive designs
- Possible differences in effectiveness for men and boys as compared to women and girls, and the mode of intervention best suited to each sex
- The extent to which benefits persist in the medium to long term
- Whether follow-up programmes and booster sessions could enhance effectiveness
- Whether programmes like this can achieve measurable change in outcomes for children
- The extent to which these types of approaches 'add value' in integrative interventions combining information giving with other types of parenting support.

Commentary 3.2d
Parent outcomes: Emotional and mental health

Introduction

Poor parental mental and emotional health has long been regarded as an important target for parenting support initiatives. Though the prevalence of mental health problems amongst the general population of parents is unknown, in some specific groups, for example parents living in areas of high deprivation, poor emotional and mental health parents may be widespread. For example, in a recent study as many as one in five (21%) of parents in a representative sample of 1,750 parents in poor environments across Britain self-reported high scores for symptoms on the Malaise Inventory, indicating high risk of depression (Ghate and Hazel, 2002).

We know far more about the implications of poor mental health in mothers and its significance for child care and child development than we do about how paternal mental health impacts on these areas. However, there is now a clear body of evidence indicating that parents with poor mental or emotional health often cope less well with the demands of parenting, and that this can have measurable adverse effects on children's wellbeing. Poor maternal mental health, for example, has been shown to adversely affect children's attachment (Stein et al, 1991), and long-term emotional and mental health (Rutter, 1972). It has also recently been shown to be predictive of persistence of children's mental health difficulties (Meltzer et al, 2003; Buchanan and Ten Brinke 1997), and is associated with high levels of both physical and behavioural problems in children (Ghate and Hazel 2002).

Included in this section of the report are studies that focus on the **general emotional well-being of parents**, (including their general self-esteem and psychological distress) as well as **specific mental health issues** such as prevention of depression and post-natal depression. However, we have not included programmes that specifically aim to treat post-natally depressed mothers as our focus is on non-clinical groups. We cover interventions that target, for example, new mothers, some of whom may be depressed, but have not been selected on the basis of their depression status. Our discussion therefore focuses on primary prevention programmes or else secondary prevention programmes that target those at risk for disorder. There is of course of a vast literature on interventions for promoting mental health amongst adults generally, some of whom will be parents, but in line with our remit to focus clearly on interventions aimed specifically at those in a parenting role, we have not touched on this literature in this commentary. By the same token, readers should be aware that many interventions that go under the banner of parenting support may have impact on mental health indicators (for example, family therapy), and specific 'mental health promotion' services are not the

only way parents might gain support in this area. Conclusions drawn in this section rely predominantly on the synthesis of individual intervention studies rather than reviews, as few reviews focus on issues of preventative interventions with 'mainstream' groups of parents.

Typical populations and programmes

Many of the interventions in the area of parental emotional and mental health focus on parents bringing up children with severe physical and/or behavioural difficulties. Given that the focus of the present review is on parenting of 'mainstream' populations of children, many of the former studies have been excluded, although some dealing with parents of children with difficulties in the non-clinical range are included, such as the study by Sutton (1995), which focused on parents of pre-school children with behavioural difficulties. Other studies involve programmes targeted at particular groups such as low-income families, or ethnic minority families (e.g. Miller-Heyl, MacPhee and Fritz, 1998; Wolfe and Hirsch, 2003). Most target mothers rather than fathers, with some rare exceptions (e.g. McBride, 1990). Many target parents in the neonatal period or with pre-school age children, but there have also be successful interventions aimed at parents of older children such as a programme reported by McGillicuddy, Rychtarik, Duquette, and Morsheimer (2001), which was effective in reducing depression, anxiety and anger scores among parents of substance abusing 12 to 21 year olds. A programme in the UK aimed at parents of young people involved with the youth justice system also showed reductions in parents' sense of stress, by self-report, as a result of participation (Ghate and Ramella 2002). Most programmes are medium duration (eight to twelve weeks), and the content varies enormously from discussion groups to formal educational training, including structured training in specific therapeutic techniques such as rational emotive therapy (e.g. Joyce, 1995).

Effectiveness

Pre and post natal interventions

There have been many mental health interventions targeting women in the pre- and postnatal phase. Preventative programmes of this type typically report negative findings in relation to improvement in postnatal mental health outcomes. A recent review examining early interventions enhancing the mental health of children and families (Barnes and Freude-Lagevardi, 2002) found that programmes delivered in the pre- and postnatal stage tended to be more effective when they focused on physical health rather than mental health outcomes. Among preventative interventions, two evaluations report findings that show slightly *worse* mental health outcomes for the intervention group compared to the control group. However, both studies lacked pre-intervention assessment of mental health status, which cannot be

ruled out as a confounding factor. One of the studies involved evaluation of in-home support provided by trained workers over 10 visits during the first 28 days post-natally (Morrell, Spiby, Stewart, Walters and Morgan, 2000). The authors suggest that the results may be explained by participants experiencing a negative withdrawal effect after the intervention ended. The other intervention involved evaluation of a one-off debriefing session provided by midwives following operative (e.g. caesarian section) birth. Despite 94% of the intervention group reporting that they found the debriefing 'helpful' or 'very helpful', the control group rather than those receiving the intervention were in fact found to have better emotional functioning at six weeks post-natally (Small, Lumley, Donahue, Potter, and Waldenstrom, 2000). Given the generally positive feedback from participants regarding helpfulness and satisfaction with the services offered, there may be other benefits to such programmes, but these have not assessed by evaluators. Once again, this underlines the point made earlier in this review that even when participants report 'feeling helped' by an intervention, this does not necessarily result in a measurable improvement in other types of outcomes.

Brugha et al (2000) also report no mental health benefits for a postnatal preventative intervention involving cognitive and problem solving and enhancement of social support, delivered by nurses and occupational therapists over eight sessions. The authors suggested that in order to achieve significant results, participants may require greater exposure to the intervention both in terms of greater frequency of attendance and longer duration of programmes. They also suggest the need for well-trained facilitators with specific knowledge of psychological interventions. This raises the more general need to consider the match between the staff skill level, the nature of intervention being delivered, and the severity of parental emotional or mental health difficulty being addressed. A study by Davis and Hester (1996), for example, found that while group sessions led by trained parent co-ordinators resulted in improved parental self-esteem among a 'high-risk' group of mothers, the intervention did not produce significant changes in depression scores. Therefore to alter outcomes of clinical significance (i.e. to help clients shift from severe symptom levels associated with impairment to reduced symptom levels that allow 'normal' functioning), professionals with relevant training in psychological interventions may be more effective than volunteers or paraprofessionals delivering interventions of limited duration (see also Chaffin, 2004). Prevention of mental health problems – even ones as common as depression – may be too complex to be improved under these circumstances.

Other types of parental mental and emotional ill health

A systematic review of RCTs assessing the effectiveness of parenting programmes aimed at improving maternal psychosocial health by Barlow, Coren and Stewart-Brown (2001) concluded that a number of different approaches have been shown to

be effective in improving maternal depression, anxiety/stress, and self-esteem levels. Many of the evaluations included in the review focused on interventions for parents of children with severe behaviour or health difficulties, unlike the present review. Hence these studies are not covered in detail here. Interestingly, Barlow and colleagues reported that a diverse array of parenting programmes were successful, leading them to suggest that common 'process' factors in the delivery of programmes may be a more important factor influencing effectiveness than any one theoretical approach. However they were unable to comment in detail on what this might mean in practice as issues concerning implementation and delivery of programmes tend to be reported in qualitative studies and were excluded from their review.

Among interventions that offer support for parents with young children, perhaps Newpin is the best known UK example. Newpin is a long-established service offering social support to parents in order to reduce parental emotional difficulties (described in detail in the Programme profiles in Appendix 1). The scheme offers an initial home visit followed by attendance at local centres, where befriending by volunteers as well as therapy and training are on offer. Although service users are most likely to be single mothers referred because of both social isolation and depression (Oakley, Mauthner, Rajan, and Turner 1995), quantifiable outcomes have been assessed in terms of changes in mental health and child-parent interaction rather than in terms of social isolation. In a study involving a comparison group (from another location, but not fully matched) Cox, Pound, Mills, Puckering, and Owen (1991) found that there were significant improvements in the psychiatric condition of mothers, but only after more than six months involvement. The lack of comparability of the intervention and control group within the study means however that these results need to be viewed with some caution; however, again this points to the need for interventions of longer duration for these kinds of parenting support needs.

Another evaluation of Newpin, this time without a comparison group, reported limited benefits. Oakley et al (1995) found that more than half of women referred to Newpin never used the service, and while there were some women who reported feeling helped by Newpin, a similar number reported that involvement with the scheme did not bring benefits. On the basis of the available evidence, Newpin appears to make a significant difference to the mental health of *some* clients. Before conclusions can be drawn about the value of the scheme more rigorous evaluation studies need to be carried out.

Future research

Although it is clear that there have been a number of successful interventions for parents at risk for emotional and mental health problems, more studies are required

to identify the precise style of programme (in terms of content and delivery) that can most effectively reduce this risk. Length or intensity of intervention and the training level of those delivering the service appears to be important, and it is clear that there may sometimes be a delicate balance to be struck between offering effective support and fostering potentially damaging levels of dependency. It does appear that some interventions have the capacity to make things worse instead of better for parents, and that many result in little or no improvement on 'hard' mental health indicators even where they appear to have increased parents' sense of self-esteem or to have been generally welcomed by those taking part.

In terms of schemes such as Newpin, more rigorously controlled studies need to be carried out before we can be sure of who is most likely to benefit and what range of outcomes may be involved, and how those benefits may be extended to a larger target group. Little attention has also been paid to the mental health needs of fathers, whose problems in this area may also adversely impact on children, but who are not well catered for at the service level (and who are virtually absent from the evaluation literature). By the same token few studies have been able to comment on the possibly differing needs of parents from different social and ethnic backgrounds. Lastly, future research is also required to measure parental mental health outcomes in the longer-term, as there are few studies with long-term follow-up data.

Summary: Parental emotional and mental health

Programmes that have worked typically involve:
- Group work lasting a minimum of eight to twelve weeks
- Mostly parents of pre-school age children, though there are exceptions, especially for parents of children with more severe behavioural/emotional difficulties
- Staff whose level of training matches the type of intervention being delivered and the severity of the outcome being targeted

Programmes that have not worked typically involve:
- Brief interventions for prevention of post-natal depression (some of which show worse outcomes post-intervention)

Future research is needed to address:
- The precise components of service delivery (ie process issues) that influence the success of the diverse range of programmes on offer
- Further exploration of interventions that reduce risk for postnatal depression
- Mental health needs of fathers, and how to support them
- Mental health needs of parents from different ethnic groups, and how to support them
- Mental health needs of parents from social backgrounds, and how to support them
- Outcomes in the long-term

Commentary 3.2e
Parent outcomes: Social support

Introduction

Social support refers to social relationships with both individuals and institutions that have the potential to provide emotional and practical support, and is known to play a significant role in parenting. Support for parents comes from a variety of sources, often broadly grouped into *informal* (from family, friends and neighbours, arising from parents' own pre-existing 'natural' networks), *semi-formal* (often provided through community-based organisations, and generally by the voluntary sector), and *formal* support (organised services, often needs-led, and provided by the statutory sector alone or in partnership with the voluntary sector) (Ghate and Hazel ,2002). Some groups in the population may be less well socially supported than others; for example, black and ethnic minority parents in poor environments (Ghate and Hazel, 2002). Social support is associated in complex ways with coping with parenting and an absence of support does not always predict problems, but research also shows that for some groups, the presence of an impoverished social environment distinguishes families who are at high or low risk for various difficulties, including child abuse and neglect (e.g. Garbarino and Sherman, 1980).

One way in which social support is thought to be important for parents is as a means of buffering the effects that stressors have on mental and physical health. Such stressors may stem from parenting itself (for example, in the case of parents bringing up children with particular health or behavioural problems), or from other areas such as marital conflict or economic difficulties. It may also help to bolster parents' self-esteem and sense of efficacy (Vaux, 1988). An absence of social support can lead to emotional, mental and physical ill health, which may impact on ability to cope with parenting (Ghate and Hazel, 2002). The present commentary examines the impact of interventions that aim to **enhance social support** and **reduce social isolation.** Conclusions drawn in this section rely on the synthesis of individual intervention studies rather than reviews, although few have been entered into the grid as there were very few methodologically robust studies to report on. Given the links between lack of social support and poor mental health, some of the studies discussed below are also of relevance for mental health outcomes discussed in the previous commentary.

Typical populations and programmes

Many interventions aimed at enhancing the social support networks of parents have focused predominantly on its role in the parenting of infants (including parents-to be) and pre-school children. To a lesser extent there are interventions that focus

specifically on particular populations such as teenage parents (e.g. Kissman, 1992; Roker and Richardson, 2002), or parents bringing up children with particular physical, emotional or behavioural difficulties. The interventions themselves take many different approaches to addressing social support. Some interventions provide specific training in an area such as social skills as a means of enhancing parent's ability to interact with others and harness support outside the intervention, and typically are short to medium length (e.g. four to twelve weeks). In other cases the intervention itself is the source of support, as in befriending schemes, where the intervention's home visitation and group participation processes act as a means of facilitating peer support and guidance. Participants' involvement with these schemes tends to be open-ended, unlike time-limited parenting classes. There are other interventions that tackle social support less directly, in which social support is seen as an additional rather than core benefit of the programme. Examples of this include interventions targeting a related but distinct area such as communication skills where the aim is to improve communication between parent and children, but with the 'knock on' effect of improving communication in other relationships including support figures. Lastly, interventions that have the objective of increasing awareness and uptake of services also fall into this broad category.

Effectiveness

Examples of interventions that directly focus on increasing social support within 'mainstream' populations include befriending schemes. In the UK, one of the largest and longest running programmes offering social support to families of young children is Home Start. The service involves home visitation provided by trained volunteers, aimed at offering support, friendship and practical help to young families under stress. A review by Shinman (1996) reported that in 1995-6, Home Start had helped over 11,000 families and 27,000 children, most of whom were under the age of five years at the time of referral to the scheme. There have been several evaluations of the service (e.g. Shinman, 1994; Oakley et al, 1995; Frost, Johnson, Stein, and Wallis, 1996) showing that according to participants, volunteers and organisers alike, Home Start is an acceptable, flexible and useful service. Whilst reported outcomes are generally positive, studies have tended to be largely descriptive, and in the absence of randomised controlled trials it is difficult to draw definitive conclusions about its effectiveness. Randomised controlled trials have been described as unsuitable for imposition on such a flexible and diverse community-based service when practical and ethical issues are taken into consideration (Shinman, 1994). However, further evaluation of Home Start involving a comparison group is underway at the time of writing (McAuley, Knapp, Beecham, McCurry and Sleed, forthcoming).

Aside from befriending schemes, more short-term interventions that use group work focusing for example on information, education, skills training, or discussion are also

known to foster a sense of 'belongingness'. Qualitative evaluations often provide evidence of the enhanced feelings of support that parents experience as a result of participation in a group programme, even when quantifiable outcomes remain unchanged (Wheatley and Brugha, 1999). A qualitative study by Law, King, Stewart and King (2001), for example, highlighted the feelings of kinship that arose among parents of children with disabilities who attended classes aimed at helping them cope better with raising their children. Support derived from parenting group participation may be important in the case of parents who are parenting under unusual or rare circumstances, where connecting with others facing the same difficulties may reduce their sense of isolation. However, little is know about how far such feelings of kinship permeate into participants' lives in the long-term, or whether the group format provides parents with a social support model that translates into lasting social support networks that persist outside the intervention. Indeed, there is some evidence that without continuing professional facilitation the networks will wither away over time (Ghate and Ramella 2002).

For those interventions that address social support needs indirectly, perceiving it to be a 'by product' of an intervention that actually targets other areas of parenting skills, it is also unclear how far changes in social support can be sustained beyond the life of the parenting group. It may be the case that sustained changes in social support are produced when parents are provided with personal resources and skills that can be transferred to their wider context outside of the (usually short-lived) intervention. A study of group sessions for pregnant adolescents, for example, was successful in producing changes in utilisation of social support when the young women were given training that specifically addressed skills such as asking for help from support figures in times of need (Kissman, 1992). Another study, of parenting programmes offered to parents of young offenders in England, showed that parents reported significantly increased awareness of 'where to turn for help' with problems with their child after participating in the programmes, though there was no information on whether parents capitalised on this knowledge to gain greater access to support in the longer term (Ghate and Ramella, 2002).

Interventions also need to be of sufficient duration when we consider just what enhancing a parent's social network entails. Whilst for some 'high risk' parents social isolation may arise from factors such as having newly moved to an area and being geographically or culturally isolated, for others lack of social support results from a lifetime of insecure attachment (involving for example, mistrust and avoidance; Bowlby, 1982). When the reasons for poor support involve the latter, interventions may need to be of sufficient intensity and duration to provide the necessary power to overcome entrenched ways of thinking and behaving in relationships, as well as persuasive techniques for attracting reluctant parents to participate in the programme in the first instance. Sufficient duration of social

support provision may also be required to impact measurably on other significant outcomes such as parental mental health (e.g. Pound, 1994).

Future research

Overall there have been relatively few studies of sufficient methodological strength to be able to draw firm conclusions about what works in enhancing social support for parents. Evidence from befriending schemes shows promise, but such programmes require more rigorous evaluation. Findings regarding other forms of interventions such as time-limited parenting classes show very mixed results. One difficulty in drawing conclusions about the effectiveness of interventions focusing on social support arises from the different way in which outcomes are measured across studies. There is great variability, from measures of the type and number of support figures available or utilized, to measures assessing qualities of support, and perceptions or feelings of support. More consistency of measures across studies is required, but with sufficient breadth of outcome to increase understanding of the potential benefits of interventions. We also know next to nothing about the different social support needs (and how to meet them) of fathers as opposed to mothers, and relatively little about the most effective interventions to increase social support to parents from different ethnic groups. Lastly, there are indications in the literature that parents of children with special problems and needs may feel especially isolated and can gain substantial benefits indirectly from the social opportunities afforded by group-based parenting support interventions, but the lasting impact of these in bolstering access to social support in any substantial sense is unknown.

Summary: Parental social support

Programmes that have worked typically involve:
- Unknown

Programmes that are 'promising' involve:
- Befriending schemes, but these require more rigorous evaluation.
- Services that offer specific information and advice on accessing support from agencies etc in the local areas
- Services that help isolated parents 'rehearse' how to seek help (e.g. through role-play)
- Some time-limited parent group programmes. Although the elements that make them successful or not are unclear, the group situation may lessen feelings of isolation and promote a sense of 'kinship' with others in similar situations.

Programmes that have not worked typically involve:
- Unknown

Future research is needed to address:
- The extent to which support needs and effective services may differ by demographic and cultural factors (ethnicity, social class, sex of parent etc)
- Whether interventions of longer duration and/or greater intensity are required to produce sustained effects
- Longer-term outcomes beyond a feeling of 'kinship' felt within a parenting group
- The extent to which greater service awareness as a result of attending a parenting support intervention are translated into measurable benefits in other domains for parents, and for children
- The need for interventions that tackle social support needs directly, rather than as a secondary factor or as a 'by-product'
- The benefits of support groups for families coping with children with rare or unusual problems

Commentary 3.3a
Parent-Child Outcomes: Parent-child relationships

Introduction

The quality of the parent-child relationship is fundamental to effective parenting support of all kinds: without good communication and warm relations between parent and child, even the most promising programmes may fail to deliver good outcomes. Studies reported in this section of the report involve a series of outcomes grouped for convenience under the umbrella term of 'family relationships'. They include studies where outcomes are measured in terms of changes in some aspect of family relationships, generally involving either **parent-child communication and interaction** or **attachment patterns**. Specific outcomes include reductions in negative interaction, expressed anger, criticism and conflict and, at the more severe end of the spectrum, prevention of child abuse and neglect; increases in warmth-promoting, constructive responses such as praise and greater levels of involvement and interaction between parents and children; improvement in 'felt' qualities of the relationship such as unconditional love and acceptance of the child; and for the child, more 'secure attachment' to the parent (involving different patterns of parent-child bonding and relating). Some of the studies described below also report changes in related areas such as parenting skills/practices, parental attitudes, and also child behaviour. However, the focus of this section is on those interventions whose primary focus in terms of measured outcomes is parent-child communication (of all kinds) and attachment. Studies whose main focus involves related outcomes are reported in other sections of the report accordingly.

By 'family relationships' we mean those that include both parents and children, rather than studies focusing on adult-to-adult interaction. Readers should note that we have not touched on the considerable literature on services for improving relationships between adults in families (e.g. reduction of domestic violence, mediation and so on) even though there is substantial data to indicate that poor relationships between adult couples are associated with substantial negative outcomes for children. This evaluation literature is covered elsewhere and fell outside the remit of this review. The conclusions we have drawn here stem from a combination of existing research reviews and primary evaluation studies. Reviews were more often used in drawing conclusions about work with infants, where there are a considerable number of studies, as compared to work with adolescents, where we were more reliant on our own distillation of individual evaluation studies.

Typical populations and interventions

The types of intervention available cover a broad range, but typically involve some form of skills training for parents, the nature of which tends to differ according to the age of the child. In relation to newborns and infants, many interventions focus on enhancing parental sensitivity to infant behavioural cues as a means of fostering more secure attachment in the infant. Secure attachment during infanthood has been linked with more 'compliant' behaviour in the preschool years (Klein and Durfee, 1979), and fewer problem behaviours at primary school age (Lewis, Feiring, McGuffog and Jaskir, 1984). These interventions tend to involve training for mothers on a one-to-one basis, either through home-visitation or centre-based approaches. For older children, training parents in 'filial therapy' (see below) has been used with diverse groups of children to encourage expression of children's feelings and to foster greater empathy in parents. For even older children, parenting programmes (some of which were described in commentary 3.2a on parenting skills and commentary 3.2c on parenting knowledge), have focused on improving communication skills such as negotiation, alongside provision of information about adolescents' risk in relation to substance abuse or delinquency.

In terms of child abuse and neglect, only literature on primary prevention programmes are reviewed below, in keeping with the present review's focus on interventions designed for mainstream rather than populations already experiencing difficulties. Primary prevention programmes generally aim to prevent the incidence of child abuse and neglect by providing a form of support to parents that enhances family stability, promotes good parental emotional and mental health, and bolsters coping skills (Cook, Reppucci & Small, 2002). Some have also provided information by written materials posted to all new parents on common sources of injury to children, including for example the well-known 'Don't Shake the Baby' prevention programme against Shaken Baby Syndrome[20] started in Ohio, USA in the late 1980s (Showers 1992). Surprisingly, though parental use of harsh physical punishment is well-known as a risk factor for child physical abuse (not to mention a host of other poor outcomes at the child level; see Ghate 2000 for a review), other than 'Don't Shake the Baby' we could not find any evaluations of primary prevention programmes that provide education on constructive discipline and how to avoid risky forms of punishment and then assess the outcomes in relation to prevention of child abuse. However, one could also include in this category the banning of physical discipline altogether, as twelve countries now do, as the 'ultimate' form of primary prevention.

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[20] 'Shaken baby syndrome' describes a collection of serious and sometime fatal head trauma symptoms associated with the violent shaking of small infants.

In the discussion of effectiveness below, these differing approaches to parenting interventions are discussed in terms of the age of the child, with a separate section on prevention of child abuse and neglect. Note that as is common across the many outcome areas covered in this review, with a few honourable exceptions 'parents' mostly means 'mothers' in this literature.

Effectiveness

Infants and young children

An example of an intervention with newborns is the Brazelton Neonatal Behavioural Assessment Scale (BNBAS; Brazelton, 1973). Although originally devised as a assessment tool for newborns, the BNBAS has been used as a means of enhancing parent-infant interaction and attachment in high and low risk families by increasing parental awareness of the infant's individuality and capabilities (e.g. Beeghly et al, 1995). It involves eliciting a number of responses from the infant to assess neurological condition, demonstration of which to parents is believed to increase parental awareness and responsiveness to infant behaviour as well as enhance feelings of nurturance towards the baby.

A meta-analysis of BNBAS-based interventions with newborns concluded that there was a small to moderate beneficial effect on parental behaviour in relation to reciprocity, sensitivity and responsiveness to infant cues (i.e. parents' ability to read and respond in interactions with infants (Das Eiden and Reifman, 1996). Several factors have been suggested as potentially increasing or lowering the effectiveness of the intervention. These include the intensity of the sessions (in terms of the number of repetitions of the procedure required to bring about and sustain change) and the interaction of this with maternal risk factors for poor outcomes such as low socioeconomic status. Passive observation of the procedure versus parental administration of the BNBAS may also affect its impact, although results of trials in this area have produced mixed results. Further research into these moderating factors is required to produce more consistent findings regarding effectiveness. Long-term follow-ups are also required to assess whether the initial short-term enhancement of parental sensitivity leads to more positive parent-infant interactions, and indirectly to other positive outcomes in the longer-term. In the meantime, Britt and Myers (1994) suggest that the BNBAS should not be viewed in isolation, but seen as an initial component of a longer-term or more intensive intervention.

Another intervention that enhances parental sensitivity to infant behaviour and promotes security of attachment is a maternal skills-based programme that has been tested with irritable infants in Holland (van den Boom, 1995). The intervention consisted of three home visits lasting two hours, in which mothers were taught constructive responses to both positive and negative behaviours ('cues') in their six-

month old infant. Follow-up of the children at two years showed that intervention group mothers were more sensitive to their children in terms of responding to things that the child did, sharing of interest in objects and activities, allowing toddlers greater autonomy and using less direct instruction. This in turn was associated with the toddlers themselves taking more notice of their mothers, showing more cooperation and engagement in meaningful activities, and using more verbal interaction. At age three years the children receiving the intervention were more likely to have secure attachment than control group children and showed less behaviour problems. This study demonstrates that enhancing maternal sensitivity and responsiveness to babies using a relatively short intervention can lead to more secure attachment which in turn produces positive effects on toddler behaviour. How far these results are generalisable to non-irritable infants is not known, and would be a promising area for future investigation.

Parent-child communication has also been enhanced by an intervention known as 'filial therapy', which can be used with older children as well as younger children. Filial therapy provides a means of non-verbal expression of children's feelings in a healthy, constructive way. It involves a therapist acting as a facilitator of child-centred play therapy with the parent, usually over the course of a 10 week training period. Parents are trained either individually or in groups in child-centred play therapy principles and skills to provide play sessions in their home environment. Filial therapy has been used with a diverse range of populations and settings including families where children have emotional and behavioural difficulties, physical disability and chronic illness, and families of low-socioeconomic status and across many ethnic groups. A review by Rennie and Landreth (2000) cites evidence showing that filial therapy has been effective in facilitating parental empathy and acceptance of the child, reducing parental feelings of stress, improving family interaction, and reducing child behavioural problems. They conclude that filial therapy is effective in promoting the conditions necessary to enhance parent-child relationships, but that more long-term studies are required to assess lasting effects. A recent meta-analysis of play and filial therapy that included studies conducted with and without parental involvement concluded that parental involvement increased the effectiveness of the therapy, as did the number of sessions up to a peak of 45 (Ray, Bratton, Rhine, and Jones, 2001). The authors also commented that group therapy was as effective as individual therapy, suggesting thereby that group sessions may be a cost-effective way of promoting good outcomes in this area.

Older children and adolescents

Parenting adolescents is a challenge that some families find themselves unprepared for. The issue of effectiveness of interventions aimed at older children is complicated by consideration of whose perspective is taken into account when changes in family relationships are measured. Unlike studies of infants, evaluations of interventions

for parents of older children sometimes (though not often) include reports of changes in family relationships from the perspective of the child as well as the parent. Interesting differences can emerge, such as those from a parent skills programme aimed at enhancing communication within step-families with children in the 6 to 18 years age group (Nelson and Levant, 1991). Although the programme succeeded in training parents to better reflect their child's feelings and express their own feelings, and also to eliminate physical punishment and yelling, their children did not perceive either increased acceptance or decreased rejection from parents, perhaps due to persistence of some 'undesirable' parental responses. Another example in the UK literature can be found in Ghate and Ramella (2002), involving parents of young people at risk for antisocial behaviour. Parents reported significant changes in their relationship with their teenagers between the start and end of a parenting support intervention, including better communication, less conflict and a greater sense of mutual understanding and empathy. Young people, however, reported less dramatic changes (though this may also have been due to the smaller numbers of young people than parents who responded to the evaluation questionnaire). More typically however, studies assess parents' views concerning changes in family relationships rather than children's. While many programmes theoretically link improved family relationships with improved outcomes for children, few actually measure child outcomes directly.

There are several interventions that view enhanced family relations as a protective factor for adolescents at risk of problem behaviours such as substance misuse or offending. These programmes typically involve skills building via a parent group format using information giving, video vignettes, discussion, and homework assignments. In the 'Preparing for the Drug Free Years' parenting skills programme (Kosterman, Hawkins, Spoth, Haggerty, and Zhu, 1997), for example, family bonding is developed as a means of reducing risk for substance abuse by teaching parents and children more constructive ways of communicating, including negotiating, managing anger, and encouraging expression of affection, as well as providing information about risk factors for substance misuse. The programme is peer-facilitated (run by other parents, who have received training) and involves children (age 8 to 14 years) and their parents. It has been shown to be effective in reducing negative interaction and enhancing proactive communication (including reasoning, listening, and assertion skills), and in reducing growth in alcohol use by adolescents.

Interestingly, differences in findings for mothers and fathers emerged, with fathers' improvements in communication being more evident in family problem solving situations, and mothers' improvements in communication being more evident in more general family interactions. These results imply that mothers and fathers employ different skills in managing family relations, and this may have an important influence on the design of future parenting skills programmes. As yet

there are still gaps in our knowledge of the respective roles of fathers and mothers and their independent influences over outcomes for children.

Child abuse and neglect: primary prevention

A recent review of child maltreatment interventions by Cook et al (2002) recommends the use of universal prevention programmes that involve parent education, family support and/or home visiting components. However, robust evaluations of primary (rather than secondary or tertiary) preventive efforts to reduce child abuse and neglect are minimal, and more studies that go beyond measuring parent-level outcomes (parental knowledge and awareness, perceptions of usefulness of educational interventions) and include post-intervention changes in rates of child abuse and neglect need to be conducted (Leventhal, 1997). Relatively little is known about the effectiveness of primary prevention programmes – studies typically measure changes in the rates of child maltreatment after participation in secondary and tertiary prevention programmes (e.g. Britner & Reppucci, 1997; Olds et al., 1997; Naughton & Heath, 2001), rather than after primary prevention interventions over the long term, as is necessary to provide convincing evidence of effectiveness. That said, evaluation of the 'Don't Shake the Baby' prevention program in the USA suggests substantial benefits not only in terms of parents' perception of its 'helpfulness' (75% of respondents to an evaluation questionnaire said it was helpful; Showers 1992), but also provides limited evidence for the programme's effectiveness at reducing admission to hospitals of infants with Shaken Baby Syndrome (Council on Child Abuse of Southern Ohio, 2003). Lastly, there is evidence from some countries that have introduced legislation banning the use of corporal punishment that this may be especially effective in reducing (though not entirely preventing) child abuse and neglect, as well as being associated with host of other desirable outcomes. The introduction of an anti-smacking policy in Sweden, for example, has been associated with increased identification of children at risk of abuse; as well as reductions in theft and narcotics crime, youth assaults on young children, youth rape, youth suicide, and alcohol and drug use by young people. It may also have helped to reinforce a shift in parental attitudes and beliefs about corporal punishment and to establish an ethos of more nurturant parenting related to changes in public acceptance of violence against children (Durrant 1999)[21].

Of course, heightened public awareness of child maltreatment issues following legislative change may paradoxically lead to increased reporting of abuse cases over the short term, making measurement of impact on child maltreatment especially difficult. Indeed, a frequently mentioned methodological concern related to research

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[21] There is however debate about the particular social context of the Swedish situation that may bear on the relationship between attitudes and legislative activity in this area (e.g Roberts 2000); however, the beneficial impact of the ban on identification and reporting of children at risk, and the fact that child death rates have decreased (albeit from rare to very rare) in Sweden has not been disputed.

on all programmes aimed at preventing child abuse and neglect is the issue of measurement of outcomes. Reports to protective agencies may be an inaccurate outcome measure because of the hidden nature of child abuse and the possibility of detection bias (some families are more likely to be known to and identified by the authorities than others). Home visitation interventions, for example, are likely to have higher reporting rates because an outsider (the home visitor) has frequent access to the home, and therefore more opportunities to recognise and report injuries (MacMillan, 2000; Guterman, 1997). In addition, the use of parent self-report measures (including parenting attitudes, practices) and medically-related indicators (reports of accidents, poisoning, hospitalisations etc.) as proxy measures of child abuse raises concerns about validity. MacMillan (2000) argues that an unacceptable number of false positives (i.e., overestimating the likelihood of child abuse) feature in research assessing risk potential for future child abuse and neglect. Equally, other authors have drawn attention to the pitfalls of under-reporting of abuse (Ghate and Spencer, 1995). However, the validity of some results can be increased by systematically analysing and categorising injuries, a strategy recommended by Leventhal (1997). In the UK, recent research has done useful work establishing 'norms' in patterns of injuries amongst community samples, which in the long term may be very helpful in clarifying measurement issues (Marjorie Smith and colleagues, forthcoming report for the Department of Health).

Future research

There appear to be a range of interventions that show at minimum some promise in terms of enhancing family relationships, defined variously in terms of improved parent-child interaction, child attachment, and parent communication. More needs to be known about how to enhance these interventions so that they can be generalised to diverse parent populations. Exploration of the significance of improved parent-child relations for child outcomes is also needed, taking into account long-term as well as short term outcomes, and encompassing the perspective of children too.

Summary: Parent-child relationships

Programmes that have worked typically involve:
- For enhancing parental sensitivity and responsiveness to infants: the Brazelton Neonatal Behavioural Assessment tool (although only small to moderate changes are reported); and home visiting involving skills-based training for mothers of irritable 6-month old babies.
- For enhancing parental empathy and acceptance: filial therapy
- For enhancing parent-adolescent relations: skills-based programmes for adolescents and their parents that build on protective factors (e.g. 'Preparing for the Drug Free Years')
- For primary prevention of child abuse and neglect: home visitation programmes (begun prenatally); multi-component programmes including education, advice, information and practical forms of support; and, possibly banning all physical violence against children including physical punishment.

Programmes that have not worked typically involve:
- Unknown

Further research is required to address:
- Factors that can enhance the effectiveness of the BNBAS
- The generalisablity of the effectiveness of home visiting skills-based training for mothers in the case of non-irritable infants
- The specific characteristics of home visitation programmes for primary prevention of child abuse and neglect (e.g. who the visitor should be and level of training required)
- Whether primary legislation banning corporal punishment by parents, which showed promise in Scandinavia, could have the same impact in countries with different socio-cultural contexts and higher rates of child maltreatment
- Outcomes for young people, as seen from their perspective
- Mothers' and fathers' contributions to family relations independently to understand the significance of gender roles in parenting
- The effectiveness of interventions in the longer term

4. Process and implementation issues

Introduction

As many of the foregoing commentaries note, 'process' issues (aspects of the delivery and implementation of a parenting support service) form the critical, but sometimes hidden, backdrop to any assessment of an intervention's effectiveness. In their review article, Assemany and McIntosh (2002) observe that data from those studies that have collected this information suggest that perhaps as many as half of all parents referred may drop out prematurely from behavioural parent training programmes. They found that even in the most promising 'empirically supported' programmes perhaps as many as two fifths of parents will continue to experience problems with their children after treatment has ended. The observation that many parents do not fully engage with or benefit from services designed to help them and their children probably holds true for many different types of interventions described in this review. In truth, we do not know the full extent of engagement failure and negative treatment outcomes in this area because many researchers do not collect or report the data, and even where they do, if outcome results are negative, papers may be less likely to be accepted for publication by scientific journals (Stoiber and Kratochwill 2000). Mindful of a potential political backlash, practitioners and funders are also at times selective about the evaluation results they allow to enter the public domain after evaluation of a particular intervention, and will require that research reports de-emphasise negative or equivocal results and concentrate on positive ones. This is sometimes presented as a wish to focus on and learn from 'good practice', but is a dangerous habit to encourage, obscuring the real and important learning that can be gleaned from examining reasons for failure. Understanding causes of negative results and determining if they are due to implementation failure or other factors is critical if we are to avoid wasting resources by setting up services that cannot effectively be delivered.

There is a general assumption in the literature that parents who fail to attend appointments after initial referral to a service, or who miss some or all of their scheduled sessions will have poorer outcomes than those who engage more actively. Moreover, unlike clinical research, evaluation reports of community-based interventions relatively rarely analyse the impact of differential engagement on outcomes to explore whether there is any 'dose-response' effect (ie. whether the amount of exposure to the intervention - for example, number of hours of contact - is in fact associated with better outcomes). Practitioners, funders and sometimes researchers implicitly expect that services are generally beneficial to all families who may use them, even where there may in fact be limited hard evidence to support this assumption. A recent salutary review of strategies to engage parents and children in

support interventions by Staudt (2003) points out that "*there is little support for the widely-held assumption that clients who drop out of treatment have poorer outcomes than those who complete…or that they would be better off had they remained in treatment. It may be that they do continue…but do so with another provider….(or) it may be that the families who drop out of treatment are making well-informed decisions that the services they receiving are not helping, or perhaps they have found alternative sources of help outside of the formal service delivery system*". Of course, this may well be true. On the other hand, studies of 'hard-to-reach', high-need parents who notoriously fail to engage with services show that many who are 'persuaded' to attend parenting support services even against their own inclinations (e.g. by court-mandated attendance, as with the UK's Parenting Order system) report being glad they attended and perceive significant gains in parenting confidence and competence as a result of having attended (Ghate and Ramella, 2002).

Assuming, then, for the moment that there are at least some 'opportunity costs', for at least some people when parents fail to take up a service or drop out prematurely, what do we know about how and why some services fail to engage with parents, and how or why some parents fail to benefit from the services available? In fact, there is surprisingly little robust research on what makes for effective implementation, and very few properly-designed experiments have been conducted (and these only in the United States). Thus, much of what follows in this section of the review is based either on qualitative studies, or drawn from 'practice wisdom' or researchers' own observations and informed speculations rather than rigorously tested and evidenced through controlled designs. With this caveat in mind, in this section we discuss issues associated with the implementation of parenting support (i.e. how to set up and deliver a programme to families), also often referred to as 'process' issues in the literature. In addition we also discuss the issue of cost-effectiveness, as this is another aspect of interventions (alongside process issues) that ultimately affects whether programmes are deemed to be effective or not.

Characteristics of successful implementation

At a basic level, *how* parenting programmes are delivered may be as critical a factor in achieving positive outcomes as *what* their content is. Even the best-designed services may fall at any one of a number of key implementation hurdles. The first hurdle is 'getting' parents (persuading parents to attend the service in the first place); the second is 'keeping' them (persuading them to attend sessions regularly and complete the course); the third is 'engaging' parents: making it possible for them to engage actively with what the service has to offer (listening, taking part in interactive elements, completing 'home-work' assignments, reading supporting materials etc). Clearing each of these hurdles requires considerable effort and strategic planning on the part of service providers, yet it is clear that in fact, quite often much more effort and thought goes into designing the content of the

intervention than in planning how to deal with implementation challenges. Most experienced evaluators have witnessed at first hand the dispiriting situation that Staudt (a practitioner; *op cit*) bravely admits to – where practitioners put a great deal of work into designing and resourcing a parenting support intervention, and then sit waiting fruitlessly for parents to turn up and take part.

The experienced practitioner-researchers, Forehand and Kotchick (2002), identified four groups of factors that can influence effective implementation - *practical, relational, cultural and contextual*, and *strategic* – to which we would add a fifth group on the basis of the wider literature, *structural*. Although most of these factors have been identified with reference to interventions that involve face-to-face contact with parents, some of them apply equally well to 'remote' or information-based interventions such as telephone help-lines and newsletters.

Practical factors

Under this heading are included a range of concrete factors that can, if put in place, contribute to the ease with which services can both get and keep parents. They address some of the most common practical barriers to participation in family support services, noted in scores of evaluation reports. In terms of getting parents, a key issue (often overlooked by services) is knowing the 'market' for the service and then publicising it appropriately so that potential users and referral agencies know it is there (see Levant 1987 for a case example; also Roker and Richardson, 2002; Ghate, Shaw and Hazel, 2000). Making sure the service is run at a time convenient to users, and ensuring they can reach the venue easily and without cost has also been raised by scores of evaluations (Forehand and Kotchik, 2002; Ghate, Shaw and Haze,l 2000). Provision of child care is vital when a service is delivered out of people's homes – even when interventions are concerned with parenting teenagers, as many families will have children of all ages (Forehand and Kotchik, 2002). Lastly, a comfortable, non-stigmatising and conveniently-located venue that provides refreshments appears to be a factor in keeping parents attending regularly.

These factors are summarised in the box below.

Summary: Practical factors positively affecting implementation and delivery of parenting services

- Child care facilities, near to where the service is provided on site, so that parents can leave infants and young children safely whilst they concentrate on attending the service
- Provision of paid-for transport to and from the service site (where not a home-based intervention), especially where low-income or rural families are the users
- Selection of a convenient location (e.g. a place where parents might want to go for other purposes)
- Non-stigmatising, comfortable and welcoming venues
- Delivery at convenient times (including evenings and weekends where there is a demand)
- Ensuring that the service is properly advertised and marketed, so that parents and agencies on whom referrals may depend know about it

Relational factors

Relationships between individuals lie at the heart of all forms of social support (Thompson 1995; Ghate and Haze,l 2002). Relational factors (those which refer to relationship issues) appear to be important both for 'getting' and 'keeping' parents, but absolutely critical for overcoming the 'engagement' hurdle. Without them, parents may become hostile and disaffected (Ghate and Hazel, 2002), or may simply feel that the service is talking a language they do not understand. They include issues relating to staffing as well as programme delivery style and content.

Staffing issues
The quality of the staff employed in direct work with families appears to be a vital component of successful implementation. Research on user perceptions of services consistently shows that the extent to which families feel they can 'trust' staff or service workers, and the extent to which they feel staff empathise with them contributes to user satisfaction and to motivation to attend regularly (Forehand and Kotchik, 2002). These factors may be especially important when trying to reach certain groups of parents, such as ethnic or cultural minorities; see below, Cultural sensitivity). Conversely, staff with poor inter-personal skills or a judgmental or unsympathetic manner are off-putting to users, many of whom may be feeling vulnerable and highly stressed. Although some practitioners worry that it is important to match the personal attributes of staff to users (e.g., to have male staff to work with fathers; to have an ethnic match etc), in fact there is no robust research evidence to support this position in respect of keeping and engaging parents. User perceptions of 'what makes a good worker' tend to focus on style of working and interpersonal skills rather than fixed attributes, and studies that have directly asked these questions suggest that it is not vital to have staff matched for sex, ethnicity, age

etc. Rather, the ability of individual staff members to form constructive relationships seems to transcend this. However, it may be that the 'visible' mix of a staff team is important for making a service seem to reflect the 'normal world' (see for example Ghate, Shaw and Hazel, 2000), and that this may be a relevant factor in 'getting' parents (ie encouraging them to attend in the first place). It is also self-evident that when working with parents in distinct linguistic or cultural groups that it may be easier to build initial rapport when staff are perceived to be 'same' rather than 'other' in relation to user groups (Gross, Julion, and Fogg, 2001; Hawkins et al, 1988). Training of staff in the wide range of skills they will need for working with parents is also important (Forehand and Kotchick, 2002), and needs to extend beyond parenting and child care issues to related areas like child protection and risk assessment, domestic violence, mental health, substance misuse (Ghate and Ramella, 2002).

Delivery style
The way in which services are delivered in terms of the style in which they are presented, or the content of what is presented may also have a profound impact on keeping parents motivated to attend a support service. If users are dissatisfied with the service they have received, they may be more likely to drop out before the completion of the intervention, or they may benefit less from the service and have poorer outcomes. (It must be said, however, that the key word here is 'may': though many evaluations report 'soft' impact measures such as general user satisfaction, there is in fact no published evidence that higher satisfaction levels mean better attendance, or that they are necessarily associated with better outcomes). Measures for building rapport with parents before they begin formally using a service (for example, using home visits by facilitators both for assessment and introductory purposes) can be very helpful in this respect (Forehand and Kotchik, 2002; Ghate and Ramella, 2002), and in general it is worth spending time on this aspect of service delivery. Once parents have agreed to participate, research suggests that the style of delivery needs to be interactive and reasonably 'fun' in style rather than didactic and overly-serious. Above all, staff should avoid leaving parents with the feeling that they have been doing things wrong, or that they do not know what they are doing. Recognising parents' expertise in their own lives, and emphasising partnership by doing things *with* families rather than *to* them (Forehand and Kotchik, 2002; TSA/PRB, 2002; Ghate and Hazel, 2002) is critical here. Incorporating user-feedback into the development plan for the service, and making this process visible to users (PRB/TSA, 2002) can help emphasise a partnership approach.

A summary of the relational factors (including staffing issues as well as delivery style and content) are summarised in the box below.

> **Summary: Relational factors positively affecting implementation and delivery of parenting services**
>
> - Using 'trusted' local professionals where possible (e.g. staff who are already known to parents)
> - Recruiting staff with excellent inter-personal skills, which generally matters more than personal attributes such as the sex or ethnicity of the staff member
> - Ensuring that all staff are fully trained for the job
> - Building rapport with parents before they begin formally using a service (for example, using home visits by facilitators both for assessment and introductory purposes)
> - Using interactive rather than didactic style of working
> - Avoiding 'talking down' to service users or making them feel belittled or inexpert in their own lives
> - Ensuring that user feedback is incorporated into changes to the service, and that this is conveyed to users

Cultural, contextual and situational factors

This group of factors refers to the ecological context of parenting, and the importance of recognising that parenting is influenced by a wider range of interactive and interdependent factors. Attention to and understanding of users' life circumstances (including their sex, living situations and general well-being) as well as their cultural and ethnic background appear to be a fundamental pre-requisite to engagement of parents with services. Below we discuss three key groups of situational factors that are thought to influence services' ability to get, keep and engage parents.

Life circumstances and stresses
It is now widely accepted that living in high stress situations has a measurable, negative effect on parenting (Conger et al, 1994). Paying attention to families' pressing background needs often turns out to be the starting point for would-be parent educators, with workers finding their job to be as much about individual case management as about teaching and developing parenting skills *per se* (Forehand and Kotchick, 2002; Ghate and Ramella, 2002). Many practitioners describe this work in terms of 'preparing' families to participate in parenting support; and indeed, many families arrive at support services seeking help with a wide range of issues, not just those that professionals might regard as being closely related to parenting. As Forehand and Kotchick put it: "*Parents cannot fully engage in parent training unless their other basic needs have been adequately addressed*".

Failure to address wider problems with life circumstances has also been shown to be associated with early drop-out from services. Prinz and Miller (1994) note, "*focusing on parenting to the exclusion of other family and adult concerns can drive some families out of treatment*", and while higher levels of life stress (e.g. being a lone parent, having a low income) are known to be associated with greater likelihood of formal support-seeking (Redmond, Spoth, and Trudeau, 2002) and service use (Ghate and Hazel, 2002), the few studies that have explored reasons behind differential engagement of families referred to parenting support services have repeatedly found that those who drop out early have greater background levels of socio-economic disadvantage and life stress (e.g. Kazdin and Wassell, 1999; Webster-Stratton, 1992).

In addition to the effects on *engagement* of parents with support services, there is also some research evidence that shows that life circumstances can have a 'moderating' influence on treatment *outcomes,* often in complex ways. Reuter, Conger, Ramisetty, and Mikler (1999) for example showed that men with fewer life stresses (specifically, poor marital relationships or financial worries) at the start of enrolment in a parenting skills training programme benefited more than men with greater life stresses, although women with higher levels of these types of stresses gained more. Especially since parenting in two-parent families is something both partners contribute to, the marital relationship itself may need to be assessed at the outset of a parenting programme involving both parents. The quality of the marital relationship has also been found to influence the effectiveness of parenting programmes. A study by Dadds, Schwartz and Sanders (1987) found that parenting skills were less likely to be maintained in the context of a discordant marital relationship. Hence parenting training alone may be insufficient in some cases, where additional support for the couple may be required.

In a slightly different sense, other studies have provided evidence for the importance of recognising that parenting takes place within a social context and within an existing set of social networks that include wider family, friends and communities. Evaluating the outcomes of a project to send first-time mothers a monthly newsletter about parenting and infant development, Walker and Riley (2001) demonstrated that mothers who shared and discussed the content of the newsletter with people in their social networks reported greater changes in their parenting, independently of the extent to which they read and saved the newletters. The study showed that encouraging discussion and wider sharing of issues within users' own natural networks not only promulgates learning but may also enhance the effectiveness of the intervention at an individual level.

Sex of participants
The sex of the parents using a service is now known to be an important situational factor in delivering effective support. Qualitative studies have suggested that fathers and mothers may want different things from family support services (Ghate,

Shaw and Hazel, 2000), and because many services are designed with mothers' needs and preferences in mind rather than those of parents of both sexes, men may be harder to get, keep and engage as service users than women. Redmond et al (2002) found that men were less likely to participate in parenting programmes, as did Spoth, Redmond, Hockaday, and Shin (1996), who also report that fathers were less likely to apply information they had learned than mothers. However, a review by Coplin and Houts (1991) concerning fathers' involvement in parenting programmes for children's oppositional behaviour reports that fathers are not only equally effective at learning and applying parenting skills but that fathers' involvement may enhance maintenance and generalization of parent training effects. This may stem directly from improved father-child interaction or from increased consistency in both parents' methods for dealing with behaviour problems. Alternatively there may be an indirect effect produced by enhancing fathers' emotional support of their partners' parenting. Coplin and Houts suggest that more needs to be known about the differences and similarities in parenting strategies employed by fathers and mothers in order to inform the design of parenting programmes, in terms of both content and delivery style.

Cultural sensitivity
Given that in the developing world non-Caucasian families are often more likely to experience the many risk factors associated with parenting difficulties, such as poverty, unemployment, and poor health (e.g. National Statistics Office, 2001), the need for parenting services among this group may be high. However, while need may be high, uptake of formal support services is typically low (Ghate and Hazel, 2002). There is a historical trend of underutilisation of formal services within certain ethnic groups, resulting not only from linguistic and cultural differences but also from differences in knowledge of services and willingness to use them. Traditional recruitment methods may be ineffective at overcoming these barriers. Moreover, the programme content and delivery method may be unacceptable to some cultural groups (Catalano et al, 1993). Short and Johnston (1994) identify the main barriers to participation as issues of language, fear of stigmatisation, and lack of culture-compatible programming, including differences in child-rearing practices and values. They comment that most parenting education programmes in America have been developed and evaluated in mainly Caucasian, American samples, with the result that interventions are less successful with other sociocultural groups.

Efforts to improve recruitment of participants in the United States have often involved offering monetary rewards. However, an American study of low-income non-Caucasian parents found that while monetary incentives acted as a device for attracting initial interest to the intervention, they are not necessarily sufficient to sustain participants' interest over time (Gross et al, 2001). The study examined the effect of various incentives on recruitment and retention of parents in a parenting skills course for parents of pre-school children. Parents rated the location of the

scheme (at the children's day care centre) as the most important factor in encouraging their involvement in the programme, reflecting the need for convenience and ease of access of programmes, as described earlier. A free videotaped session of the parent playing with their child was also cited as important, more so than the financial compensation for taking part.

In the same study, the personality and trustworthiness of the recruiter was also cited as an important incentive, in 90 per cent of cases. The programme employed workers from the same racial-ethnic group as participants, who lived in communities similar to the one where the scheme was located. Similar findings emerged from another American study of ethnically diverse parents enrolled on the 'Preparing for the Drug Free years' programme (Hawkins et al, 1988). Key individuals were identified who could access social networks of potential participants, such as church and school community personnel (Harachi et al, 1997). These individuals offered credibility and a personal connection between the programme and the cultural community that enhanced recruitment.

In terms of retention of participants, in the Gross et al (2001) study cited above, offering the programme on weekday evenings was the only incentive that related to retention of minority ethnic participants, again reflecting the issue of convenience for participants. The authors concluded that it is important to identify recruitment and retention strategies that are *meaningful* to participants, and that the discovery of 'what works for whom' needs to be applied as much to recruitment and retention issues as it does to the nature of the intervention itself.

In terms of the content of programmes, cultural appropriateness needs to be considered. Recognition that notions of what constitutes 'good parenting' may vary between groups (as well as within groups) is critical here. Responsibility for childcare and child welfare, for example, may extend to other family members outside the nuclear family in non-Caucasian families, whereas parenting programmes typically target mothers and fathers as the key figures holding such responsibility. There may also be cultural differences in the acceptability of certain models of child-rearing promoted within parenting programmes. Some cultures, for example, expect children to show deference in relation to adults, which is at odds with parenting programmes that strongly endorse a model of mutual respect and negotiation. Forehand and Kotchick (2002) suggest that practitioners need to learn from their clients by asking them about their parenting beliefs, expectations and practices.

To increase the cultural sensitivity of parenting programs, changes can be made in content and/or delivery. Cheng Gorman (1996) describes three types of programmes that have evolved as a result of such changes: **translated**, which as its name suggests involves the translation of a programme into the language of the

target population, without changing any of its cultural content; **culturally adapted**, whereby an existing programme incorporates to some degree the cultural values of the target group and involves bicultural parenting rather than adoption of a wholly mono-cultural (North American)approach; and **culturally specific** programmes that attempt to enable successful parenting *within* the target groups' culture, rather than working with a modified version of a traditional programme. An example of a cultural adaption is given by Forehand and Kotchik, which was devised to overcome the resistance they encountered among African American parents to ideas of rewarding or reinforcing children for compliance. They had to re-label such interactions as 'showing your child that you love her' as part of improving parent-child relationships rather than using the usual parenting programme language of 'rewarding' good behaviour.

A review of culturally sensitive parenting support programmes by Cheng Gorman and Balter (1997) suggests that culturally specific programmes are relatively rare in comparison to the other two types. They stress the need for development of future programmes that are both relevant and acceptable to all populations, and also the need for robust methodological studies, both qualitative and quantitative, to assess efficacy of culturally sensitive studies. To this we would add that whilst greater appreciation of cultural differences could certainly advance the field of parenting support, it is however important not to fall into the trap of 'cultural relativism'. Within-group variation is likely to be at least as great as between-group variation in respect of beliefs and attitudes about parenting and child care, and stereotyping parents on the basis of their membership of a particular cultural or ethnic group can easily result from slavish preoccupation with cultural sensitivity, as Forehand and Kotchik (2002) warn. More robust evaluation work is needed before we can be sure what it is that makes a programme culturally sensitive, and why, and before we can comment on whether so-called culturally sensitive programmes also show better outcomes for their users.   The REU's 'Strengthening Families, Strengthening Communities' parenting support programme developed from an American programme for use in the UK with black and Asian parents is an example of a programme thought to offer greater cultural sensitivity to its users due both to content and style of delivery. However, there is as yet no strong evaluation evidence to support this claim and we need to know more about such programmes and how precisely they differ from others in order to pull out generalisable messages for practice.

The box below contains a summary of the factors thought to impact on service implementation and delivery in relation to cultural, contextual, and situational issues.

Summary: cultural, contextual and situational factors positively affecting implementation and delivery of parenting services

- Awareness of parents' personal context in terms of a number of factors that may affect uptake, engagement, and effectiveness of the service, including single parenthood, marital discord, mental health, poverty, poor housing unemployment, gender, culture and ethnicity etc.
- Good interagency working practices so that clients may be referred to other services if contextual factors are likely to impede parents' ability to use and benefit from the service
- Awareness that the content and style of programmes and their style of recruitment and retention may need adaptation for fathers whose approach to use of services may differ, as may their contribution to the parental role.
- Awareness and respect for different models of parenting that arise within different cultures, and the need to tailor programmes accordingly, while at the same time recognising the commonalities of parenting within different cultures
- The use of workers with sufficient credibility and trustworthiness in relation to the clients' cultural background
- Provision of incentives for uptake and engagement of the service that are meaningful to clients within their culture, context or situation.

Strategic factors

A group of factors relevant to implementation concern 'strategic' aspects of delivery – essentially, things that services can do to incentivise attendance at family support services and discourage dropping out. Persistence in the recruitment of families has a strong bearing on services' success in getting 'hard to reach' users (e.g. fathers; highly stressed families). Experimental studies in the United States reviewed in Staudt (2003) have shown that follow-up reminders after initial referral (by phone, or letter) can reduce the 'no-show' rate at first appointments, though the contact method itself made no difference (both were equally effective). Telephone calls to clarify the helping process and discuss concerns in detail with potential service users both prior to and after an initial visit to a service have also been found to increase attendance and engagement rates, probably because they not only alleviate anxieties but perhaps also help parents to have realistic expectations of what services can do for them (Forehand and Kotchick, 2002). Requiring newly referred parents to invest time in completing various forms and assessment questionnaires prior to a first visit may also reduce the no-show rate, presumably by raising parents' motivation and commitment to attend, (though as Staudt comments, this may also have put off some of the 12% families who subsequently failed to turn up for their appointments). Another study (Parrish, Charlop, and Fenton, 1986) experimented with threats or 'warning contingencies' (warnings that parents would be demoted to the bottom of a waiting list for the service if they missed more than three appointments), as

opposed to rewards (the chance to win gift vouchers each time they attended), and found that the 'warning contingency' seemed to promote higher attendance both at initial and subsequent appointments, perhaps because the threat of service withdrawal and the emphasis on limited places made the service seem more desirable in parents' eyes. Lastly, a recent study in the UK of parents mandated to attend parenting support services by court order found that although there were a number of ethical and philosophical problems with this approach, it had nevertheless resulted in higher rates of attendance and completion by parents when compared to a similar group of voluntarily-referred parents (Ghate and Ramella 2002)[22].

Addressing parents' concerns and anxieties about service use in a serious way also seems to be effective at reducing rates of premature drop-out from services. Comprehensive Referral Pursuit and Maintenance Approach (CRPMA; Szykula, 1984) and Enhanced Family Treatment (EFT; Prinz and Miller, 1994) are two approaches that involved specially trained workers being assigned to supporting parents one-to-one to negotiate a range of barriers to service use, and which reported successful results. Of course, these are expensive options. Other less expensive (and unproven) incentives commonly mentioned in the UK literature also include providing 'hooks' to encourage parents in to services (trips and outings, sports activities, beauty treatments, computer training; see e.g. Roker, and Richardson 2002), which also seem to be especially important for getting and keeping fathers at services (Ghate, Shaw and Hazel, 2000). Positive re-inforcement in the form of rewarding service users by providing a visible 'end product' for their involvement (e.g. a qualification or certificate in parent education) have also been used to apparently good effect in some UK services. In the United States, some services use monetary incentives for programme attendance. Strategic factors influencing implementation and delivery issues are summarised in the box below.

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[22] Outcomes of participation were not, however, affected by route of referral.

> **Summary: Strategic factors positively affecting implementation and delivery of parenting services**
>
> - Investing persistent effort in the early stages of referral and attendance (including telephone 'recruitment' calls and reminders by phone or letter)
> - Pursuing non-attenders vigorously and persistently
> - Working on situational factors that may impede parents' attendance
> - Providing one-to-one contact before, during and after services to support parents to keep attending
> - Rewarding regular attendance (e.g. with certificates and qualifications)
> - Incentivising attendance by providing access to useful or fun activities not necessarily related to parenting
> - Warning families that services may be withdrawn if they miss sessions
> - Mandating high risk parents to attend

Structural factors

Structural factors are principally about the *format* or *mode* of service provision, and mainly affect the success of keeping and engaging parents. For example, though group-work is often well-received by parents and is thought to be more cost-effective than one-to-one work (though we do not know this yet definitively), groups often do not work well for the most highly stressed or vulnerable families, in part because the hurdle of taking part in a 'public' event may be too exposing for these types of service users. People with multiple personal life stresses may also need one-to-one support before and during a group work programme to ensure that pressing background issues are addressed adequately. On the other hand, for other parents, the social aspects of group work may prove one of the most attractive and rewarding elements of taking part in a parenting education intervention (Ghate and Ramella, 2002). Most of the literature concurs that offering services to both parents where relevant (and making efforts to ensure both take part) seems to enhance positive outcomes and reduce the effects of couple disputes arising when the non-participating parent may feel threatened by the new insights and skills that the participating parent brings back to the family home (See also Contextual factors, above). However, where the service is delivered by group format there is an ongoing practice debate about whether both halves of a couple should be accommodated within the same group. Some practitioners maintain that groups should not generally include both partners, as this can influence the dynamic of the group for other participants, lead to the airing of personal conflicts etc, and prefer that couples should be accommodated separately. Others prefer that both parents attend, to ensure maximum buy-in from both parties. At present, there is no robust scientific evidence to support either position, however.

The content of an intervention (for example, the type of materials used – written, video, computer-based etc) may also be an important part of effective implementation. Most qualitative evaluations that comment on this issue concur that interactive rather than didactic methods are more stimulating, and that delivery needs to allow for 'fun' and sharing as well as formal learning (TSA/PRB, 2002).[23] Although written supporting materials are important and parents usually cite these as useful, the literacy levels of participants are clearly an important issue here. Most parents enjoy audio-visual presentations, providing these show families and children that are recognisably 'like' participants (as opposed to different in terms of social class, age, ethnicity etc). Some studies indicate that allowing parents to chose the supporting materials they can use (videos, books, leaflets etc) in a flexible way may enhance outcomes (McDonald-Culp et al, 1998). Alternatives to face-to-face delivery may be especially helpful where services cannot reach parents. Nixon (2002) suggests that when access to face to face sessions is difficult because of personal or geographical circumstances, the use of alternative methods of delivery of programmes needs to be considered, involving videotaped training, telephone training and, potentially, the internet.

Offering parallel work with young people as well as with parents is increasingly being recommended as more effective than work with parents (or young people) alone and 'taster' sessions to allow parents to try out services before they commit to attending on a regular basis may also be helpful in acclimatising families to a particular service (Roker and Richardson, 2002). A summary of the structural factors affecting implementation are provided in the box below.

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[23] Note that these observations are drawn from studies of mainly female clientele, however. Some commentators suggest that fathers may prefer more formal methods of delivery and may not be so comfortable with the informal 'sharing' style, which can feel emotionally more threatening/demanding.

Summary: Structural factors positively affecting implementation and delivery of parenting services

- Using interactive and 'fun' rather than didactic, formal style of working
- Consider alternative and innovative methods where face-to-face delivery is difficult for practical or resource reasons
- Provision of supporting materials (leaflets, books, videos etc) that reflect users' own lives and situations and do not seem over-simplified or patronising
- Tailoring written materials to the literacy levels of users
- Careful selection of group vs one-to-one format according to the needs of the user
- Active attempts to include and engage couples in two parent-families (though not necessarily within the same sessions)
- Taster sessions before the intervention starts to allow parents to acclimatise to the service and adjust expectations

Cost-effectiveness

The present report has discussed the notion of 'effectiveness' in relation to several aspects of programmes, including the need for programmes to attract and retain participants, as well as bring about change in outcomes for parents and children. Another aspect of effectiveness to consider is that of cost effectiveness. While this is of course a fundamental consideration of policy makers, it has received less attention in terms of research from which we can draw firm conclusions. We know something about *costs*, but relatively little about the *cost-benefits* equation. We know, for example, that the cost of supporting children with conduct disorder into adulthood is ten times the cost of provision for children without such disorder (Scott, Knapp, Henderson, and Maughan, 2001). We also know something about the costs of providing parenting support, as some of the cost data quoted in the grid that accompanies this report shows. What we are lacking is research focusing on robust cost-benefits analysis so that we can make a comparative analysis of different forms of support and their outcomes against the costs of unsupported groups of parents, taking into account the broad impact that lack of parenting support may have in terms of education, health, social services and criminal justice costs. The situation is complicated immensely by the fact that there are two types of costs that need to be considered: *costs to the wider society* (for example, the social costs of antisocial behaviour, including its impact on 'quality of life' factors such as fear of crime), and the *costs to the exchequer* (ie costs to the state, for example the costs of providing custody for those convicted of a crime, the costs of providing mental health services to offenders etc). The former are typically more nebulous and harder to measure, though the latter can also be surprisingly difficult to accurately define and calculate. There are also several time frames over which costs need to be weighed against

outcomes - ie short-term and immediate costs, as well as costs and benefits over the medium term and longer term.

This latter complication in particular presents challenges for policymakers in weighing up the benefits of parenting support, not least because parenting support interventions straddle at least two generations. Almost by definition, the time lag between the funding and delivery of a programme and the point at which we could possibly expect to see potential benefits from it may extend to many years. For example, interventions aimed at reducing antisocial behaviour by means of preventative intervention involving parents in the early years of children's lives (i.e. before the age of five years) may not have substantial impact in terms of crime reduction and cost savings until the children themselves reach teenage years, when antisocial behaviour peaks. A study by the RAND organisation (1996) makes just this point in a comparison of four methods of reducing criminal involvement. The effectiveness and programme costs of four different pilot approaches were compared: home visits by child care professionals from pre-birth to age two years; parent training and therapy for families with children showing conduct problems in school; four years of cash and other incentives to encourage disadvantaged high school students to graduate; and monitoring of high school age delinquent youths. Results suggested that graduation incentives for high-risk youths would be most cost effective, and the cost benefits could be felt rapidly, as the youths were close to their most crime-prone age. The parent training programme was also considered relatively cost effective, but would produce no significant *crime prevention* impact during its first five years as the children were only aged seven to ten years during the intervention and had not reached their peak age for crime proneness. However, the report only took into account program costs relative to incarceration costs, and hence did not take into account more immediate savings to education, health, and social services resulting from the parenting intervention during the five years before children reached peak age for juvenile crime. Interestingly, the report also points out the potential immediate effects that parenting training may have in terms of reducing one particular type of crime among parents rather than children – that of child abuse and neglect.

These results also raise the more general question of the extent of the benefits of programmes, and how far they go beyond the immediate participant population to reach future generations of parents to come. We could hypothesise, for example, that a parent-training programme is more likely than a graduation incentive scheme to produce effects that are carried over into the next generation of parents. Children of parent-training participants may have a more positive parenting experience, which in turn may impact on the way they themselves parent, through, for example, 'social modelling' (following a good example set by one's own parents), or attachment processes. If parenting programmes can go some way to breaking the intergenerational cycle of disadvantaged parenting, then they indeed represent long

term investments that will be very cost effective. However, these are speculative suggestions that await further research, but nevertheless point to the need for consideration of just how long-term the effects and savings of parenting support may be.

In terms of specific programmes that have been shown to be cost effective, there are several research studies demonstrating this for a number of programmes, most notably in the US literature, and most frequently in relation to programmes targeting children's antisocial behaviour (e.g. cost effectiveness of Multidimensional Treatment Foster Care has been described by Moore, Sprengelmeyer, Chamberlain, 2001; cost effectiveness of Multisystemic Treatment has been described by Borduin et al, 2000; Henggeler et al, 1998). There are also a number of older US studies focusing on interventions for special difficulties that demonstrate the cost benefits of *early* intervention in particular (e.g. for children with special education needs, Wood, 1981; for children with handicaps, McNulty, Smith and Soper, 1983). There are also more broadly targeted programmes that focus on early intervention which have been shown to be cost effective, such as the Perry Preschool project, for example, which reported benefits to participants followed-up to age 27 years (see commentary 3.1c).

Generally, in provision of an intervention there is a trade-off to be considered between the cost of providing a universal preventative programme (in which some participants of low risk status do not need the programme) versus a more selective (and typically more expensive) programme that only targets high risk groups. Another study by the RAND organisation (1998) is particularly interesting in this context. It examined costs of the Perry preschool project and the Elmira Pre-natal/early infancy project, and the risk status of participants relative to cost savings. The study took into account the programme costs in comparison to the eventual government savings in relation to welfare, health, education and criminal justice system costs. For high risk families in the Perry pre-school project the savings to government were about twice the cost per participating family, while for the high risk Elmira participants government savings were about four times the cost of the project. However, for the lower risk families in the Elmira project, the savings for government were not likely to offset the cost of the programme. When additional 'benefits to society' other than savings to government were considered, it was estimated that this was at half the programme costs for the low risk Elmira participants, around a hundred percent of the programme for the high risk Elimra participants, and twice the programme costs for the Perry preschool project participants. It is important therefore, to consider the characteristics of participants in terms of their risk status when establishing cost-effectiveness, and to consider the extent of benefits beyond those direct savings to the government purse.

In terms of parenting support in the UK, we still have some way to go in terms of providing basic programme cost data relative to cost data for other forms of provision. Studies such as the RAND organisation's reports have been very informative for comparing cost-effectiveness across various forms of provision and for various client groups. More of this type of work needs to be undertaken in relation to programmes in the UK. However, even before we can establish a programme's cost-effectiveness, there is still much to be done in establishing the other forms of effectiveness described in this report. We are still lagging behind the US in terms of providing rigorously conducted trials for assessing the lasting changes for parents and/or their children, and (to a lesser extent) how to attract and retain parents. Once this assessment of effectiveness takes place, then assessments of cost effectiveness can follow. Put simply, until we get better at measuring outcomes, we cannot improve our ability to solve the cost-benefits equation.

5. Discussion and conclusions for policy

In this review, we were asked to collate, sort and summarise the international (English language) evaluation literature on the effectiveness of parenting support programmes across a range of outcomes for both parents and for children. Specifically, we were asked to summarise what is known so far about what works, what looks promising, what doesn't work and what remains unknown. We were asked to restrict our focus to specific interventions, and to concentrate in general on interventions aimed at 'mainstream' populations and parenting issues except in the case of one or two outcome areas that were of special interest to our policy-based funders.

As might have been expected, it was a challenging task to make sense of what is, now, a substantial international literature. Taking only the formally published literature into account we identified well over 2,000 separate journal articles and book chapters written on this subject since 1985. Several aspects of the task bear further comment. In reviewing the literature to arrive at our conclusions regarding what works, a number of issues became apparent regarding the quality of the available research evidence, and also the lack of research evidence in some specific areas. We thus begin with a discussion of these issues, as an appreciation of the deficits in the current state of knowledge is important for contextualising and understanding the limits to the messages about 'what works'. Finally, we set out our conclusions about what works in parenting support, in terms of the key messages we have been able to distil for policy. We reflect on the messages for policy in terms of what types of 'good practice' should be supported; what kinds of research should be encouraged; and lastly what implications arose out of the review for the more 'macro' aspects of national policy making.

The quality of the evidence

Quantitative evaluation design

Once we had decided that only studies that reached a particular level of methodological rigour should be included, it was strongly apparent that there is a substantial divide in the quality of the evidence base between the UK and North America. In the US literature, there were many evaluations to chose from that were rated at or above level three on the SMS scale – that is, they employed designs involving pre- and post intervention assessment, and used properly controlled and replicable designs with appropriate comparison groups, many of which were randomly allocated. By contrast, evaluation studies in the UK tended to use idiosyncratic designs that could not be replicated, rarely had convincing comparison

groups (let alone control groups randomly allocated), and more typically rated at level two and below on the SMS scale. As a result, if we apply extremely rigorous scientific criteria, we simply cannot say what works (or doesn't) in the UK, and it is unclear whether the findings of the more rigorously tested US-based interventions can be generalised to the UK context. Put simply, it will never be clear what works *in the specifically UK context* until researchers, policy makers and service planners invest in more methodologically rigorous evaluations of interventions. This means studies involving comparison groups (and preferably randomised control groups) and pre- and post-intervention assessments, preferably with follow-ups over the medium to long term. This requires active partnership between the three communities, so that intervention design and delivery can facilitate good evaluation.

Qualitative versus quantitative studies

Another limitation of the evaluation literature (and this applies equally to the US and the UK evidence base) is that studies tended to be either quantitative or qualitative, but rarely both. Consequently, it is usually only possible to comment on an intervention's effectiveness either in terms of its statistically quantifiable impact or else its effectiveness in terms of service implementation and delivery issues. To develop a fully rounded picture of the success of an intervention, and given our discussion regarding process issues and their importance in delivering effective services, future studies that employ both types of methodology would be welcomed. Furthermore, in the same spirit of the remarks above in relation to quantitative research, this means supporting qualitative research that passes basic quality control thresholds: it is still remarkably common to find papers even in otherwise reputable academic journals claiming firm findings based on 'qualitative' research studies with samples of participants only just into double figures, no discussion of how the sample was obtained, and no reflections on the generalisability of the findings to the wider population of service users or the likely limitations of such methods in terms of informing practice. As noted earlier, the British government have recently commissioned an expert team to develop a framework for determining the quality of qualitative evaluation studies (Spencer et al *op cit*), and it is to be hoped that the messages from this work will help to drive up quality standards in this aspect of research methods.

'Measureability'

This in turn leads to another (larger) discussion concerning the quality of evaluation science more generally, i.e. that we tend to measure what is easily measurable, rather than what we really want or need to know. This is reflected at all levels of evaluation science, and especially in the UK: in choice of approach (we choose qualitative methods because these are generally less challenging to implement than rigorous quantitative designs rather than because the issues we are interested in lend

themselves best to qualitative methods); in sampling (we sample parents, rather than children because children are harder to reach; we sample mothers because fathers are harder to reach); and in instrument design (we use either pre-existing tools that may not always fit our purposes fully, or untested new instruments rather than invest time and money in developing good tools that are of known reliability and validity). We still have much to do to improve the quality of measurement in this field, and this requires investment in methodological enquiry as well as in actual evaluations. We need to increase the number of properly tested and validated tools available to researchers to measure the various outcomes in which we are interested. This would mean that more standardised and less idiosyncratic evaluation designs could be implemented, and their results compared one with another. Unless studies can be replicated, we can never truly rely on findings of effectiveness or lack of it. To show something once is not enough.

Gaps in knowledge

Types of interventions that work

It is evident that we know considerably less about the effectiveness of certain types of service provision than we do about others. In particular, we know far less about the impact of some types of open access or universal services than we do about those that target a specific type of user. One of the reasons for this, it is often claimed, is that community-based open access and universal services are technically much harder to monitor and evaluate. Many of these services (especially, for example, drop-ins) operate on the principle that they collect no data on who uses the service, as a way of normalising service use and so that users will feel less stigmatised in accessing whatever support the service has to offer. This means that researchers cannot easily construct samples for evaluation purposes, and that even the presence of a research team can be seen as threatening the casual, normalised ethos the service tries to create. Or else (runs another argument), the catchment area of the service is so wide and fluid that whole communities would need to be surveyed and compared with other whole communities in order to capture the impact of the intervention, and this would be too expensive, time-consuming, or scientifically complex to undertake. It is imperative that we find ways to evaluate this kind of service approach, however, if the claims that are made for them are to be substantiated. In particular, the practice of not even keeping basic head-counts of users runs counter to all indications of good practice in the development of evidence-based services, and all services should be required to develop proper methods of recording who has used their service, when, and with what intensity, at least until it is clearly established that a particular type of service does indeed benefit users and is a good use of resources.

Children's perspectives

Another by-product of the emphasis on easily measured outcomes described earlier is the striking lack of research focusing on the views of children. As the ultimate recipients of enhanced parenting support, there is a need to incorporate assessments of children's views about the impact of parenting changes, and to explore what makes a difference to their experience of being parented. Though there is an increasing recognition of the need to take account of the views of the child and the 'user perspective' within research and services affecting children, as we commented earlier, there is still a pervasive tendency amongst researchers, practitioners and especially amongst policy makers to view children mainly as 'developing adults' rather than as people in their own right. This means that outcomes investigated always tend to focus more on implications for future development than on children's experiences of being parented in the here and now. Most studies also take measures from adults rather than triangulate[24] these with children's self-reports, and though we do not definitely know that these may sometimes be discrepant, there is some suggestion in the literature that they may be. We would therefore encourage further research that integrates the views of children, which are curiously missing in research on parenting support.

Longer term outcomes

We also know far less about the medium to long-term impact of interventions than we do about their short-term impact. Generally, this could be remedied by investment in rigorous longitudinal research, though in practice because of the expense and difficulty this only makes sense for the larger and more promising interventions that are likely to attract continuing policy support over a long time frame. Still, it is a significant limitation of the evidence base that we know relatively little about the lasting impacts of parenting support for parents, children or whole families. For most interventions we therefore cannot say how sustainable the benefits are, and we also lose the opportunity to identify latent or delayed effects that may reveal themselves as children (and parents) grow up.

Protective factors and developing a 'strengths-based' approach to parenting support

It was striking that despite this huge body of work, some aspects of the effectiveness of parenting support are still much better researched than others. There is, for example, a substantial focus on interventions that prevent or reduce known risk factors for poor outcomes for young people, but not a correspondingly large literature on services that address themselves to building protective factors.

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[24] Ie, take measures from other informants for the purposes of validation and cross-comparision.

Sometimes, of course, risk and protective factors are two halves of the same coin, but often they are not. The focus, it seemed to us, is still very much more about weaknesses and deficits in parenting skills rather than about recognising and developing strengths. It is a question for debate whether focusing on strengths might deliver just as good if not better long-term outcomes for young people, perhaps at lower cost than at present. Garbarino, Vorrasi and Kostelny (2002) remind us that risks to parenting arise not only from direct threats but from '*the absence of normal, expectable opportunities*'. They suggest that there is much to be gained by reconceptualising parenting research, policy and practice in terms of 'accumulated opportunities' instead of 'accumulated risk'. Such a model implies that risk factors may be neutralised or partially offset by introducing opportunities into other realms of the child's (or indeed, parent's) life, even when risks are believed to be impervious to change, but we know relatively little about how this might work in reality.

Diversity issues

Although there is an increasing recognition in the literature that parents come in two varieties (male and female), it is also still the case that most interventions predominantly serve women, and most evaluation samples contain insufficient numbers of men to be able to draw definitive conclusions about what works for fathers, and whether this is different from what works for mothers. At present, precisely speaking we still cannot say we know about 'parenting support' – rather, we mainly know about 'supporting mothers'.

In a similar vein, our knowledge of parenting support is mostly based on knowledge of interventions with white families. Issues of attracting and retaining ethnically diverse groups of parents are still under investigation, as are issues connected with how best to develop and adapt programmes to accommodate differing perspectives on what constitutes appropriate parenting. Too often research that claims to investigate issues of ethnic diversity simply reports findings based on samples from one or other ethnic group, and assumes that because of the nature of the sample, the findings must self-evidently tell us something about ethnic diversity issues. We have very few good comparative studies on which to draw, and in terms of practice and the question of what are the features of *generic* good practice in parenting support as opposed to the features of good practice that *specifically and only apply* to certain ethnic groups, we are still very ill-informed. As a result, much practice development in this area is led as much by ideology as it is by hard evidence. To take this forward, again, we need a partnership between service planning and research, delivering the same interventions in carefully controlled ways to different groups of participants, and measuring outcomes within a comparative framework.

Cost-effectiveness

Finally, there is very little detailed information about cost-effectiveness or the cost-benefit equation in this area of service provision. Only a few studies have even attempted to address this question, and most at rather general levels. There is clearly a whole new academic discipline waiting to be developed here, bringing economics more centrally into the social care field and applying the techniques being developed in mainstream health care to family-based interventions. Training of social researchers in economics (or economists in social research) to enhance scientific capacity in this regard is clearly much needed.

What works: messages for policy about 'good practice'

So, do we know 'what works' in supporting parents? The answer is both yes and no. As our commentaries and the summary boxes that close each commentary section in this report have shown, as the weight of good scientific evidence grows, it is now becoming possible to isolate examples of services that have delivered positive outcomes for both parents and for children and young people. In addition, where we do not definitively know that something works, we often have a fairly strong indication that the approach is 'promising'. Below, we summarise the main conclusions of the review in relation to policy messages for service planning and service delivery practice.

The aims and objectives of intervention

Interventions tend to be more successful when they know not just where they want to go, but also have a clear idea of how they are going to get there. That is, programmes that have been demonstrated to be effective generally have clear statements of the theoretical basis on which they rest, and can clearly describe the precise 'mechanism of change' they are expecting. This means having not just a general idea of overarching aims, but a clearly articulated set of concrete, measurable objectives. The expected sequence between inputs by the service and outcomes for users needs to be considered and precisely documented. In the UK, far too many interventions adopt a 'developmental' approach to delivery in which the final shape of the intervention as it is delivered to users seems to bear little or no resemblance to the original description of the programme's aims at its inception. Though practitioners often account for this as 'necessary evolution' and as part of tailoring an intervention to the emerging needs of the user group, the end result is that it can often be hard to identify what exactly the intervention has delivered, and well nigh impossible to evaluate its effectiveness. Theoretically-based programmes have been shown to be particularly important in areas such as prevention and treatment of antisocial behaviour in young people and are likely to be significant in other areas of parenting support. Good practice requires that practitioners clearly articulate and

document how, precisely, they expect their planned intervention to benefit participants, and to set objectives in concrete terms that can be measured over time, and funders should require evidence of this before supporting new services. This will make it possible both to evaluate programmes in terms of anticipated, hoped-for outcomes as well as unanticipated ones that may emerge over time, and which may be just as illuminating in terms of practice development.

Timing, basis and duration of intervention

Generally, though prevention is always better than cure, the evaluation evidence suggests that benefits can be derived from both early <u>and</u> later intervention. Early interventions in general report better and more durable outcomes for children; late intervention seems to be better than none, although it may be more beneficial for parents than for young people themselves (e.g. in dealing with parenting stress, rather than modifying outcomes for young people). However, families under multiple stresses will not be able to benefit fully from parenting support interventions unless their other needs are met as well. This should not mean that parenting support services have to be all things to all parents - though those that can offer 'wraparound' services (like MST) certainly seem to be highly efficacious. Instead, services need a clear understanding as to which levels of the 'ecology of parenting' they are working on, and to have a system for undertaking a comprehensive assessment of needs at the outset. Effective multi-agency working is clearly required to enable parents to access other appropriate services that can meet a wider range of needs. Further, use of terms like 'holistic' in this sense can be misleading: given the complexity of many struggling families' needs, it is unrealistic to expect a single service (how ever sophisticated in conception) to meet all needs. To use a term much over-worked but still apt: policy makers need to require and support genuinely 'joined-up' services where practitioners have the time and capacity to foster meaningful links with one another, and sufficient understanding of each others' professional cultures to be able to refer on families as and when appropriate.

Relatedly, programmes need to provide a good match between parents' level of need and the duration and frequency of the programme. Parents with complex problems and multiple needs do better in programmes of longer duration and greater intensity; brief interventions on the other hand work well in achieving simpler objectives like the giving of information or modifying straightforward behaviours. The use of intensive interventions seems to be recommended where problems are severe and where intervention is late rather than early. Although expensive to run properly, they may have longer term pay-offs in terms of cost effectiveness, for example. In some cases, however, families may need 'taster' services and brief pre-intervention work to prepare them for more intensive work over the longer term.

Who to intervene with

The literature suggests that parenting support services should generally be offered to *both* parents in two-parent families (though not necessarily to both physically together at the same time). However, we do not know for certain the extent to which working with both parents actually increases the benefits; this awaits further research. Similarly, to maximise the chances of affecting outcomes at the child behavioural level, parenting support programmes that have been most successful have worked directly with children as well as parents wherever possible, though again, not necessarily both at the same time. Again, the precise 'added value' of parallel working has yet to be established, however. Services that are making efforts to develop this type of working in the UK need to be given every support to do so, and enabled to carry out research on this specific aspect of service delivery and its impact.

Who should intervene

Quality and training of staff is vital to programme success, as is good support and supervision. Programmes of proven efficacy tend to use professionally trained workers and paraprofessionals rather than volunteers, though there are also examples of promising programmes (e.g. Home Start) that make extensive use of peer volunteers. Training and support for staff and volunteers are critical, however, and newly emerging evidence from very rigorous RCT studies in the United States is suggesting that training in *specific issues* that are most strongly predictive of poor outcomes rather than just generic support skills must be provided if workers are to support families effectively. Policy in this area, as recognised in the recent Green Paper (*Every Child Matters*) therefore needs actively to support the development of a high level of practice skill amongst the social care workforce, as though volunteer and peer supporters clearly can play a worthwhile role in interventions to support parenting, there will be no substitute for a well-trained and well-supervised professional workforce. In addition, research shows that a critical factor is also the ability of staff to build good relationships with parents. So, whilst authoritative staff are important, working effectively with parents also requires the skills to build a sense of partnership with service users. If parents do not feel respected, they are unlikely to engage well with a programme.

Implementation aspects of intervention

Multi-component programmes appear more likely to succeed than uni-modal designs. They can be multi-component in the sense of addressing more than one area of need (without losing sight of their core objectives) as well as in the sense of varying the mode of delivery - involving for example components for parents, for

children, and involving different methods of delivery such as group work, home visitation sessions, and use of a variety of materials to support the learning. It has not proved possible so far to isolate which elements of multi component programmes work best in parenting support. Although some commentators have expressed the view that this is in any case an unnecessary exercise – that it is in itself the 'interactive' nature of multi-modal programmes that makes them effective, nevertheless, some greater understanding of which combinations of intervention modes are most powerfully effective would be helpful.

'Manualised' programmes with centrally-monitored, systematised delivery are preferable as they tend to deliver better outcomes: programme integrity matters. There is strong evidence that programmes that have a clear idea of what they want to deliver, and then stick to it, have better results than those that adopt a more developmental and fluid approach. This may seem counter-intuitive to practitioners, who worry that sticking firmly to a single 'recipe' for support may drive out the flexibility to respond to or adapt to families' individual and changing needs; however, policy makers and funders should be aware that it is clear from the evaluation literature that the 'ad hoc', fluid approach taken by very many UK support services is of unproven effectiveness, and is likely always to remain so, given the impossibility of robust evaluation of this model of working. This does not mean that interventions cannot incorporate an element of flexibility; only that there must be at least some elements of the core service offered that are clearly planned and rigorously implemented if we want to get to closer to understanding whether that service 'works'.

More successful programmes also pay very close attention to implementation factors such as how to 'get', 'keep' and 'engage with' parents and promote good attendance. There are many factors that appear to be important in this respect (see Section 4), and some commentators believe that *how* parenting support is delivered may matter more than *what* is delivered. At the same time, it is important to note that all programmes - even ones that show good success for some parents and children - experience a degree of implementation failure and have users who drop out or who do not engage well with the service. The message here seems to be that what is important is to have a good range of complementary alternatives locally available, so that parents may have more than one opportunity to find something that 'works for them'.

Type of intervention

Process issues aside, the type (or component) of intervention that is best offered to any one parent depends substantially on the outcomes that are desired. Though parents may draw a wide range of benefits (both predicted and unexpected) from a parenting intervention, the blanket application of a particular type of programme

irrespective of the actual needs of the family can be very counterproductive. This does not mean that individual services themselves have to adapt to meet all needs; rather it implies that services need to have a clear idea of their own 'market', and be prepared (and able) to refer families to other more appropriate services when their own model seems inappropriate. One size does not fit all, making it especially important that practitioners assess needs and identify clearly the desired outcomes before referring users to their own service or to others. Behavioural programmes (or elements of them), for example, work best for achieving changes in more complex parenting behaviours and skills (like disciplining children), and in achieving measurable outcomes at the child behaviour level. 'Cognitive' programmes are effective at modifying parenting beliefs, attitudes and self-perceptions but are not so effective in changing behaviours. Knowledge-based interventions can be effective at delivering health promotion-type messages and in achieving change in 'simple' parenting behaviours (like food preparation behaviours).

Mode of delivery

We still require further studies to investigate the relative benefits of group work versus one to one work. However, there seems to be a growing consensus in the literature that group work with parents can achieve positive outcomes in many areas of intervention, including those aimed at child health outcomes, children's emotional and behavioural difficulties, and parenting skills. It is likely that group work is also more cost-effective, and we know it also has spin-offs connected with the social aspect of the learning environment that help to engage parents' continued participation. Some parents are however unsuited to group work, or may have pressing personal needs that require one-to-one attention from a practitioner. Thus, the facility for one-to-one work, sometimes as preparation for later group work, needs to be available alongside group programmes. Finally, home visitation is described as an effective method of delivery in scores of programmes now and has been recommended to reduce risks to child health, and risk of abuse and neglect, and also seems promising in terms of reducing parents' isolation and improving emotional and mental health.

Summary of key messages for policy about 'what works' in practice

- Both early intervention <u>and</u> later intervention; early interventions report better and more durable outcomes for children; but late intervention is better than none and may help parents deal with parenting under stress
- Interventions with a strong theory-base and clearly articulated model of the predicted mechanism of change: services need to know both where they want to go, and how they propose to get there
- Interventions that have measurable, concrete objectives as well as overarching aims
- Universal interventions (aimed at primary prevention amongst whole communities) for parenting problems and needs at the less severe end of the spectrum of common parenting difficulties - though some types of universal services require more evaluation to determine their effectiveness
- Targeted interventions (aimed at specific populations or individuals deemed to be at risk for parenting difficulties) to tackle more complex types of parenting difficulties
- Interventions that pay close attention to implementation factors for 'getting', 'keeping' and 'engaging' parents (practical, relational, cultural/contextual, strategic and structural; see Section Four)
- Services that allow multiple routes in for families (i.e. a variety of referral routes)
- Interventions using more than one method of delivery (i.e., multi-component interventions)
- Group work, where the issues involved are suitable to be addressed in a 'public' format, and where parents can benefit from the social aspect of working in groups of peers
- Individual work, where problems are severe or entrenched or parents are not ready/able to work in a group, often including an element of Home Visiting, as part of a multi component service, providing one-to-one, tailored support
- Interventions that have manualised programmes where the core programme (i.e., what is delivered) is carefully structured and controlled to maintain 'programme integrity'
- Interventions delivered by appropriately trained and skilled staff, backed up by good management, support and supervision
- Interventions of longer duration, with follow-up/booster sessions, for problems of greater severity or for higher risk groups of parents
- Short, low level interventions for delivering factual information and fact-based advice to parents, increasing knowledge of child development and encouraging change in 'simple' behaviours
- Behavioural interventions that focus on specific parenting skills and practical 'take-home tips' for changing more complex parenting behaviours and impacting on child behaviours
- 'Cognitive' interventions for changing beliefs, attitudes and self-perceptions about parenting
- Interventions that work in parallel (though not necessarily at the same time) with parents, families and children

What is still not known: messages for policy about research

Whilst we now know quite a lot about what works (or what looks very promising), much less is known however about studies that fall into the 'what does not work' category. A cynical reading of this review might be forgiven for asking how this can be, when in this short study alone over 2,000 research papers were considered for inclusion? There are various reasons why this statement holds true, however.

One is a general problem affecting research the world over. In addition to reflecting the various practical and methodological shortcomings highlighted earlier in this section, in large part the gaps in our knowledge are due to an often-acknowledged bias towards reporting of positive outcomes in academic publications, and also in some non-academic ones. It has therefore proved difficult for the current review to provide definitive conclusions on interventions that do not succeed, and this is a gap that should be addressed. Perhaps there should be a call for information - published or not – that demonstrates 'what hasn't worked' as well as what seems to have been successful. Researchers should not be prevented from reporting negative or equivocal findings, provided it is clear that methodological inadequacies have not been wholly to blame. Policy makers and practitioners should not be deterred by results that fall short of what was hoped – rather, they should welcome the opportunities afforded by these experiences to learn how to do things better in future.

A second problem is however specific to the UK context. In large part, as a glance at the accompanying grid of individual studies will reveal, the research base derives from North American work. Over and over again, in writing this review we were struck by how little high quality research is available that specifically addresses the UK service provision scene, and how dependent our policy-makers and service planners have been on US-based research evidence of what is effective. Yet that same research often demonstrates that even within the US itself, impact does not always transfer from one social or cultural group to another. Interventions that show promise when delivered to Caucasian samples often disappoint in relation to other groups in the ethnically diverse population of the United States. How then can we have confidence that interventions shown to work or to be promising in the US will also be successful in the very different social and cultural conditions of the UK? Simply, the answer is we cannot. For this reason it is imperative that interventions imported from other countries and adapted for use in the UK are subject to rigorous home-grown monitoring and evaluation, using the most scientifically robust methods available. Though over the next few years major scientific studies such as the national evaluation of Sure Start will begin to build a firmer foundation for a home-grown evidence base, it is important that policy makers do not take for granted that interventions that work in other countries will necessarily work in the UK. Some will, and some will not. Rolling out major national initiatives prior to

home-generated evidence of effectiveness at a local level becoming available will always run the risk of misapplication of resources. Some may think this worth the risk - but it is a risk that should be honestly acknowledged.

With this in mind, what kinds of research methods should be supported and encouraged in the UK to help take the field forward? First, it is impossible to discuss this question without running up against what is fast becoming an old chestnut for debate: to randomise or not to randomise? Whenever researchers call for greater commitment to properly controlled evaluation studies using randomised controlled trials (RCTs), they are met with accusations of naivety, positivism and the like. Many practitioners, policy observers and even some researchers claim that RCTs are largely inappropriate to the UK service context: that they are too difficult to set up and maintain; that they are ethically questionable because they require denying a service to people who would otherwise qualify; that they consume disproportionate amounts of resource relative to the costs of actually providing the service; that most UK services work with small numbers of users and that only qualitative or semi-quantitative methods are feasible in this situation and so on. This is not the place for an in-depth discussion of the complex issues involved here, though there is a growing body of writing and debate on this subject for those who are interested (see e.g. Ghate, 2001; Little and Mount, 1999; Chaffin, 2004; Macdonald and Winkley, 1999; Pawson and Tilley, 1997); it would be negligent of us not to say what seems to us the unmistakeable implication of this work: it is vital that policy makers who fund service development (and evaluation) in the UK consider how far they are prepared to support and invest further in initiatives that *have not been adequately proven to be effective*. Without research that at least incorporates a robust comparative element where those receiving a service are evaluated against those who have not received the same or a similar service, all service investment is leap of faith. Services have also to be enabled to understand why research and evaluation is a vital compliment to their own work, and (more saliently, perhaps, since most practitioners are now persuaded of the value of research) given adequate resources by their funding bodies to engage in the extra work that participating in evaluation and assisting researchers always requires.

Second, in this review we have made a strong case for supporting a range of research approaches, both quantitative and qualitative. In our view, the literature demonstrates that research designs that offer only one type of approach should always be questioned, since generally both types of approach are required to illuminate both impact and implementation issues. However, in addition there is the issue of quality in research, and what 'counts' as evidence. Although (as we stated in the Introduction to this review) there are many types of evidence, not all types are created equal when it comes to determining, from a scientific viewpoint, what works and what does not. Practice wisdom, self-evaluation, user-led action research: all of these are invaluable tools for services wanting to critique and develop

their own work. However, in order to produce scientifically validated evidence of effectiveness that generalises beyond the small scale, local context to the larger scale and national context, investment in robust research led by professionals trained in the application of validated research methods to real life interventions is undoubtedly required. From a policy perspective, this means investing in research infrastructure and capacity-building in general as well as investing in specific research projects; it means ensuring that research commissioning bodies are themselves trained to evaluate the quality of research design and execution; and it means ensuring that research reports are fully peer-reviewed and any useful learning (not just in relation to findings but also in relation to methods) is disseminated to the widest possible audience.

Third, there are some specific messages for policy in relation to research that emerge from a comprehensive review of the literature. One of these is that though it would be helpful to the development of practice to understand a little more fully the potential additive impact of multi-component interventions (or multiple services offered to the same family), it may not be worth expending large amounts of research resource on trying to disentangle the specific effects of different combinations of intervention. Many of the more complex briefs to researchers state this as a research objective, but few if any studies have been able to provide real insights here. Given that it may well be that it is the very nature of multi-component initiatives that makes them so promising, it is questionable whether it is presently worth the considerable resources required to disentangle this complex question. There are, after all, many more basic questions that remain unanswered and should perhaps be dealt with first (see the box below). Thus whilst understanding *which combinations* of multi-mode interventions are most promising seems a worthwhile exercise, trying to understand *which elements of which combinations* are most promising may be a step too far, given the current state of evaluation science. Another specific point that stuck us forcefully in reviewing both the published and the grey evaluation literature is how relatively unsuccessful are research designs that depend to any great degree on practitioners themselves generating and collecting data for the research. There is now a wealth of writing that attests to the fact that this is rarely feasible: most service workers tend to be too busy, or to have too many competing higher priorities that rank above research to do this well. The result of relying on service workers to provide or collect data on behalf of researchers tends to be patchy, partial data sets that contain vast amounts of missing data or data that are of questionable validity. Though this type of design tends to be the inevitable result of limited budgets and rapid timescales for research, the evidence shows that it is far more cost-effective to leave data collection to trained researchers, and let the service workers get on with doing what they do best: delivering services.

This is not to say that no national service development should take place until research tells us is safe to do so, or until we have the resources to implement gold-

standard research designs across the board; patently this would be a foolish position and one that would impede creative development of new ideas and approaches in service provision. What we can say however is that in relation to research generally, there is still plenty of work to do, and this needs to continue alongside and as an integral part of future service development.   In the box overleaf we summarise what is still not known in relation to specific aspects of parenting support.

Summary of key messages for policy about what is still 'not known' from the existing research base

- How effective (as opposed to merely 'promising') UK parenting interventions are, which cannot be determined without more robustly scientific research methods than are currently the norm
- The extent to which interventions developed and shown to be effective in other countries such as the US can 'translate' to the very different UK context
- What 'doesn't work' (because of the bias against reporting negative or equivocal research findings)
- The specific characteristics of participants and programmes that contribute to success for programmes that show promise or are effective - i.e. not just 'what works', but 'for whom under what circumstances'
- Whether positive changes in parenting behaviours and child behaviours associated with parent support interventions can be sustained over the long term
- How changes in parents' knowledge and attitudes can be translated into changes at the behavioural level
- How to retain and engage families in 'high risk' groups in parenting support interventions more successfully, and how to ensure better outcomes for them more consistently
- What aspects of resilience and which protective factors in parenting moderate the outcomes of parenting support for both parents and children
- What aspects of parenting support interventions are most effective when working with fathers and how programmes may need to be better designed to meet their needs
- What aspects of parenting support interventions are most effective with black and Asian parents and how programmes may need to be better designed to meet their needs
- How children themselves perceive the effectiveness of parenting support programmes
- The optimal duration for different types of interventions to achieve the best outcomes
- The characteristics of home visiting that contribute to its success, i.e. training levels of staff, frequency and duration of visits, and content of the session
- Whether and to what extent parenting support interventions in the UK are cost-effective
- The relative efficacy of group versus one-to-one intervention in the medium to longer term

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Other messages for policy in relation to research:
- There is a need to commission more rigorous and robust research designs that can really tell us 'what works', including randomised controlled trials ('RCTs') wherever possible, and certainly more comparative and quasi-experimental designs. More qualitative research of better quality is also needed
- There is a need to build capacity in this field, including funding 'developmental' studies that advance methodologies in this field
- Continued commitment to wide dissemination of research findings is essential, but not only of 'good' results that suggest effective practice. Negative and inconclusive results may also contain important learning. Commissioning a review of 'what doesn't work' in a number of areas might be enlightening.
- Especially but not only at the local level, there is a need for commissioners of research to be better trained in research methods so that they are able to assess and promote good design and execution in evaluation research

Parenting support in policy context: messages for overarching policy

It is clear that parenting is an emotional and private area of functioning for most people, and policy should tread lightly here if it seeks to help. The debate about the appropriate boundaries beyond which the state should or should not intervene in family life is at the time of writing an extremely 'live' one in the UK, characterised nowhere more starkly than in the public outcry at 'failures' by the systems of the state to save vulnerable children from their dangerous carers (as for example, after the murder of eight year old Victoria Climbié in early 2000, contrasted by further outcry at the possibility that the state might legislate to restrict parents' 'right to smack' (media coverage of the proposed amendment to the Children Bill July 2004). Sometimes it seems that the state is damned if it does, damned if it doesn't.

However, the strong policy message from the literature shows that most parents welcome support, and stressed parents especially welcome it. Although even the best designed services typically experience some level of drop-out and show that some proportion of the sample do not benefit, this should not discourage the provision of services for the remainder of families, who can and do benefit. Some element of 'failure' is simply a fact of life in the provision of any service, which can never be all things to all people, and which is often struggling against the effects of years of chronic background problems. In 1985, Dumas and Albin commented:

Many families characterized by severe adverse social and material conditions may be unable to benefit from (parenting services), regardless of the extent to which they participate in treatment.

Though nearly twenty years of practice learning have elapsed since they reached this conclusion, the same is probably still true, but perhaps of a diminishing group. The evidence increasingly suggests that though some families cannot and will not be helped by social interventions, there are still many families in the community who could benefit from parenting support in various forms, and as the quote above suggests, tackling wider issues of social disadvantage may be the key to putting more parents into this position. In addition, the apparent lack of impact of a particular intervention on some of the families who use it should not necessarily be taken as a sign that the intervention itself is a failure: no intervention should be expected to work one hundred percent of the time, and the literature shows that even the best-designed and carefully (and expensively) delivered interventions have surprisingly high 'failure' rates when figures are examined closely. This is a fact of life in this most complex area of social intervention, and policy makers (and perhaps the media, too) need to made be aware that important learning can result from the close examination of 'failures'. Practitioners should not be discouraged from honest reflection on strengths and weaknesses because they fear the closure of a service due to failure to reach arbitrary targets for 'success', or because they fear vilification by the media seeking someone of some organisation to blame. Sadly, it is apparent from the sometimes fearful response by both practitioners and funders to making public any negative or even somewhat ambivalent research findings in this field that this is a very real fear for many. It is to the detriment to the whole field when this occurs.

It is also clear from the international literature that as well as intervening in a 'micro' way, at a macro level there is still much that can be done at a public policy level to change the social context in which parenting support service are provided. The link between public policy, the individual responsibilities of parents, and the ultimate outcomes for children is expressed by Garbarino et al (2002) as follows:

…the state plays an important role in setting the parameters for parental responsibility, and in many ways determines the realms in which variation in parenting skill affects child development.

We take this to mean that the state has a dual role: it both legislates for the aspects of child care in which parents bear sole responsibility for child nurturance and socialisation, but at the same time can influence (though not entirely determine) the extent to which parents with varying social and personal circumstances can offer an equally good home environment to their children. Implicit in this is the notion that inequalities for children and their families can be externally reduced where

government takes responsibility for regulation of some of the 'variation' to which families are subject: in quality of environment and housing; in quality of local services; in access to education, training and employment, and so on. When the state takes an active role in reducing social inequalities, outcomes for children are less likely to depend on family and individual level variables such as parental social class, educational level and personal history, with the result that risks to children may be reduced.

Opportunities for policy makers to support parents and to influence outcomes for children come in many shapes and forms. They are delivered not only through the funding of programmes that directly engage parents, but also through the introduction of policies that influence the context of parenting and ultimately affect outcomes for children; for example by reducing unemployment and poverty, or improving housing. Within an 'ecological framework', as described in the introduction of this report, intervention can be targeted at all levels of the system from the micro to the macro level (Bronfenbrenner, 1979; Garbarino et al, 2002). The focus of the present review has been very much at the level of the micro system, specifically on interventions with individual parents. However, as the ecological perspective helps us to understand, parents and children exist within several interconnected and interdependent systems including family, community, economy, culture and ideology, all of which provide potential avenues for intervention. The recent thrust of central policy has been to a large extent in tune with this perspective: in the past few years the British government has been tremendously active in putting in place many important and potentially far-reaching policy initiatives (and the money to drive them) that reflect an implicit understanding of the multiple and complex pathways to good child outcomes (see for example the *Child Poverty Review*; HM Treasury July 2004). Thus, we have multifaceted initiatives aimed at reducing child poverty (New Deal for Lone Parents; various tax credits and other fiscal policies), increasing readiness for learning and good child health outcomes (Sure Start), reducing crime and antisocial behaviour amongst young people (Youth Inclusion Programmes), bolstering risk and protective factors against antisocial behaviour (On Track), improving the school environment (Excellence in Cities; Behaviour Improvement Programme; Safer Schools Partnership Programme), general child and family well-being (Children's Fund), and so on. Given the interdependence and interconnectedness of the different the systems within which families live, it seems perhaps to be stating the obvious that policy and practice need to work together to deliver a *consistent message*. This is not an easy task: there are inherent tensions in the relationship between state intervention in family life whilst upholding parents' rights to autonomy and self-determination and children's right to protection; in balancing the need to parcel out limited resources in the most effective and equitable way, including balancing the need for universal access to services for all whilst ensuring that the most needy get the most intensive kinds of help; in allowing local determination in the way that resources are deployed whilst

exercising central control over quality of delivery; and in balancing the need to reduce family poverty through access to employment without damaging families' ability to care for children in their earliest and most important years.

Given the challenges, it is probably unrealistic to expect any government to be able to develop an approach that is consistent in all respects. In general, however, the Green Papers *Supporting Families* and *Every Child Matters* have tried to give attention to balancing these tensions, and have given serious thought to consistency through the delivery of services that join up to provide what is sometimes referred to as a 'continuum of care'. They have placed a strong emphasis on providing every possible support to parents through new structures such as Children's Centres and Extended Schools, and by encouraging the development of voluntary sector initiatives to extend support such as the Parenting Fund. At the same time, recognising that the system has also to act as back-stop, recent initiatives have tried to find ways to increase the effectiveness of system responses through mechanisms such as Information sharing and Assessment (ISA; the sharing of data between all agencies involved with children). Though the means to make this work in practice and the ability to navigate the genuine data protection concerns that this raises still need to be resolved, these initiatives do seem complimentary to one another and therefore look promising.

Yet at the end of this pathway, where community-based support and voluntary methods do not resolve problems, these initiatives give way to more draconian elements of state intervention in family life, as exemplified in the measures introduced via the Crime and Disorder Act 1998, and recently strengthened and extended in the White Paper on Antisocial Behaviour[25]. Here, consistent policy has to navigate more difficult waters, and policy at the centre and practice on the ground sometimes seem to pulling in opposing directions. For example, the strong statements made by central government about 'reinforcing parental responsibilities', enforced by measures delivered through the criminal justice system such as Parenting Orders often sit uneasily with the supportive ethos of services on the ground. Although there is evidence that the support services offered in connection with youth justice system involvement in family life can be beneficial to families (see for example Ghate and Ramella 2002), there is no evidence that the small 'hard core' of parents who refuse this support and who then incur criminal sanctions as a result (fines, imprisonment) come out of these experiences 'better' parents, or that their children have better outcomes. Other examples include the removal of convicted parents with dependent children to custody, without due consideration of the very real risks to children of growing up with disrupted care patterns and absent parents. It is also contradictory to spend large amounts of public money providing skills-training for parents to develop authoritative but non-punitive parenting practices,

[25] *Respect and Responsibility – taking a stand against antisocial behaviour.* Home Office 2003

whilst at the same time upholding the right of parents to hit their children, especially when it is known that harsh parenting practices including over-reliance on physical punishment are linked to a number of adverse outcomes for children. Similarly, messages from central policy sources for some years have been indicating strong support for increased involvement of fathers in child care, and for the first time funding has been available for the national and local development of services that promote this. This is certainly to be welcomed, but it is questionable, for example, how much progress family support services can be expected to make in engaging fathers more centrally in childcare when British fathers work the longest hours of any parents in Europe (Burghes, Clarke, and Cronin, 1997). The challenge for policy makers therefore is not only to establish what works at the level of individual parenting programmes and interventions, but to provide an overarching policy context which is consistent with parenting support across the entire 'ecology' of parenting. That is, a policy approach that addresses in a consistent way the multiple risks that adversely influence parenting, and at the same time enhances the opportunities that promote resilience. Henricson (2003) stated in a recent review of tensions in parenting policy: " *The Government's record shows a serious commitment to supporting families….(but) a regular, in-depth policy review could establish some broad principles and reconcile some of the disparate strands of policy*". Our review certainly supports this conclusion.

Put succinctly, the overall policy message from this review is that in addition to beginning to have a much clearer (if still partial) picture of 'what works' at the micro level in parenting support programmes, we also know that outcomes for children will be enhanced if macro policy effectively addresses social inequalities in the broader context of parents' lives. To the extent that current policy does seem to recognise this, we are on broadly the right track. What remains now is to put sufficient resources behind the new thrust of policy to make it work on the ground, and to begin to address the remaining inconsistencies that both research and practice clearly flag up.

Lastly, it is apparent from the review that despite the sometimes difficult task of gaining an overview of such a varied area, and despite the gaps that we have identified, the field of parenting support has come on in leaps and bound in the last few years. There is a great deal of activity going on, and many examples of successful and promising practice. What we now need to do is to build on what we already know, and refine our understanding of the detail underneath the big picture. While in some areas of parenting support we are still at a stage of asking 'what works?', in many areas we are now in a position to ask 'what works for whom?' and 'why?'.

Summary of key messages for national policy from the evaluation literature

- Parenting support benefits families, and this review has clearly shown the potential benefits that may be realised through continuing investment in this type of social intervention
- Many parents need support at some point in their parenting career and efforts to 'normalise' access to support as a universal right seem likely to generate strong benefits. The message that it is not unusual to need support from time to time needs to be conveyed in policy rhetoric, to help increase rates of access, especially at critical points for early intervention
- There needs to be a consistent message about supporting parents delivered across the board, reflecting the wider ecological context of parenting, from the provision of individual programmes to the implementation of national policies. The broad thrust of current policy in the UK appears to be in tune with this, but the impact of new policy initiatives needs to be monitored constantly to ensure that policy in one area does not inadvertently pull against policy in another.
- Across the board, in order to better support parents, policy needs to embody an evidence-based model of parenting linked to good outcomes for children, (e.g. encouraging authoritative, non-punitive parenting rather than harsh parenting; promoting and enabling fathers' involvement in childcare)
- Results show time and time again that it is difficult for stressed families to benefit from parenting programmes when they face multiple disadvantages, thus policies that reduce the everyday stresses in the lives of families (including poverty, unemployment, poor health, housing and education) will support parents in caring for their children
- We need to recognise that there will always be a minority of parents who cannot or will not benefit from parenting support services. This does not mean a service is 'all bad', or that anyone is necessarily to blame. The media should be helped to understand this.
- It is questionable whether punishing those who fail to benefit from parenting support with draconian sanctions is consistent with promoting better outcomes for their children.
- It will be vital for the future of this field that government invests in building capacity and skills in the social care workforce and related professions that provide parenting support. Supporting families without compromising their autonomy is a demanding and delicate job, and highly skilled and appropriately trained staff will get better results

Glossary of key terms used in the review

Early intervention
Services that are aimed at families where early signs of problems may be visible at a low level, provided with the intention of nipping difficulties in the bud and preventing their evolution into bigger problems

Effect/Effect size
The effect size indicates the underlying strength of the relationship between the independent variable i.e. the factor that researcher is systematically varying (e.g. parenting skills training), and the dependent variable i.e. the factor that the researcher is expecting changes in (e.g. child behaviour). While significance focuses on the *probability* of the relationship between the variables occurring by chance, effect size focuses on the *magnitude of the effect* of one variable on another. It therefore provides an estimate of the extent of effect of an independent variable on a dependent variable.

Group work
Services that are delivered to groups of parents at the same time, either in a classroom style setting or more often in a workshop or informal discussion-based format

Individual work (also called one-to-one work)
Services that involve a worker (professional or voluntary) and a single individual recipient

Intensity and duration of interventions (corresponds to the medical concept of 'dosage')

Low/short   six weeks or less, in sessional format (one off or regular)

Medium   six to twelve weeks, in regular sessional format

High/long   twelve to twenty six weeks, in regular sessional format

Intensive   over twenty six weeks; or continuous for some sustained period
                   (e.g. 'wraparound' and residential services)

Manualised intervention
The intervention has a written manual or protocol describing the objectives of the intervention, the 'theory of change' that underlies the intervention, what precisely should be delivered in terms of content (ie, a curriculum), and giving guidance to the practitioner about how to structure and lead sessions.

It will also be noticed that some parenting support interventions have names and are described as recognisable 'programmes' or 'brands' of intervention (e.g. 'Multi-Systemic Therapy- MST'; 'Webster-Stratton'), whereas others are described in more general terms. As we compiled this review, it struck us with some force that there was no centrally accessible, up to date list of common parenting support programmes, and as a result, we have put together in an Appendix to this report (Appendix 1) a list of 'programme profiles' for those that have names and clear protocols. Some of these are now very well-known; others less so.

Non-experimental
Unlike experimental designs, non-experimental designs do not provide evidence of causality, although some non-experimental designs may be strongly suggestive of causal effects. Non-experimental approaches such as correlational designs, for example, can show associations between two variables that may imply a causal relationship. However, whereas experimental designs are able to demonstrate that systematically changes one variable (e.g. parenting skills) leads to change in another variable (e.g. child behaviour), the same cannot be concluded from non-experimental studies.

Paraprofessional
Often used in the US literature to denote workers who have a basic level of training in a given area, but who are not highly qualified

Peer worker (or peer supporter)
Used to describe parents who are involved in delivering an intervention (paid or unpaid),often offering informal befriending and support on the basis that they share the same social circumstances and have had similar experiences

Primary prevention
Services that are aimed at addressing a need that may not yet have become apparent, or at preventing a problem from developing in the first place

Professional
A worker with specialised training and qualifications in a particular area.

Quasi-experimental
Quasi-experiments do not use random assignment of participants to treatment and control groups, but do involve an experimental approach in which the effect of one variable on another is assessed. However, lack of randomisation of participants means that inferences about the causal relationship between factors are more ambiguous. Quasi-experimental designs vary in terms of the number of experimental groups involved and the number of points at which participants are assessed. They include: a one group posttest only design, a one group pretest-

posttest design, a non-randomised post-test only design, and non-randomised groups pretest-posttest design.

Randomised studies (*also known as random allocation; randomised controlled trials; RCT*)
Randomised studies are experimental studies characterised by the random assignment of participants to experimental conditions, such as an intervention or treatment and a control group. They enable the researcher to assess casual effects by examining the effects of one factor (the 'independent' variable) on another factor or outcome (the 'dependent' variable). The randomisation of participants to treatment groups reduces the probability of the results being due to prior differences in characteristics of the groups, and increases the likelihood of the results being due to the intervention.

Secondary prevention (services for 'at risk' groups)
Services that are aimed at families who are deemed especially at risk for a particular problem – for example, services for parents who are experiencing problems with parenting that could if left unattended lead to child abuse.

Significance
A test of significance helps to determine whether results are 'genuine' or not. Typically the cut off point for deciding on the significance of a result is set at the 5%level, or one in twenty probability level, expressed as p<.05. This means that there is a 5% probability of the observed results having occurred by chance, and a 95% probability that the results indicate the presence of a 'genuine' or 'real' effect. If the significance level of a test shows that the probability is greater than 1 in 20 (i.e. p>.05), then the results are said to be non-significant. In practice this means that any difference between, for example, a group receiving an intervention and a control group, could have arisen by chance rather than resulting from the effects of the intervention.

Single mode and multi-mode interventions
Single mode interventions involve a single activity (e.g. prescribing medication for ADHD); multi-modal interventions offer combinations of activities usually aimed at complementing each other (e.g., medication <u>and</u> a programme of education about ADHD).

Targeted services
A service that is provided to only some groups or individuals on the basis of an assessment of their particular need (e.g. social work; speech therapy; services for parents of children with conduct disorders).

Tertiary prevention / Treatment
Services provided for families who have identified problems in an area of functioning and who need help to regain adequate or 'normal' levels of functioning.

Universal services
A service that is provided to everyone, irrespective of levels of need (in the UK, examples would include primary health care services (GPs, the Health Visiting service, and ante-natal classes)

Appendix I: Programme profiles

Throughout the present review and its accompanying grid, reference has been made to many different parenting programmes that vary tremendously in terms of scale, format, popularity, government backing, and effectiveness. In this section of the report we provide a more in depth description of some of the interventions that we believe to be more noteworthy than others. Programmes have been included within these 'programme profiles' on the basis that they have either been robustly evaluated and their effectiveness is fairly well established, or else they have become popular and well-known among service providers, although evidence testifying to their effectiveness may still be forthcoming. (The latter category also includes programmes that form part of large-scale national initiatives where evaluation is still in progress). In general, many programmes from the U.S. fall into the former category, while programmes from the U.K. are more characteristic of the latter. Hence we have divided programme descriptions into two parts, the first describing U.S. and other non-U.K. programmes, and the second part describing U.K. programmes.

Programme details

For each programmes listed below we have provided a detailed summary of the target population, aims, theoretical underpinnings, content/format, generalisability, outcomes measured, and evidence of effectiveness of the programme. However, this level of detail was not always available, particularly where the UK literature is concerned, either because the required information was not readily available from the various publications or websites, or because evaluations were still in progress, or else have not been rigorous enough to provide sufficient evidence of effectiveness. In such cases, we have described the programme as fully as possible under a more general heading.

In compiling this information, we considered providing contact details/wesites for programme developers and organisations delivering programmes. However, we decided against this due to the frequency with such information is updated and consequently goes out of date. Readers are advised to use internet search engines such as Google, Lycos, Webcrawler etc. to locate the most recent programme details.

Programme coverage

Non-U.K. programmes covered in part 1 are the following:

1. Adolescent Transition Programme
2. Comprehensive Child Development Programme
3. Even Start

4. Fast Track
5. Functional Family Therapy
6. Growing up Fast
7. Head Start
8. Making Parenting a Pleasure
9. Multidimensional Treatment Foster Care
10. Multisystemic Treatment
11. Parent Effectiveness Training
12. Parenting Adolescents Wisely/Parenting Wisely
13. Parenting for the Drug Free Years
14. Parents as First Teachers/Parents as Teachers
15. Parents Who Care
16. Perry Preschool Project
17. Strengthening Families Programme
18. Systematic Training for Effective Parenting
19. Triple P: Positive Parenting Programme
20. Webster-Stratton

U.K. programmes covered in part 2 are the following:

1. Family Caring Trust
2. Family Literacy programme
3. Family Nurturing Network: Family Connections
4. Home Start
5. Kirlees Paired Reading programme
6. Mellow Parenting
7. NEWPIN
8. Nuturing programme
9. Parent Advisor Service
10. Parents Altogether Lending Support
11. Parent Network: Parent-Link
12. Parent time
13. Peers Early Education Programme
14. PIPPIN
15. Sheffield Raising Early Achievement in Literacy project
16. Supporting Parents on Kids Education
17. Strengthening Families, Strengthening Communities
18. Sure Start
19. Teenagers in Trouble: Skills for Parents

Part 1: U.S. and other non-U.K. programmes

Adolescent Transition Programme (ATP)

Programme description: ATP is a multi-level, family-centered intervention delivered in middle-class school settings (Dishion & Kavanagh, 2000). The intervention is based on Bronfenbrenner's ecological theory, draws on developmental theories of antisocial behaviour, and includes three levels, universal (all parents within the school setting participate), selected (addressing the needs of 'at-risk' families), and indicated (family treatment) levels)..

The universal level of the intervention involves the creation of a 'Family Resource Room' to promote parent-school collaboration (including weekly information about homework, problem situations and resources within the school), one-hour home visits that focus on a 'plan for success' for each middle-school child in the coming year, presentation of videotape material (focusing on risk factors in parent-child interaction), and a six-week health curriculum called SHAPe (Success, Health and Peace Curriculum) which includes weekly parent-child homework exercises for promoting school success, reducing the risk of substance abuse, and decreasing conflict. The selected intervention, the 'Family Check-Up' (FCU), is a three-session intervention including an initial interview, a comprehensive, multi-agency, multi-method assessment, and a family feedback session. This level is based on motivational interviewing techniques and self-identification. Finally, the indicated intervention, the Family Management Curriculum, provides a range of direct family-centered interventions, including brief family interventions, school monitoring, parenting groups, behavioural family therapy, and case management services (Dishion & Kavanagh, 2000). The three foci of the Family Management Curriculum are using incentives to promote positive behaviour change, limit setting and monitoring, and family communication and problem-solving.

Two evaluations of ATP indicate that the programme produced reductions in parent-child conflict, decreases in child antisocial behaviour, and reductions in substance and tobacco use (Dishion & Kavanagh, 2000).

Comprehensive Child Development Programme (CCDP)

Programme description: CCDP is a comprehensive five-year intervention targeting low-income families. CCDP's core services include case management, parenting education, early childhood education, and developmental screening for children (Goodson, Layzer, St. Pierre, Bernstein & Lopez, 2000). CCDP case managers conduct bi-weekly 30-90 minute home visits to participating families to assess family needs, prepare a family service plans, counsel parents, and make referrals to services. Developmentally appropriate early childhood education is delivered bi-

weekly to parents of children between birth and age three (usually by child development specialist), and typically includes information about infant and child development and parenting skills training. Parenting education comprises supplemental classes and workshops, support groups, informational booklets and newsletters. In addition to providing core services directly to families, the CCDP projects refers families to further services and resources when needed, including for example, adult literacy education, vocational training, employment counselling, job training and placement, adult basic education, substance abuse treatment, and health care treatment.

A recent randomized controlled trial (Goodson et al., 2002) indicates that CCDP had no statistically significant effect on children's cognitive or social-emotional development.

Even Start

Programme description: Even Start is a one-year family-focused programme that was developed with the aim of integrating child and adult education (St Pierre & Swartz, 1995). The programme includes three 'core' services - early childhood education, adult literacy training and parenting education. Criteria for participating in Even Start include having one adult who is eligible for adult basic education programmes, and a child under the age of eight in each family. The early childhood education component of the intervention aims to enhance cognitive, language and social skills development and general school readiness between child ages birth to eight years; the adult education component includes services that develop parents' basic educational and literacy skills (adult basic education, secondary education, and English as a second language courses); while the parenting education is designed to enhance parental understanding of child development, child behaviour management training, increasing parents' capacity to support their children's education, and life skills. The intervention draws on existing, commercially available interventions, including STEP and Head Start. In addition to the 'core' services, Even Start also offers support services, e.g. transportation, sibling child care, counselling, and referrals for employment – these services are either provided by Even Start professionals or by collaborating services. The intervention includes professional home-visits, and parent-child activities are the vehicle for developing parental knowledge and skills.

An evaluation of Even Start reported by the US Department of Education (2003) showed that Even Start children and parents made similar gains in literacy to families in the control group (of whom around a third were also in receipt of other family services).   It has been argued that more intensity and duration of intervention are required to make significant differences to the types of disadvantaged families that took part in the scheme.

Fast Track

Target Population: Young children screened for behavioural problems, and identified as at risk for long-term, persistent antisocial behaviour.

Aims: Reducing adolescent delinquency and violence, high-risk behaviours (unsafe sexual practices, substance abuse, offending), school failure and psychopathology.

Theoretical underpinnings: Parenting practices play a crucial role in determining child behavioural adjustment - harsh, inconsistent discipline, low supervision and monitoring, low parental involvement in child activities, and escalating coercive parent-child interactions reinforce socially inappropriate and aggressive behaviour in children, and are key indicators of future antisocial behaviour (Bierman et al, 2002). Child risk factors, including neuro-psychological deficits contributing to inattention and impulsivity add to, or interact with poor family environments, increasing child risk. Additional contextual risk factors contributing to poor child behavioural outcomes include family poverty, instability, many siblings, criminal victimisation in the family, and high residential mobility. Cumulative risk exposure increases the likelihood that children enter school with immature emotional control, poor cognitive/intellectual development, are rejected by prosocial peers, and experience school failure.

Content and Format: Fast Track is a long-term, multi-site, multi-component preventative intervention, based on the developmental theories and longitudinal research surrounding early onset conduct problems. The programme addresses multiple risk factors (classroom, school, individual child and family risk factors) and includes a universal component (curriculum delivered in classrooms) and selective components (parent groups, child social skills training, parent-child sharing time, home visiting, child peer pairing and academic tutoring).

The universal component of the programme is delivered by classroom teachers, and covers four domains of skills: skills for emotional understanding and communication, friendship skills, self-control skills, and social problem-solving skills. The selective interventions were offered to 'high-risk' children and their parents, and consists of extra-curricular 'enrichment programmes', delivered by counsellors and social workers. The parent skills training focused on establishing positive family-school relationships, building parental self-control, promoting developmentally appropriate expectations for child behaviour, and improving parent-child interaction. The child social skills training includes 'friendship' groups, focused on reviewing and practicing skills in emotional understanding and communication, friendship building, self-control, and social problem-solving. In addition to the 'enrichment programmes', individual, in-home support, child 'peer-

pairing' (both of the latter designed to assist parents and children in generalising or consolidating their acquired skills to other settings), and child academic tutoring (primarily promoting reading skills) were provided by paraprofessionals.

Generalisability/Applicability of the programme: Fast Track has successfully targeted U.S. parents and children from different ethnic backgrounds (European American, African American, Hispanic etc.), family structures, and geographical origins.

Measured outcomes: Child social cognition and reading, child peer relations and social competence, parenting behaviour, child aggressive and disruptive behaviour.

Effectiveness: Two recent evaluations of Fast Track (both randomised controlled trials) (Conduct Problems Prevention Research Group, 1999, 2002), suggest high effectiveness. Parents in the intervention group decreased their reported use of physical punishment, displayed more warmth and positive involvement, more appropriate and consistent discipline, and reported increases in parental satisfaction. Furthermore, these changes were maintained over time (Conduct Problems Prevention Research Group, 2002). In addition, positive changes in almost all the targeted areas of skills-acquisition for children were found one year post-intervention, including increases in emotional and social coping skills, reading skills, peer relations, and school grades. The results of a later evaluation provide evidence that the intervention also contributed directly to a reduction in conduct problems in high-risk children.

Functional Family Therapy (FFT)

Target Populations: Families with children/young people displaying antisocial, delinquent and/or criminal behaviour.

Aims: FFT primarily aims to reduce defensive communication patterns, increase supportive interactions, and promote supervision and effective discipline in families with delinquent children/adolescents (Brosnan & Carr, 2000).

Theoretical underpinnings: FFT is based on systems approaches which recognise the importance of environmental contexts or systems in determining behaviour (Haas, Alexander & Mas, 1988). In addition, FFT draws on behaviourism, particularly the social learning variant of the behavioural model, which emphasises concepts such as reciprocity, coercion and the 'functionality' of positive and negative behaviours (Haas et al., 1988).

Content and Format: FFT is a brief multisystemic family intervention typically consisting of twelve one- to two-hour sessions (although 26-30 hours are offered to

particularly problematic families) extending over a three month period (Mihalic, Irwin, Elliott, Fagan and Hansen, 2000). FFT was originally divided into four treatment phases, including acquaintance-impression, assessment, induction-therapy, treatment-education, and generalisation-termination (Haas et al., 1988), but has recently been reduced to include the following components:

Phase 1: Engagement and motivation. This phase focuses on facilitating reattribution, using techniques to alter maladaptive attitudes, perceptions, beliefs and emotions. Participating families are taught to respect individual differences and values, encouraged to develop a trusting relationship with the therapist, to reduce resistance and negativity, and raise their expectations for change (Mihalic et al., 2000).

Phase 2: Behaviour change. The second phase of treatment involves developing and implementing culturally appropriate, context sensitive intermediate and long-term behaviour change plans which are tailored to the individual characteristics and needs of each family member. The therapist's role is to facilitate behaviour change and address skill deficits through the delivery of communication skills training, problem-solving skills training, contingency management and contracting, limit-setting and reinforcement training (Haas et al., 1988; Gordon, Graves & Arbuthnot, 1995).

Phase 3: Generalisation. FFT clinicians help families apply the techniques and skills they have acquired in a range of settings and situations, and encourage the maintenance of changes by linking participants with community resources and services (Mihalic et al., 2000).

Assessment is an ongoing, multi-faceted process that informs every phase of FFT, and involves therapists identifying adaptive and maladaptive relational or interaction patterns among family members; consequently, assessment is focused on family functioning rather than clinical diagnosis (Gordon et al., 1995).

Generalisability/Applicability of the programme: FFT has been successfully implemented internationally and cross-culturally, in urban and rural settings, and in a range of treatment systems (including clinics, home-based programmes, juvenile courts and independent providers) (Mihalic et al. 2000).

Measured outcomes: Delinquent and criminal behaviour (recidivism); foster care placement.

Effectiveness: FFT has demonstrated its effectiveness in reducing recidivism (including serious and adult criminality) and foster care utilisation in a number of methodologically rigorous studies (e.g. Barton, Alexander, Waldron, Turner & Warburton, 1985; Gordon et al., 1995). In addition, there is evidence of FFT's long-

term effectiveness, and positive post-intervention outcomes when delivered by paraprofessionals (Barton et al., 1985; Gordon et al., 1995).

Growing Up Fast

Programme description: Growing Up Fast is a two-session primary prevention programme including both didactic and experiential components, aimed at the families of adolescents (aged 11 – 19 years). The intervention focuses on enhancing and maintaining family strengths and capabilities, on setting goals which facilitate adolescents' development and progression towards adulthood, and on showing acceptance of this process (Henricson & Roker, 2000).

Growing Up Fast seeks to achieve five goals: supporting and assisting families in developing their own idiosyncratic definition of what it means to become a successful adult; to identify what the adolescent is already doing to support/enhance this definition; identify the activities the adolescent can engage in to further support the definition; recognise the role played by parents in supporting the adolescent's ability to achieve this definition; and to develop a plan to support and assist all family members in realising their definition of successful adulthood (Gavazzi, 1995). The five core goals of the intervention are negotiated in the first session, while the second session was developed to assist families in expanding and extending their definitions of successful adulthood, and includes specific family skills-building exercises (Gavazzi & Law, 1997). The programme differs from many other interventions in its solution-focused perspective, emphasis on rites of passage, and its attention to cultural issues (Gavazzi, 1995; Henricson & Roker, 2000).

Growing Up Fast has been delivered since 1991, and until recently, was only offered at Ohio State University, although efforts have been made to move the programme off-campus and into the community. Documented evaluation efforts have been limited to qualitative data on participant satisfaction (Gavazzi, 1995), case studies (Gavazzi & Law, 1997), descriptive data on outcome measures, including initial outcomes (goal articulation and goal-supporting activities), intermediate outcomes (problem-solving/decision-making skills, resource utilisation and unpleasant family events), and longer-term outcomes (e.g. recidivism) (Gavazzi, Wasserman, Partridge & Sheridan, 2000).

Head Start

Target Population: Low-income families with children aged 3 to 5 years (Head Start); low-income families with children aged 2 to 3 years (Early Head Start).

Aims: The Head Start programme was developed in 1965 to promote school readiness, and focuses specifically on cognitive and social skills development (Department of Health and Human Services, 2002).

Content and Format: Head Start is a comprehensive early childhood development (preschool) programme designed to provide education, health and social services to low-income children and their families.

Generalisability/Applicability of the programme: Head Start has been widely implemented in the U.S.

Measured outcomes: Indicators of school achievement and competency, including letter recognition, writing, vocabulary, mathematics (Head Start); language development, social and emotional development (e.g. attentiveness, aggressiveness), parenting (e.g. parental supportiveness, disciplinary strategies), parental self-sufficiency, subsequent births, fathering and father-child interactions, and parental mental health (Early Head Start).

Effectiveness: Evidence suggests that although children participating in Head Start do improve on key indicators of school success (e.g. vocabulary, letter recognition, writing and mathematics), their scores remain below the national average (Department of Health and Human Services, 2002). However, a recent evaluation of Early Head Start reports modest, but significant post-intervention improvements in child language development, child social and emotional development (e.g. attentiveness, aggressiveness), parenting practices (e.g. parental supportiveness, disciplinary strategies), parental self-sufficiency, mothers' subsequent births, and fathering and father-child interactions (Love et al, 2002). Interestingly, Head Start has also been found to reduce a gender gap in mathematics, and an income gap in reading and mathematics (Booth-Kreisman, 2003). (Note: Evaluations of Head Start have not been entered into the 'grids' because studies typically lack sufficient project-level detail and indicators of effectiveness.)

Making Parenting A Pleasure (MPAP)

MPAP is a group-based parenting programme developed by the 'Birth to Three' Programme in Oregon and the University of Utah. The programme is delivered by the Department of Health in Washington to support parents of young children, and aims to prevent child abuse by educating parents about child development and facilitating more effective parental stress and anger management techniques. This six week curriculum is divided into thirteen modules that include parental self-care, understanding and managing stress, anger management strategies, verbal and non-verbal communication skills, child development information provision, child behaviour management and effective disciplinary techniques. Participants either

attend on a voluntary or statutory basis (court order) (Washing State Department of Health, 2001).

Multidimensional Treatment Foster Care (MTFC)

Target Populations: Foster carers and chronic, serious juvenile delinquents/offenders (male and female), abused/neglected pre-school-aged children, adolescents displaying inappropriate sexual, aggressive and/or antisocial behaviour, children and young people with borderline intellectual functioning, and mental health problems (aged 12 to 18 years).

Aims: The primary aims of MTFC are to provide youth who have serious or chronic behavioural problems with delinquency with close supervision, fair and consistent limits, predictable consequences for rule violation, a supportive relationship with at least one adult, and limited access to, and contact with deviant peers. MTFC programme goals are outlined as follows:

- Provide the youth with close supervision
- Closely monitor peer associations
- Reinforce normative and prosocial behaviours
- Specify clear and consistent limits and follow through on rule violations with non-violent consequences
- Encourage youth to develop positive work habits and academic skills
- Support family members to increase the effectiveness of their parenting skills
- Decrease conflict between family members
- Teach youth new skills for forming relationships with positive peers and for bonding with adult mentors and role models (Fisher & Chamberlain, 2000).

Theoretical underpinnings: MTFC is based on social learning principles, and is an expansion of earlier behavioural family therapy and parent training intervention approaches developed by the Oregon Social Learning Centre (Moore et al, 2001). Interventions utilising social learning principles are based on the assumption that deviant behaviours are learnt via modeling, and maintained by positive reinforcement operating in multiple settings or systems, including families, peer systems, schools and communities (Chamberlain, 2003).

Content and Format: MTFC was developed as a cost-effective, family-based alternative to group or residential treatment, incarceration and hospitalisation for adolescents who display chronic antisocial behaviour or psychological disturbances. Group care settings have been identified as a significant risk factor for continued aggressive and delinquent behaviour because they facilitate frequent association with deviant or delinquent peers, increasing the likelihood of social identification among group members (Fisher & Chamberlain, 2000; Mihalic et al, 2000).

MTFC recruits, trains and supervises foster families to provide MTFC-placed children/adolescents with a detailed, structured, and individualised programme aimed at reducing antisocial or deviant behaviour and increasing prosocial behaviour (Chamberlain, 2003). Once MTFC foster parents have been screened and recruited for participation in the intervention, they receive twenty to thirty hours of pre-service training, which includes a step-by-step approach to analysing behaviour, demonstrating procedures for implementing the individualised daily programme for the participating youth (e.g. positive and negative reinforcement strategies), communication and problem-solving skills, training on developmental issues, and methods of working with the youth's biological/guardian family (Fisher & Chamberlain, 2000; Moore et al., 2001).

The MTFC programme is based on a detailed plan for activities, behavioural expectations and rewards for the child or young person. MTFC involves the use of a three-level point system which provides the child/adolescent with structured feedback on his/her behaviour - points are gained for appropriate/prosocial behaviour; and points are lost for rule violations. Level 1 includes constant foster parent supervision, and lasts for approximately 3 weeks or until the youth earns 2 100 points, at which point the youth is eligible for advancing to level 2. Level 2 includes limited unsupervised free time in the community, and privileges are expanded and offered on a weekly rather than daily basis. On level 3, privileges are expanded further, and the youth follows a less structured programme, allowing for some unsupervised peer contact and activities (Fisher & Chamberlain, 2000; Mihalic et al., 2000; Chamberlain, 2003).

Staff members delivering the intervention include foster parents (the primary programme deliverers), behaviour support specialists (youth problem-solving, social skills training), youth therapists (advocate for the youth), family therapists, consulting psychiatrists (monitoring youth medication regimes), Parent Daily Report callers (telephonic interview/progress report), and case managers (clinical team supervisors) (Fisher & Chamberlain, 2000). Ongoing consultation, supervision and support are provided to foster families and youths to monitor progress and identify and discuss problems. Family therapy is provided to the youths' biological or adoptive families, as well as basic MTFC training to facilitate the youths' successful return home post-intervention. The MTFC case manager maintains frequent contact with parole/probation officers, teachers, work supervisors and other involved adults to monitor participating children/adolescents' activities and progress outside the foster placement (Chamberlain, 2003; Mihalic et al., 2000).

Generalisability/Applicability of the programme: MTFC has been successfully used with a number of hard-to-reach populations, including children and young people with histories of abuse and/or neglect, inappropriate sexual and aggressive

behaviour, antisocial behaviour and delinquency, juvenile offending, mental health problems, and youths with borderline intellectual functioning (Fisher & Chamberlain, 2000; Moore et al., 2001).

Measured outcomes: Re-arrest rates, institutionalisation, criminal/delinquent behaviour, drug use, unprotected sex, family relationships/functioning, emotional regulation, developmental delays.

Effectiveness: According to Fisher & Chamberlain (2000), five evaluations of MTFC, two of which have been randomised clinical trials, have demonstrated the effectiveness of the programme. MTFC has produced reductions in youths' delinquent and criminal behaviour, decreases in re-arrest rates, increases in youths' return home to live with parents/relatives, and enhanced emotional regulation (Chamberlain & Reid, 1998; Fisher & Chamberlain, 2000; Moore et al., 2001).

Multisystemic Treatment (MST)

Target Populations: Families with children and adolescents displaying antisocial behaviour (including severe/extreme antisocial behaviour); those at risk of out-of-home placement (residential care, psychiatric placement, correctional facility).

Aims: Improving family functioning (parenting style, family relationships) and reducing child antisocial behaviour.

Theoretical underpinnings: MST is based on a vast literature demonstrating that antisocial behaviour is multi-determined (Henggeler et al, 1998). General systems theory and Bronfenbrenner's theory of social ecology provide a theoretical basis for understanding the multiple, simultaneously occurring, interrelated, reciprocal and mutually influencing causes of antisocial behaviour (Henggeler et al., 1998). The systems theory focuses family systems, shifting the emphasis of treatments away from the individual child or parent's problems or pathologies, towards recognising the role of reciprocal contextual and interpersonal influences in developing and maintaining negative or destructive behavioural patterns. The theory of social ecology expands upon this idea by recognising how development is determined by reciprocal exchanges between the individual and the multitude of systems in which the s/he is embedded – including a range of settings such as home, school/work, neighbourhood, etc. Individual development is understood as the result of increasingly complex reciprocal exchanges (which can be direct or indirect) between the individual and the 'layers' of his/her environment (Henggeler et al., 1998). In addition, MST also draws on aspects of behavioural parent training and cognitive behavioural therapy (Borduin et al, 2000).

Content and Format: MST is a comprehensive, flexible, and individualised family intervention for treating clinically significant antisocial behaviour in children and young people (those who are likely to have been given a psychiatric diagnosis of conduct disorder or oppositional defiant disorder; or labelled 'delinquent' by the juvenile justice system). MST is based on nine treatment principles, which are implemented according to the unique needs and circumstances of each family system:

a) The use of assessment (or hypothesis building and testing) to understand the 'fit' between the identified problems (e.g. child aggression, truancy, offending) and their broader systemic context (e.g. maternal substance misuse, marital discord, poor parental monitoring, lax discipline, poor home-school bond).

b) Therapists emphasise the positive, and use family strengths as levers for change.

c) Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.

d) Interventions are present-focused (focused on present contingencies for negative behaviour) and action-oriented (promoting positive and observable changes in family functioning), targeting specific and well-defined problems, and setting clear and well-defined treatment goals (including overarching and intermediate goals).

e) Interventions target sequences of behaviour within or between multiple systems that maintain the key problems.

f) Interventions are developmentally appropriate and fit the developmental needs of the youth.

g) Interventions require daily or weekly effort/input by family members.

h) Intervention effectiveness is evaluated continuously from multiple perspectives, and providers assume accountability for overcoming barriers to successful outcomes.

i) Interventions are designed to promote the generalisation of treatment outcomes, and foster long-term maintenance of therapeutic change by empowering caregivers to recognise and address family members' needs across multiple contexts.

MST is usually delivered by a trained and supervised masters level therapists, who each have a caseload of between four to eight families. MST is typically delivered at the homes of participating families, however, the setting may vary according to the individual needs of the family. The therapist is available to the family twenty-four hours a day, seven days a week, however, treatment gradually decreases towards the end of a 3 to 5-month course of MST. The primary task of the therapist is to provide mental health services, promote access to other services, support, guide and

empower parents to accept responsibility for affecting therapeutic change (Henggeler et al., 1997; Borduin et al., 2000).

Generalisability/Applicability of the programme: The vast majority of evaluations of the effectiveness of MST have been conducted in the U.S. However, within the U.S., MST has been successfully implemented in both urban and rural settings.

Measured outcomes: antisocial behaviour, criminal activity, substance abuse, parental psychopathology, family relations, peer relations, school failure, out-of-home placements, future employment (e.g. Henggelar et al., 1998; Woolfenden et al, 2003).

Effectiveness: MST has received the most empirical support as an effective family-based treatment for serious antisocial behaviour (Borduin et al., 2000). Most studies evaluating the effectiveness of MST have been randomised controlled trials including delinquents, maltreating parents, juvenile sexual offenders, violent and chronic juvenile offenders, and substance misusing juvenile offenders (Henggeler et al., 1998; Borduin et al., 2000). MST's effectiveness has been demonstrated in decreasing behaviour problems (particularly aggression and delinquency), reducing association with deviant peers, improving family relations, reducing recidivism, reducing re-arrest rates, decreasing sibling delinquency, and reducing the time spent by juvenile offenders in institutions (e.g. as reported in Henggeler et al., 1998; Borduin et al., 2000; Woolfenden et al, 2003). In addition, cost-benefit analyses suggest that MST is a highly cost effective intervention (Henggeler et al., 1998; Borduin et al., 2000). (Note: evaluations of MST have not been entered into the 'grids' because the intervention typically focuses on clinical samples with very severe behavioural disturbances.)

Parent Effectiveness Training (PET)

Target Populations: Parents of 'normal' children and adolescents, as well as parents of children and young people with behavioural or developmental problems.

Aims: Teaching parents to master effective communication, particularly relating to anger and conflict (Legaz, 2001). Parents are taught to adapt their language (verbal and non-verbal cues) to communicate acceptance, active listening skills, effective ways of confronting children (using 'I-messages'), changing unacceptable behaviour by modifying children's environments, democratic conflict-resolution skills (substituting the use of parental power for negotiating mutually acceptable solutions to resolve conflict) (Gordon, 1975). The overarching goal of the intervention is the development of 'democratic families'.

Theoretical underpinnings: P.E.T. is informed by the work of Carl Rogers, the founder of humanistic, person-centred therapy in the U.S. The Rogerian approach to therapy is based on the core principles of empathy, genuineness and unconditional positive regard, which characterise the client-therapist relationship.

Content and Format: P.E.T. is a structured, self-help intervention which aims to alter ineffective communication patterns that rely on negative emotions such as blame and guilt, and are based on the use of power and force (Gordon, 1975).

P.E.T. (basic/one-parent training package) has four interactive components, a video presentation, a 240-page Adult Workbook, an audio cassette and a 22-page Study Guide that explains how to follow the programme. The two-parent package includes an additional Adult Workbook, while the combined Parent-Teenager package adds a 122-page Young Adult Workbook for young people (Legaz, 2001). The programme is divided into eight sessions which should be completed in up to six weeks, either individually, or in group sessions.

The first session focuses on the importance of dialogue in families, and on defining the concept of 'democratic families'. The second session establishes the 'principle of participation' (motivation for adhering to rules is based on participation in rule-setting); while session three demonstrates how different individuals may interpret the same action/behaviour differently (as a function of his/her own experiences), assists parents in understanding acceptable and unacceptable behaviours (using the 'behaviour window'), and in identifying their needs and feelings to determine who own a presenting problem. Sessions four to eight cover the disadvantages of using power and punishment, and emphasise the importance of using 'I-messages', avoiding 'put-downs' (personal criticisms), and participative or mutual conflict resolution. Six steps are outlined to ensure 'no-lose' conflict resolution, which should be implemented with the use of key communication tools, namely active listening, honest, non-blameful 'I-messages', respect of others' needs, openness to changing, and entering discussions without fixed solutions (Legaz, 2001).

Generalisability/Applicability of the programme: P.E.T. has been implemented in rural and urban populations, with socially and economically disadvantaged families, families of children and young people of all ages, and families of children with special needs, e.g. children with disabilities.

Measured outcomes: Parental attitudes, values, perceptions and behaviour, marital satisfaction, child cognitive development, self-concept, perceptions of parents, family interaction and communication, child-parent problem resolution, parents' ability to counsel and empathise with their children.

Effectiveness: Most of the existing evaluations of P.E.T. were conducting pre-1980's (and therefore do not appear on the 'grids'), with few current or more recent evaluations of the intervention. In addition, although there are over sixty evaluations of P.E.T., these studies have varied in their methodological adequacy, thus preventing meaningful information on the effectiveness of the intervention (Cedar & Levant, 1990). The results of a meta-analysis of twenty-six evaluations of P.E.T. produced a small overall effect size (.328), however, when effects are divided into categories of outcomes, results indicate the P.E.T. has a large effect on parents' knowledge, small-to-moderate effects on parenting attitudes, parent behaviour toward children, and child self-esteem, and these effects endured up to twenty-six weeks post-intervention (Cedar & Levant, 1990). Although not large, the effects of P.E.T. are comparable to similar interventions, for instance, family enrichment programmes (Cedar & Levant, 1990).

Parenting Adolescents Wisely/Parenting Wisely

Target Population: Originally developed for parents of adolescents.

Aims: Increasing parents' knowledge of, and belief in effective parenting skills (non-coercive parenting practices), and increasing parents' ability to generalise and apply acquired parenting skills in multiple settings.

Theoretical underpinnings: Parenting Adolescents Wisely was developed on the basis of family systems theory, which emphasises the inter-dependency of family members, and the reciprocal, bi-directional nature of family relationships (Kacir & Gordon, 1999). The programme comprises elements of both behaviour modification and relationship enhancement. The former approach focuses on changing children's social systems by reinforcing positive, prosocial behaviours, and consistently punishing, or providing no reinforcement for negative, deviant behaviours. Relationship enhancement typically emphasises positive communication between parents and children, problem-solving skills, and corrective emotional experiences to strengthen family relationships.

Content and Format: Parenting Adolescents Wisely is an interactive videodisk training programme developed at Ohio University's Psychology Department over 3 years, which focuses on skills training in the following areas – active listening, communication, contracting, monitoring of child behaviour, problem-solving, assertive discipline, positive reinforcement of child behaviour, using 'I' statements, speaking respectfully, contingency management, and team parenting. The skills are taught through the presentation of a series of video clips which depict families in nine problem situations (e.g. siblings fighting, children not doing household chores etc.). In each case, parents have to choose one of three possible solutions to the problem, which is then played back to them. The parent is then given feedback of

the positive and negative consequences of their choice, and given an opportunity to choose another solution. Once the correct solution has been selected, an on-screen quiz is provided to test parents' knowledge of their acquired skills. Parenting Adolescents Wisely includes instructional sessions on how to use the programme to increase user-friendliness.

Generalisability/Applicability of the programme: Parenting Adolescents Wisely has been implemented with a number of different populations, including substance abusing parents, low income ethnic minority parents (Portuguese, Asian, Hispanic, African-American, African-Caribbean), court-referred parents (whose children were juvenile offenders), parents of children with conduct disorder, adolescent parents, parents of adolescents and pre-adolescents with behavioural problems, and socially isolated rural parents.

Measured outcomes: Parenting knowledge, parenting attitudes and behaviours, child behavioural problems.

Effectiveness: Existing evidence of the effectiveness of Parenting Adolescents Wisely is promising, however, few research studies have used randomised controlled trials to determine the success of the programme. Generally, quasi-experimental evaluations indicate significant improvements in family communication (both parent-child and parent-parent communication), more effective discipline (particularly less yelling and hitting), increased parental monitoring of child activities, increased parental involvement in child activities, and fewer child behaviour problems, also in clinical populations (Lagges & Gordon, 1999; Kacir & Gordon, 1999). Parenting knowledge has generally been shown to increase post-intervention. However, evidence of the translation of knowledge into adaptive parenting behaviour is not consistent. In addition, there is a lack of knowledge about the long-term effects of Parenting Wisely.

Parenting for the Drug Free Years (PDFY)

Programme description: PDFY is based on Hawkins and Catalano's social development model which proposes that parental norms for appropriate behaviour and child management practices (including child monitoring, rules and discipline) determine child socialisation processes (including family involvement, rewards for family involvement, drug refusal skills, and problem-solving skills) (Park et al, 2000).

Aims: Overall, the programme aims to reduce family-related risks for early alcohol and drug abuse by teaching parents to consistently communicate clear norms against child/adolescent substance abuse, reduce family conflict, promote strong parent-

child bonds, and help children develop skills to resist antisocial peer influences (Park et al., 2000).

Effectiveness: A randomised controlled trial with several long-term follow-ups indicates that PDFY can significantly reduce the growth of alcohol use and improve parental norms for adolescent alcohol use (Park et al., 2000). However, more studies of this kind are needed to support these findings.

Parents as First Teachers (PAFT)/Parents as Teachers (PAT)

Target Population: Parents of infants and children up to the age of five years.

Aims: The overarching aim of PA(F)T is the promotion of optimal child development through parenting education. The programme's main goals are as follows:

- Increasing parental knowledge of child development
- Empowering parents by facilitating their recognition of everyday learning opportunities and the development of skills that facilitate later learning
- Preventing and reducing child abuse
- Increasing parents' feelings of competence and confidence
- Developing home-school-community partnerships (Wagner, Spiker & Linn, 2002).

Theoretical underpinnings: The intervention was originally based on the work of Burton White, but additionally draws on developmental theories (e.g. Bowlby, 1982) emphasising sensitive or 'critical' periods in children's lives, during which specific skills should be acquired to avoid later irreversible deficits.

Content and Format: PA(F)T includes regular home visits by trained parent educators (on request; typically monthly) which involve the provision of developmental information to increase parental knowledge and enhance appropriate and effective parental responses to infant needs, and structured discussion and parent-child interaction activities (Tresch-Owen & Mulvihill, 1994; Wagner et al., 2002). PA(F)T also includes (weekly/fortnightly/monthly) parent group meetings to provide parents with opportunities to share experiences, insights, information/knowledge, and to develop informal social networks (Wagner et al., 2002). Finally, PA(F)T involves periodic developmental screenings, and referrals to community support services, as needed (e.g. health visitors, play groups etc.) (Wagner, Spiker and Linn, 2002).

Generalisability/Applicability of programme: PA(F)T has been implemented throughout the U.S. (2600 local programmes), in six additional countries, including

the U.K., and has been received by adolescent as well as more mature mothers, middle-class and low-income families, and ethnic minority groups (Wagner & Clayton, 1999; Wagner et al., 2002).

Measured outcomes: Parental knowledge of child development, quality of the home environment, parental attitudes, parenting stress, perceptions of social support, parenting satisfaction, indices of child development (e.g. cognitive and language abilities), adaptive child behaviour, child health and health care.

Effectiveness: PA(F)T has been well-evaluated in the U.S. over the past twenty years, and in the U.K., evaluations of the programme are beginning to emerge (e.g. Social Policy Unit, Buckinghamshire Chilton University College, is conducting an independent evaluation). Recent evidence from randomised controlled trials, however, indicates limited effectiveness, with few statistically significant post-intervention effects (e.g. Trech-Owen & Mulvihill, 1994; Wagner & Clayton, 1999; Wagner et al., 2002). It is interesting to note that effects seem to be greater for lower-income and ethnic minority families (e.g. Wagner & Clayton, 1999; Wagner et al., 2002).

Parents Who Care

Programme description: Parents Who Care was developed in 1996 by Dr. David Hawkins and Dr. Richard Catalano, and is an early prevention programme focused on parenting adolescents. The intervention consists of an instructional handbook and video, which include a series of exercises for parents and families, and can be delivered in groups or individually. Parents Who Care focuses on social, environmental and individual predictors of behavioural difficulties in young people, and encourages adolescent involvement in family processes such as decision-making and rule-setting (Henricson & Roker, 2000).

Perry Preschool Project

Target Populations: Low-income families (often ethnic minorities) with pre-school aged children at risk of school failure.

Aims: Promoting school readiness in high-risk populations.

Theoretical underpinnings: The Perry Preschool Project is based on the theoretical work of Jean Piaget, which emphasise individualised, developmentally appropriate learning, and view the child as an active learner, who learns best from activities s/he has planned, carried out, and reviewed him/herself (Schweinhart et al, 1993).

Content and Format: The Perry Preschool Project is a structured classroom-based programme that focuses on language, literacy and numeracy and social development. The programme runs for a minimum of twelve-and-a-half hours per week, and relies on a 'plan-do-review' routine which encourages child-initiated learning activities. Active learning is promoted by providing children with a supportive adult, who prompts and guides child learning activities, and a materials-rich environment. Teachers use as a framework a set of active learning 'key experiences' drawn from child development theory to encourage children to engage in play activities that facilitate decision-making and problem-solving, or otherwise stimulate intellectual, social and physical development. Teachers use open-ended questions that initiate conversations, and provide a consistent daily routine including 'plan-do-review' sequences and small group activities. Teachers are trained and supervised, primarily through workshops, observation and regular feedback, and offer weekly one-and-a-half hour home-visits to parents, providing an opportunity for discussion and modelling of child activities in the classroom to support child development at home. In addition, the intervention includes monthly parent group meetings.

Generalisability/Applicability of the programme: The programme has not been delivered outside of the U.S.

Measured outcomes: Indicators of school achievement, including reading, language and mathematics, I.Q., socio-economic status, education and achievement levels in adolescence and adulthood, arrest rates/criminal behaviour in adolescence and adulthood.

Effectiveness: A randomised controlled trial assessing the long-term effectiveness of the Perry Preschool Project demonstrated enhanced school readiness at age seven years; significantly higher achievement scores on reading, language and mathematics test at age fourteen years; better literacy skills at age nineteen years; and higher education and earnings, and fewer arrests at age twenty-seven years when compared to the no-intervention control group (Schweinhart et al., 1993). Another longitudinal study (follow-ups at ages fourteen to fifteen, nineteen and twenty-seven) produced similar results – the intervention group had significantly higher monthly earnings, higher percentages of home ownerships, higher levels of schooling, lower percentages of social services intervention, fewer arrests, and higher I.Q. and achievement scores than the no-intervention control group (Schweinhart et al., 1993).

Strengthening Families Programme (SFP)

Target Population: Substance abusing parents and their 6 – 12 year-old children.

Aims: SFP was designed to reduce environmental risk and enhance protective factors which increase personal resilience and foster resistance to drugs. Specifically, SFP aims to improve family environments (an important buffer against drug and alcohol use) by helping parents develop their parenting skills (Kumpfer & Tait, 2000; Kumpfer, 1999).

Theoretical underpinnings: Parental drug misuse and alcoholism increases children's susceptibility to drug/alcohol abuse (Aktan, Kumpfer & Turner, 1996; Kumpfer, Alvarado, Tait, & Turner, 2002a). Susceptibility may be increased by biological risk factors, including individual temperamental difficulties (e.g. over/hyperactivity, impulsivity, low social skills, poor concentration), which contribute to antisocial behaviour and delinquency, neurological and psychological vulnerabilities leading to poor problem-solving abilities, and enhanced reactivity to stress (Aktan et al, 1996). The quality of the family environment also impacts on child vulnerability and susceptibility to drug/alcohol misuse. Poor family environments characterised by frequent family conflict, ineffective communication patterns between family members, inappropriate developmental expectations of children, poor parental supervision and monitoring of child activities, and ineffective disciplinary practices increase the likelihood of poor child outcomes (Aktan et al, 1996; Kumpfer et al, 2002a).

Content and Format: SFP (developed in 1983) is a 14-session family skills training programme designed to reduce risk factors for substance abuse, depression, aggression, delinquency, violence and school failure in 6 to 12 year-old children of substance abusers. SFP consists of 3 components, Parent Skills Training, Children's Skills Training and Family Life Skills Training. The Parent Skills Training course is implemented using lectures, exercises, discussions and role-plays, and focuses on developing parents' ability to increase desirable behaviours in children by using attention and rewards, clear communication, effective discipline and limit-setting. In addition, the Parent Skills Training course targets parental problem-solving skills, stress and anger management skills, and provides substance abuse education. The Children's Skills Training component teaches children to increase their communication, social, and peer resistance techniques through exercises, games, colouring, workbook activities, role-plays, puppet-shows and discussions. Specifically, the topics covered during sessions include understanding feelings, coping with anger and criticism, stress management, social skills, effective problem-solving, resisting peer pressure, the consequences of substance use, communication skills, and compliance to parental rules and boundaries. The parent and child sessions typically end with Family Life Skills Training, which aims to increase co-

operation between family members, and consists of practicing newly acquired skills, including structured family activities, therapeutic child play, family meetings, communication skills training, effective discipline, reinforcing positive behaviours and jointly planning family activities (Kumpfer & Tait, 2000; Kumpfer, 1999).

Generalisability/Applicability of the programme: SFP has been widely and effectively used with non-substance abusing parents and their children, a range of ethnic minority groups (including African American, Asian/Pacific Islander, Hispanic and American Indian families), has been successfully implemented in rural and urban environments, and in a variety of settings (Kumpfer et al, 2002a; Kumpfer & Tait, 2000; Kumpfer, 1999). However, to date, no randomised controlled trials comparing the effects of culturally-adapted versions of SFP to the generic version of SFP have been conducted. Results of quasi-experimental comparative studies suggest that the generic version of SFP produces slightly better outcomes than culturally-adapted versions of the programme, but recruitment and retention of participating families has been more effectively ensured for culturally-adapted versions of SFP (Kumpfer, Alvarado, Smith & Bellamy, 2002b).

Measured outcomes: Family environment, school bonding, parenting skills, child social competence and behavioural self-regulation.

Effectiveness: SFP has been extensively evaluated (27 studies), including 12 research studies conducted by independent evaluators (Kumpfer et al , 2002b; Kumpfer, 1999). Generally, evaluations of SPF indicate that the programme effectively reduces and prevents substance abuse, child externalising behaviours (e.g. aggressiveness, hyperactivity) and internalising behaviours (e.g. uncommunicativeness, obsessive/compulsive tendencies), conduct disorders, parental depression , and increases child social competence (e.g. Kumpfer & Turner, 1996; Kumpfer et al, 2002a). There is also evidence that SFP improves parenting skills and aspects of family environments, particularly family cohesion (e.g. Aktan et al, 1996; Kumpfer et al, 2002a).

Systematic Training for Effective Parenting (STEP)

Target populations: Families with parent-child relationship problems, including those at risk of child maltreatment, as well as families interested in enhancing child social and cognitive development.

Aims: STEP is a highly structured parent training programme aimed at developing three basic skills in participating parents – developmentally appropriate and realistic expectations of children, effective communication and discipline of children, and decreasing parental isolation (Adams, 2001).

Theoretical underpinnings: STEP is a parent education programme developed during the 1970's based on Adlerian concepts (the founder of 'individual psychology', which emphasises the centrality of self and the importance of social contexts) and communication skills training (Burnett, 1988).

Content and format: STEP is a highly structured parent training programme led by a trained professional, who is responsible for conducting four-hour weekly meetings (Burnett, 1988). The programme consists of eight child management training sessions, which cover the following topic areas: understanding children's behaviour and misbehaviour (including attention, power, revenge, display of inadequacy); understanding more about children and being a parent (including emotions, family atmosphere and values, sex roles, methods of training); encouragement (including building self-esteem); communication (including how to listen to children and express feelings and ideas to children); understanding natural and logical consequences (the concept of problem ownership), applying natural and logical consequences (including discipline strategies that develop responsibility, daily chores and hygiene); family meetings; and developing confidence and using potential (Burnett, 1988; McInnes-Dittrich, 1996; Adams, 2001).

Generalisability/applicability of the programme: STEP has been implemented with some success in hard-to-reach communities e.g. isolated rural families (McInnes-Dittrich, 1996).

Measured outcomes: child behaviour, child self-concept, parental attitudes, parental behaviour (communication, listening, responsiveness, problem-solving).

Effectiveness: A review of several evaluations of STEP indicates that the programme is effective in improving child behaviour, self-concept and parental attitudes and behaviour (Burnett, 1988). More recent evaluations support these findings; Adams (2001) reports that significantly improved problem-solving, communication, affective responsiveness and behaviour control in families participating in the STEP programme. However, there is insufficient evidence of long-term effectiveness.

Triple P: Positive Parenting Programme

Target Population: Parents and behaviourally disruptive or disordered pre-adolescent children (birth to 12 years).

Aims: The programme aims to prevent severe emotional, behavioural and developmental problems in children by increasing parenting knowledge, skills, confidence, self-sufficiency and resourcefulness; enhancing family environments by helping parents provide nurturing, non-violent, low-conflict and engaging home

contexts; and fostering emotional, social, intellectual and behavioural competence in children (Sanders & Markie-Dadds, 1996; Sanders, 1999).

Theoretical underpinnings: Triple P was developed in the early 1980's, and is based on social learning theory, applied behaviour analysis, developmental models of social competence in children, and research on developmental psychopathology. Insecure attachment patterns, harsh, rigid, or inconsistent discipline, inadequate parental supervision and monitoring of children, marital conflict an breakdown, and parental psychopathology have been identified as key risk factors for the development of major behavioural difficulties in children, and have been successfully reduced by operationalising core principles of the above theories (Sanders, 1999).

Content and Format: Triple P is a multi-level, multi-disciplinary preventative family intervention designed to reach families with varying levels and types of support needs. The reach of Triple P varies from targeting an entire population to targeting only 'at risk' children in order to provide the minimally sufficient intervention required by families to prevent children from developing increasingly serious behavioural problems (Sanders, 1999). The 'strength' or dosage of the intervention is determined by the (assessed) severity of child behavioural problems, and includes the following:

Level 1: an universal population-level media information campaign directed at all families, including a self-help written materials (readings and homework tasks) with no practitioner contact.
Level 2: written materials and brief telephone consultations targeting challenging child behaviours.
Level 3: written material and active skills training (including instructions, modeling, role-playing and feedback).
Level 4: written material, active skills training and support provision (including all Level 3 components and home visits to assist in generalising acquired skills).
Level 5: 'enhanced' family intervention, including intensive behavioural parent training and therapeutic work around particular areas of family distress (Sanders & Markie-Dadds, 1996).

Triple P emphasises the development of parental self-regulation as a central skill. Specifically, the programme focuses on developing parental self-suffiency, self-efficacy, self-management skills (self-monitoring, self-determination of goals, self-evaluation and self-selection of change strategies) and personal agency or empowerment. These skills are considered necessary for achieving the key principles of positive parenting – the ability to provide adequate supervision and monitoring, facilitate child learning, use consistent, assertive rather than punitive disciplinary practices, have realistic and developmentally appropriate expectations of children,

and ensure parental self-care (including improved marital communication and stress reduction strategies).

Generalisability/Applicability of the programme: Triple P has been successfully delivered to both non-clinical and clinical populations (e.g. depressed mothers, children with oppositional/defiant disorder). However, there is insufficient evidence of the cross-cultural applicability of Triple P. In addition, there is no evidence that the programme is effective when delivered by non-mental health practitioners.

Measured outcomes: Parental competence and child behaviour are the key outcome variables. However, specific outcomes vary as a function of the level of the Triple P intervention delivered, i.e. Level 1: non-problem child behaviours (e.g. toilet training, dressing self); Level 2: specific problem behaviours (e.g. thumb-sucking, temper tantrums etc.); Level 3: less specific, more severe problem behaviours (e.g. bedtime disruptions, mealtime behaviour problems); Level 4: behavioural disorders, including conduct disorder, oppositional defiant disorder, aggressive behaviour; Level 5: severe, long-term and concurrent child and parent problems, severe conduct disorder.

Effectiveness: There have been few independent evaluations of Triple P, and studies have varied in their methodological rigorousness. However, existing evidence suggests that the programme is effective in enhancing parental efficacy and competence, and reducing disruptive behaviour and attentional/hyperactive difficulties (in non-clinical and clinical populations) (e.g. Bor, Sanders & Markie-Dadds, 2002).

Webster-Stratton

Target Populations: Parents and teachers of 2 to 10 year-old children without clinically significant behavioural problems, or identified as at risk of developing behavioural problems; parents of children with conduct problems aged 3 to 10 years; pre-school, day care and early primary school teachers of children with conduct problems; parents at risk for child abuse and/or neglect; teenagers taking babysitting classes or family life courses (Webster-Stratton, 2001).

Aims: Preventing, reducing and treating aggression and conduct problems in young children, and enhancing child social competence. Additional objectives include promoting parent competencies, strengthening family relationships, promoting teacher competencies and enhancing home-school connections (Webster-Stratton, 2001).

Theoretical underpinnings: Operant conditioning (the theory that behaviour is influenced by various stimuli and the consequences of responses to stimuli) forms the basis of parent management training (Kazdin, 1997). More specifically, parenting management training is based on extensive research on the effects of parental disciplinary practices on child aggressive behaviour. The Webster-Stratton programmes are based on a key theory within this area of research, the so-called 'coercion hypothesis' which suggests that negative reinforcement develops and maintains deviant child behaviours, as well as punitive, harsh or critical parent and teacher behaviours (Webster-Stratton, 2001).

Risk factors for early-onset behavioural problems are multiple, interactive and cumulative (Webster-Stratton, 2001). Early-onset aggression and conduct disorder in children has been associated with delinquency, antisocial behaviour, adolescent violence, school drop-out, depression and substance abuse. (Webster-Stratton, 2001) Protective factors include positive parenting and teaching skills, parental involvement with schools and other potential support systems, child social competence and school readiness (Webster-Stratton, 2001).

Content and Format: The Webster-Stratton programmes are a comprehensive set of interventions using videotape modeling, group discussion, role-playing and rehearsal techniques, homework activities and supportive telephone calls to prevent, reduce and treat conduct problems, and increase social competence in children. The programmes have been revised to facilitate the development of social support networks for parents, and promote stronger home-school bonds (Webster-Stratton, 2001).

Parent Training Programmes: including the 'Incredible Years BASIC parent training series' (10 videotapes/250 video vignettes) teaches parents of 2 to 7 year-old children interactive play and reinforcement skills, non-punitive disciplinary techniques, and problem-solving strategies over a 12-week period. The 'Incredible Years SCHOOL AGE parent training series' (3 videotapes for parents of 5 to 12 year-old children) is a multi-cultural programme emphasising parental monitoring, problem-solving with children and family problem-solving techniques. The 'Incredible Years ADVANCE parent training series' (6 videotapes) is 10 - 12 week supplement to the 'BASIC' programme, which focuses on family risk factors including depression, marital conflict, poor coping skills, poor anger management and inadequate support. Finally, the 'Incredible Years SUPPORTING YOUR CHILD'S EDUCATION' (2 videotapes) complements the 'BASIC' programme by addressing ways in which parents can foster academic competence in their children, including enhancing child reading skills and academic readiness, and promoting strong home-school connections.

Teacher Training Programme: The 'Incredible Years Teacher Training Programme was designed to train teachers in classroom management skills, specifically encouraging and motivating pupils through the use of incentives, strengthening social competence, building positive peer relationships, decreasing inappropriate child behaviours, and promoting social skills development, anger management, and problem-solving. Video vignettes are used to stimulate group discussion over either weekly 24 two-hour sessions or monthly six day-long workshops (Webster-Stratton, 2001).

Child Training Programme: 'DINA-DINOSAUR child training series' teaches children friendship skills, conflict management skills, appropriate classroom behaviours, and empathy skills (Webster-Stratton, 2001). The skills are taught using videotape modeling, fantasy play, use of life-size puppets, role-playing, practice activities, games, children's books, and feedback, reinforcement and generalisation of acquired skills (Webster-Stratton, 2001). Sessions are typically delivered two to three times a week, and last approximately 50 minutes.

Generalisability/Applicability of the programme: A number of randomised control group studies have indicated the effectiveness of the Webster-Stratton programmes as a treatment used in clinical populations (children diagnosed with Oppositional Defiant Disorder/ODD and Conduct Disorder/CD) (e.g. Webster-Stratton & Hammond, 1997; Patterson et al, 2002). Evidence of its effectiveness as a preventative intervention has also been widely documented (e.g. Scott, Spender, Doolan, Jacobs & Aspland, 2001). In addition, the programme has been adapted for different cultural groups (including Hispanics, African-Americans, Latinos), and its effectiveness demonstrated in a number of randomised control studies (e.g. Barrera et al, 2002; Gross et al, 2003). The interventions have been successfully implemented in the United States (e.g. Gross, Fog & Tucker, 1995; Gross et al, 2003; Spaccarelli, Cotler & Penman, 1992; Webster-Stratton, 1992; 1994), Canada (e.g. Taylor , Schmidt, Pepler & Hodgins, 1998), Norway and the United Kingdom (Scott et al., 2001; Patterson et al., 2002).

Measured outcomes: Child behavioural/conduct problems (e.g. Webster-Stratton & Hammond, 1997; Webster-Stratton, 1992; 1994; Patterson et al., 2002; Barrera et al., 2002; Gross et al., 1995; 2003; Spaccarelli et al., 1992; Taylor et al., 1998; Scott et al., 2001), parent-child interactions (e.g. Gross et al., 1995; Webster-Stratton & Hammond, 1997), punitive discipline (e.g. Spaccarelli et al., 1992; Webster-Stratton, 1992), parental attitudes, child social competence, parent and child problem-solving abilities, conflict management (e.g. Webster-Stratton & Hammond, 1997), parental involvement in schools, school readiness, parental stress, parental self-esteem (e.g. Webster-Stratton & Hammond, 1997; Patterson et al., 2002), parental self-efficacy (e.g. Spaccarelli et al., 1992; Gross et al., 1995).

Effectiveness: The Webster-Stratton programmes have been evaluated in a great number of methodologically rigorous studies (randomised controlled trials) which demonstrate high effectiveness on a range of child and parent outcomes (see Webster-Stratton, 2001 for review). In addition, there is evidence of the programmes' long-term effectiveness (e.g. Webster-Stratton & Hammond, 1997; Patterson et al., 2002; Gross et al., 2003).

Part 2: U.K. programmes

Family Caring Trust

Programme descriptions: The Family Caring Trust provides a great number of parenting courses in the U.K., including a series of flexible self-help programmes for parents of children of all ages, including teenagers (Henricson & Roker, 2000). Examples of these programmes include the 'Parents of Teenagers Programme', the 'Young Adult Programme', the 'Parents' Assertiveness Programme', the 'Parenting and Sex Programme', the 'Step-Parenting Programme', the 'Married Listening Programme', and the 'Couples Alive Programme' (Petford & Howkins, 1998). The theoretical bases of the interventions are eclectic, drawing on family systems, humanistic (Rogerian), Adlerian, reality therapy (negotiation and conflict management), re-evaluation counselling (parental self-reflection and awareness), and social learning approaches (Petford & Howkins, 1998; Henricson & Roker, 2000). Interventions comprise session-specific instructions and video and audio tapes depicting hypothetical family interactions, which have been delivered in a number of settings, including schools and churches (Henricson & Roker, 2000). Although the courses have largely been evaluated using qualitative methodology (with a few exceptions), existing evidence indicates that these programmes improve parental listening, communication and disciplinary skills, as well as facilitating the use of new approaches to parenting, while child outcomes included increases in prosocial behaviour and sense of responsibility (Henricson & Roker, 2000).

Group parenting programmes facilitated by health visitors are one of the most promising interventions delivered by the Family Caring Trust. These preventative programmes consist of weekly two-hour sessions extending over an eight-week period, with a different aspect of parenting addressed each week, e.g. health visitor parenting programmes in Down Lisburn Trust, Northern Ireland (Long et al, 2001), and East Berkshire (Petford & Howkins, 1998). The course focuses on understanding child behaviour and parenting behaviour; building child confidence and self-esteem; listening and communication skills; effective disciplinary strategies (consistent limit-setting and logical consequences); family negotiation and conflict management; and developing parental confidence and actualising potential (Petford & Howkins, 1998; Long et al., 2001). Quasi-experimental evaluations demonstrate significant post-intervention reductions in parental anxiety and depression, decreases in parents'

shouting at their children, and increases in parental calmness and energy (Long et al., 2001).

Family Literacy Programme

The Family Literacy Programme is a 12-week course which aims to boost parental literacy, parents' ability to support their children's reading and writing activities, and develop children's language and literacy. In 1993/94, the Basic Skills Agency established four Family Literacy Demonstration Programmes in economically and socially underprivileged areas in the U.K., including Cardiff, Liverpool, Norfolk and North Tyneside targeting children aged three to six years and their parents (Brooks et al, 1996).

Since then, the programme has been adapted for linguistic minority families with a child falling in the above age group, and in both cases, evaluations have indicated positive effects (Brooks et al, 1997, 1999). Children taking part in the Family Literacy scheme have been found to be superior to their peers in the level of support they received from their families, and in their classroom behaviour, and these effects were sustained when assessed two years later. Among parents there was an increase in the numbers taking up employment, and most of them attributed this directly to the Family Literacy scheme.

A more recent evaluation of a 'Keeping up with the children' Basic Skills agency programme also found positive results (Brooks and Hutchinson, 2002). The scheme was designed to help parents support their children's literacy and numeracy development, and was run in the form of a 12-hour course for parents, across 122 local education authorities. Evaluation showed that parents had greater understanding and involvement in their children's learning.

Family Nurturing Network (FNN): Family Connections

Programme description: Family Connections is a 14-week video-based parenting programme based on Webster-Stratton's 'Incredible Years' intervention, which focuses on developing play skills, positive reinforcement of desirable child behaviours (the use of praise and incentives), setting consistent boundaries, negative reinforcement of undesirable child behaviours, 'time–out', and the use of predictable consequences to child behaviour (Whiteley & Ball, 2001). Participants can self-refer or are agency-referred (including health visitors, social workers, GP's, schools etc.) to attend weekly two – two-and-a-half hour group sessions at local venues (Family Nurturing Network, 2002). Group sessions combine discussion, role playing and small group work, and parents are encouraged to read the provided materials and practice learnt skills between training sessions (Family Nurturing Network, 2002). The programme is delivered by trained and supervised volunteers from a range of

disciplines (e.g. education, psychology, social and health care), are offered free of charge, and include child care. At present, programmes developed by FNN are available in a number of areas in the U.K., including Abingdon, Banbury, Benson, Bicester, Oxford and Witney (Family Nurturing Network, 2002). Programme effectiveness is difficult to determine due to a lack of independent, rigorous evaluations, but the limited evidence suggests post-intervention improvements in child behaviour (Whiteley & Ball, 2001).

Home Start

Programme description: Home-Start is a **v**olunteer-led befriending service providing home-based support to stressed parents of children under five. Home-Start was developed in Leicester by Margaret Harrison in 1974, and by 2003 there were 330 community-based schemes, delivered in a range of areas in the U.K., and beyond, including Australia, Canada, Hungary, Israel, the Netherlands, and the Republic of Ireland (Home-Start Annual Report, 2003). Home-Start's aims include offering support, friendship and practical assistance to families experiencing difficulties; emphasising parents' strengths, and promoting parental confidence, and encouraging parents to widen their social networks, and utilise community services effectively.

Volunteers typically have experience as parents themselves, attend a training and induction programme, and undergo rigorous selection before providing support services. Target populations include parents with mental health problems, single parents, parents with disabilities/ill-health, travelling families, care leavers, prisoners' families, teenage mothers, single fathers, refugees, asylum-seekers, and low-income families.

Although Home-Start is regularly internally monitored and evaluated, there have been relatively few methodologically rigorous evaluations of the programme. Evidence from a small, exploratory study suggest that Home-Start volunteers work effectively with a range of families, even those with serious difficulties (Gibbons & Thorpe, 1989), while another evaluation of Home-Start, Scotland, reports a range of positive outcomes, including increased parental confidence and self-esteem, reductions in family members' physical and mental health problems, and decreases in child behavioural problems. A qualitative study conducted by Frost et al (1996) also provides promising findings, including improved parental social networks, parenting attitudes, perceptions and behaviours. An evaluation of Home-Start funded by the Joseph Rowntree Foundation is underway at the time of writing, involving pre- and post-intervention assessment of families and a control group (McAuley, Knapp, Beecham, McCurry and Sleed, forthcoming). The study examines costs and outcomes in terms of maternal mental health, parenting stress, maternal social support and self-esteem, and child development.

Kirklees Paired Reading Programme

Programme description: The Kirklees Paired Reading Project is the largest of its kind in the U.K., and aims to support schools and other agencies in training and guiding parents in the use of a technique known as paired reading (Topping, 1986). Services offered to schools etc. include briefing, planning, consultation, training sessions for parents and children, training and evaluation materials, funding teachers' home visits, general support and review meetings. Paired reading involves a parent (or other adult) and a child in joint and rewarding reading activities. Paired reading includes two phases (reading together and reading alone), and emphasises fluency, understanding and use of context; the focus of the technique is on teaching children to extract meaning from the text.

Initially, families commit to six to ten (five day) weeks of reading for between five and fifteen minutes. Associated discussion of the content and meaning of the reading material is also encouraged. Children select the books they would like to read, from any source and at any level of difficulty. The task of parents' or other guiding adults' is to correct the child if he or she makes a mistake or fails to read a word correctly after five seconds. In addition, correct reading should be consistently praised. During the first phase the pair read aloud together (the adult should adjust his/her pace and rhythm to the child's), whereas during the second phase, the child reads alone, after giving the parent/adult a pre-agreed non-verbal signal that s/he feels competent to do so. The child reads alone until s/he makes a mistake or is unable to read a word, the adult then corrects the child after approximately five seconds, and continue reading together until the child signals again that s/he feels confident to continue alone.

Paired reading is one of the best-evaluated reading technique involving parents in the U.K. (Topping, 1986). Results of past evaluations have indicated that paired reading significantly improves reading ability in children aged six to fourteen years (including those with low cognitive ability), with the average typical gain for children involved in paired reading being three times the 'normal' progress in reading accuracy and five times the 'normal' progress in reading comprehension (Topping, 1986).

Mellow Parenting

Programme description: Mellow Parenting works from the theoretical premise that the internal or emotional world of the mother determines the external world of the child (Mills & Puckering, 1995). The programme's central aim is to empower parents by fostering reflexivity – through encouraging parental insight into the effects of their own past and present experiences on their behaviour towards their children

(Puckering, Evans, Maddox, Mills & Cox, 1996). Mellow Parenting draws on another U.K. intervention, NEWPIN, particularly in terms of its simultaneous interest in the past and current needs of parents and the needs and management of children (Mills & Puckering, 1995).

The programme targets parents of children under the age of five, and runs for one full day per week over a four-month period. Criteria for referral to the intervention (from family centres, health visitors, social workers, education, clinical psychologists and child psychiatrists) include persistent child-parent relationship problems, child behavioural problems, maternal mental health problems, and domestic violence. Mellow Parenting is a group-based, structured, therapist-led programme, with each session divided into three parts – the first part involves discussion of parents' past and present experiences, and reviewing the previous week's homework; the second part includes planned joint parent-child activities, e.g. finger games, arts and crafts, outings to the park etc.; while the third part of the session comprises a structured parenting workshop, including analysis of family videotape material and personal examples. Childcare is provided during the first and final parts of each intervention session. Parents work from simple worksheets that raise topics for discussion and individualised homework assignments (Puckering et al., 1996).

Evaluations of Mellow Parenting have indicated that the programme improves mother-child interaction, child behaviour problems, maternal well-being, maternal effectiveness and confidence in parenting, and children's language and non-verbal abilities (e.g. Puckering, Rogers, Mills, Cox & Mattson-Graff, 1994). However, more methodologically rigorous evaluations of the programme are needed to support these findings.

NEWPIN (New Parent and Infant Network), now Family Welfare Ass. Newpin

Programme description: NEWPIN was developed in the London Borough of Southwark, U.K. in 1982, its development inspired by increases in the rates child abuse and neglect, and low uptake of ante- and post-natal services in the area (Gurr & Hansen, 1997). NEWPIN targets parents (typically of pre-school children) who are experiencing depression, other forms of psychological distress, social isolation and disturbed parent-child relationships (Jenkins, 1996). Centre-based services are provided by trained staff, and include social support, therapeutic group work and counselling, family play programmes, and life-skills programmes. NEWPIN's aim is to promote parental self-awareness, particularly the importance of recognising the effects of their own childhood experiences on current relationships (Jenkins, 1996). Specifically, the programme encourages parents to value themselves; to form creative and loving relationships with their children; to communicate effectively; and prepares parents for further education or employment (Gurr & Hansen, 1997).

Methodologically rigorous evaluations of NEWPIN are lacking (particularly controlled trials), however, one exemplary study (Cox et al, 1992) reports positive outcomes for intervention group mothers, including significant improvements in parental psychiatric symptoms, parent-child relationships, self-esteem and perceptions of control. The Tavistock Institute is undertaking research (2004) into mental health outcomes for parents and children.

The Nuturing Programme

Programme description: The Nuturing Programme originated in the United States, and stems from research work on treatment and prevention of child maltreatment, carried out by Bavolek and colleagues at the Kemp Centre, Denver, Colorado (Bavolek, 1990). In the UK, Family Links has been licensed to develop and train users in the programme, in addition to running Nuturing Programme parenting groups.   Family Links has been running the programme within British schools since 1994.

The programme involves separate ten-week courses for parents/carers and their children. The first part is a group-based parenting course offered on a voluntary basis, involving two-hour sessions. The group is facilitated by two Family Links Programme tutors. The second part of the programme is a schools-based programme for children facilitated by the children's teachers, who are required to undertake a two-day training in order to deliver the programme. The children's programme involves one-hour weekly sessions each term at key stage one, and 45 minute weekly sessions at key stage two. The content of the programme is based on four constructs: appropriate expectations of children; positive discipline techniques; empathy; and self-awareness and high self-esteem. The aims of the programme are to: raise self-esteem, promote emotional literacy and emotional health, develop communication and social skills, empower children to make responsible choices, enhance concentration and the motivation to learn, teach positive ways of resolving disruption and conflict, reduce bullying and antisocial behaviour, create a safe and calm environment, and improve links between school and home.

The programme has undergone qualitative evaluation (Barlow and Stewart-Brown, 2001), where results showed that parents felt they had generally benefited from the programme, including increased empathy and identification with their children. However, further quantitative investigation is necessary before the programme's effectiveness in relation to children's and parents' outcomes can be determined.

Parent Advisor Service

Programme description: The Parent Advisor Service draws on the work of Kelly (1955), Rogers (1959) and Egan (1982), and is based on a non-directive parent

counselling model. The intervention addresses the psychosocial needs of the family as a whole rather than focusing on behaviour of the child or family pathology. Specifically it aims to empower parents to use their own resources to manage difficulties while preventing them from feeling stigmatised or belittled, and to be with them and support them in the process. This is achieved by enhancing their self-esteem and sense of control to enable them to develop a clear understanding of their difficulties, develop their own goals, and devise ways of achieving them. The underlying rationale for the scheme is based on the notion that if Parent Advisors establish a 'respectful' partnership with at least one parent in the family, these parents will feel supported and valued and experience enhanced self-esteem. This will in turn reduce their feelings of anxiety and depression, and will enable them to manage parenting problems more effectively, which will in turn lead to improvements in family relationships.

Parent Advisors, who are typically health professionals such as health visitors, are required to train on a manualised course in order to acquire the basic skills for counselling families. Families are usually seen at home for an hour at a time, typically on a weekly basis initially, and then on a less frequent basis depending on their needs. The number of sessions is unlimited, but is in practice restrained by the pressure from further referrals.

The scheme has been evaluated within a variety of contexts including child mental health services for treatment of behavioural and emotional difficulties (Davis and Spurr, 1998), families with preterm infants (Marlow and Avon Premature Infant Project, 1998), and (in its original context) families of children with disabilities (Davis and Rushton, 1991). Results have been largely positive, although its benefits for use with parents of preterm infants were limited. An example of its effectiveness is provided by an evaluation of the scheme based within a child mental health service, where participating parents were found to improve in several areas compared to a matched control group (Davis and Spurr, 1998). Parents in the intervention group reported less stress, reduced severity of problems and distress in relation to parenting, decreased anxiety and depression, and improved self-esteem, more positive attitudes towards their children, and improvements in their child's behaviour. These outcomes were assessed at four months post recruitment, and longer-term outcomes are not known.

Parents Altogether Lending Support (PALS)

Programme description: PALS is a six-week, community-based parenting programme developed in Dundee, Scotland, consisting of weekly one-and-a-half hour group meetings focused on specific topics. The sessions cover themes such as using and developing existing strengths, managing child behaviour, specifying and changing child problem behaviour, and developing an 'action plan' for tackling

priority problems with the input of other group members (Zeedyk, Werritty & Riach, 2002). The final session reviews focusing on good behaviour rather than on problem behaviour, placing children's behaviour within the wider context of the family, identifying and specifying behaviours that parents' would like to modify, and being satisfied with 'good enough' as opposed to 'perfect' parenting. The four guiding principles of PALS emphasise building on existing strengths, identifying problem behaviours, considering strategies for accomplishing change, and developing an action plan for making changes. The overall aim of PALS is to develop parental self-esteem and confidence, and empower parents through facilitating active problem-solving. The groups range in size from between two and seven participants, and are lead by trained counsellors, whom in some cases, are accompanied by co-facilitators. Sessions consist of teaching time and guided discussion time, and materials used include written worksheets, videos, and observational 'homework'.

The programme has been externally evaluated by Dundee University (Zeedyk et al., 2002), and results indicate that participating parents enjoyed the course and found it beneficial, and valued the opportunity to share their experiences with other parents. More rigorous evaluations, including no-intervention control groups and validated outcome measures, need to be conducted to reliably assess the effects of the programme on parent and child behaviour.

Parent Network: Parent-Link

Target Population: Parents of children of all ages (not specified).

Aims: Parent-Link aims to increase parenting knowledge, enhance parental confidence in parenting skills and improve family relationships.

Theoretical underpinnings: Parent-Link was developed between 1984-86 by the founders of Parent Network (Sokolov & Pearson), and is a parent education and support programme based on client-centred therapy, theories of interpersonal communication, and family relationships (Davis & Hester, 1996). Risks to child adjustment identified include social isolation, parental work patterns, family conflict and breakdown. U.K. parents have reported increasing concerns not only about child mental health, emotional and physical abuse (including bullying), alcohol and drug abuse, but also their own emotional and mental well-being, particularly anxiety and depression.

Content and Format: Parent-Link consists of thirteen parent-led, loosely structured group sessions which include the presentation of information, role-playing, open discussion, and small group work. The sessions focus on assertiveness,

communication and listening skills. Additional workshops providing continuing support after the completion of the course are offered to interested parents.

Generalisability/Applicability of the programme: The programme has only been delivered to parents in the U.K., the majority of whom have been white. In addition, since parents are charged for the Parent-Link programme, participants have generally been middle-class (Davis & Hester, 1996).

Measured outcomes: child behaviour, parental anxiety and depression, family relationships, parental attitudes, confidence, and stress levels.

Effectiveness: Few independent evaluations of Parent-Link have been conducted; programme evaluations have included two self-report studies without comparison groups. However, the results of a recent, more rigorous independent evaluation of Parent-Link are promising (Davis & Hester, 1996). Children of participating parents showed a statistically significant reduction in behavioural (aggression) and social problems, internalising symptoms (anxiety and depression), and delinquent behaviour (Davis & Hester, 1996). Moreover, these changes were significant for children who scored in the normal range and the clinical range for behavioural problems. Parent-Link also produced a significant improvements in parents' self-esteem, family relationships (parent-partner and parent-child relationships), attitudes towards discipline (less authoritarian), and facilitated reductions in parental stress (Davis & Hester, 1996).

Parent-time

Programme description: Parent-time is a psycho-educational group intervention targeting parents of adolescents who are not displaying serious problem behaviour, but are demonstrating the 'normal' behavioural difficulties associated with adolescence. Parent-time has been running since 1975, and was initially developed for implementation in an outpatient paediatric division of the University of California Hospitals and Clinics at San Francisco (Cohen & Irwin, 1983). Primarily, the programme aims to enhance parental knowledge and understanding of adolescent development; increase parents' self-confidence and ability to manage their children's transition from childhood to adulthood; to reduce parental anxiety and feelings of helplessness about changes in child behaviour; and prevent parents' from labelling child behaviour as pathological (Cohen & Irwin, 1983; Henricson & Roker, 2000). The programme provides information on adolescence, teaches communication skills, effective listening, discipline strategies, including family rules, limit-setting, value clarification and negotiation, and aims to increase parents' awareness of community risks and resources (Cohen & Irwin, 1983; Henricson & Roker, 2000). Sessions are generally one-and-a-half hours long, extend over a five-

week period, and are facilitated by social workers and/or psychologists (Cohen & Irwin, 1983).

No methodologically rigorous evaluations of Parent-time are available, however, participating parents have reported increases in knowledge, awareness, confidence, enhanced capacity to listen and limit-setting post-intervention (Cohen & Irwin, 1983).

PEEP (Peers Early Education Partnership)

Programme description: PEEP is a voluntary organisation with charitable status providing early intervention to parents and children. Working in partnership with parents and carers, PEEP aims to enhance children's educational achievement and literacy in particular, by providing interventions that run from birth until the time of school entry. The PEEP project was initially developed in 1995 for use in an economically deprived area of Oxford, but has now been extended to cover other areas around Britain. The programme comprises a structured, age-appropriate curriculum for children involving specific target areas such as listening, talking, numeracy and self-esteem. The curriculum for parents involves use of specific books, rhymes, songs and activities. Group sessions for parents and their children are typically run on a weekly basis in pre-school settings for 33 weeks a year (i.e. term time), and are facilitated by a PEEP leader and assistant. There is also 'talk time' just for parents and facilitators. Parents are provided with a curriculum folder containing suggestions for activities to carry out at home, and can borrow books and activity packs between sessions.

An evaluation of the programme using a quasi-experimental design with a matched comparison group of children found a number of significant improvements in intellectual development among the intervention group (Evangelou and Sylva, 2003). After two years, participating children in the three to five year age group were found to have significant gains in vocabulary, language comprehension, understanding of books and print, and number concepts, and also had higher self-esteem when compared to matched non-participating children.

PIPPIN (Parents in Partnership Parent Infant Network)

PIPPIN is a U.K. charity established in 1994 to promote healthy early family and parent-infant relationships through the provision of early parenting education and support to new parents. PIPPIN is designed to improve and maintain parental emotional and psychological well-being, facilitate adjustment to parenthood, and promote personal resiliency in the period surrounding child birth. More specifically, PIPPIN aims to strengthen parent-infant attachment, facilitate parental self-reflection (recognising how their own experiences might influence their relationship with their

infant), develop effective listening and communication skills, and promote parental self-esteem, confidence and problem-solving. Staff from a variety of professions (e.g. midwives, health visitors, nurses, social workers, counsellors, child care workers, childbirth and parenting educators etc.), including volunteers, are trained for 50 hours to deliver group meetings, and less frequently, individual, home-based sessions. PIPPIN targets both mainstream families, and hard-to-reach families (e.g. ethnic minorities, parents with disabilities etc.) (PIPPIN, 2000).

PIPPIN is described as a non-prescriptive intervention - the role of the group facilitator excludes instruction or advice; instead, the facilitator is trained to assist parents in exploring their responses to post-birth lifestyle changes, changes in relationships, roles and responsibilities, perceiving and responding to the needs of their infants, and recognising their own emotional needs and worries.

Currently, para-professional and professional staff work with their own clients in NHS Trusts and other charities and institutions in London, Devon, Cornwall, Somerset, Bristol, Gloucester, Dorset, Hampshire, Sussex, Essex, Bedfordshire, Herfordshire, Northamptonshire, Cambridgeshire, Manchester and Lincolnshire. The programmes are adapted to suit local needs and resources, but typically, groups include four to six mothers (with fathers when possible), 6 weekly two-hour meetings from the 24th week of pregnancy; 3 two- to three-weekly two-hour review and support sessions in late pregnancy; 1 one-hour home or hospital visit to each family post-child birth; and six weekly two-hour group meetings including both parents and infants until the infant is three to five months of age. Preliminary findings of a recent evaluation indicate high participant satisfaction with services (PIPPIN, 2002).

Sheffield Raising Early Achievement in Literacy (REAL) Project

REAL is a 12-18 month early literacy education programme targeting low-income families (Hannon & Nutbrown, 2001). The aims of the intervention are to develop methods of working with parents to promote the literacy development of pre-school (under age five) children, and meet some of the literacy and educational needs of the parents of participating children. The programme includes five components: home visits by programme teachers, provision of literary resources (mainly books), centre-based group activities, special events (e.g. group library visits), and postal communication between teachers and children. Adult education opportunities offered by teachers to parents include information, advice and support in accessing local adult education from various providers, and a course developed by the REAL programme developers ('Parents' Roles in Children's Early Literacy Development') (Hannon & Nutbrown, 2001).

A randomised controlled trial evaluating the effectiveness of the programme indicated significant improvements in children's early literacy development, including letter recognition (Hannon & Nutbrown, 2001). Other positive programme indicators were high levels of participation and participant satisfaction (Hannon & Nutbrown, 2001).

SPOKES (Supporting Parents on Kids Education)

Programme description: SPOKES aims to determine the most effective ways of facilitating parental support of child learning (particularly improving literacy), and developing effective child behaviour management strategies. More specifically, SPOKES aims to reduce parental stress and the use of physical punishment, increase parental involvement in constructive learning at home, increase parents' involvement in children's school activities and progress, improve child attainment in literacy and attitudes towards reading, and reduce child aggression and anti-social behaviour.

SPOKES was developed by Oxford University and the Institute of Psychiatry, London, and includes two distinct components. The first consists of a twelve-week parenting programme that focuses on fostering positive child play behaviours, negative reinforcement of negative or undesirable child behaviours, and positive reinforcement of appropriate or prosocial behaviour. The second part of the intervention includes ten weekly sessions which provide information about child reading, and teaches parents how to effectively support children's literacy development at home. At each session a library of books and literacy activities is provided, and parents are encouraged to borrow books and games for use at home.

Central to the success of the second part of the programme is parents' mastery of the 'Pause, Prompt and Praise' technique, which involves pausing (for about five seconds) when the child is unable to read a word to give the child an opportunity to work it out by him/herself; prompting the child (giving a clue) if s/he is still unable to decode the new word; and praising the child when s/he manages to read the word correctly. Parents receive two home visits from the tutor to develop the 'Pause, Prompt and Praise' technique; during one session both the parent and child are present, and during the other session the parent and tutor critically discuss an audio recording of a home reading session.

Recent evaluation of the programme has shown it to be effective in reducing antisocial behaviour and improving reading ability (Scott and Sylva, 2003). Its success has been attributed to several factors including: use of a strong theory-based parenting programme (i.e. Webster-Stratton), using a collaborative approach where partnership with parents to identify their needs, combining a literacy element to increase attractiveness, pitching the programme as being universally relevant rather

than for 'failing' parents, establishing close partnership with the schools in which the scheme was based, and good supervision of group leaders.

Strengthening Families, Strengthening Communities (SFSC)

SFSC is a preventative parenting programme based on Dr. Marilyn Steele's U.S. programme, 'Strengthening Multi-Ethnic Families and Communities', which is now being revised for use within the U.K. context (Youth Justice Board, 2003). Central to this programme is an inclusive approach, targeting black and minority ethnic parents. The programme was developed in 1999, piloted the following year, and to date, over 300 facilitators have been trained. SFSC aims to facilitate strong ethnic and cultural roots, positive parent-child relationships, life skills, self-esteem, self-discipline, social competence, and to assist families in accessing community resources. SFSC uses a number of strategies to help achieve its aims, including providing information to parents, developing effective anger management strategies and positive disciplinary techniques, decreasing parental isolation by connecting families to community resources, and providing a cultural framework to validate the experiences of different ethnic groups.

SFSC consists of twelve three-hour sessions (and additionally an orientation session), delivered weekly. Each group includes between eight and twenty parents, and incentives, such as transport, refreshment and/or childcare are typically provided.

In the U.S., the programme has been delivered to a diverse range of populations, including African Americans, Hispanics/Latinos, Native Americans, Asian Pacific Islanders (Vietnamese, Korean, etc.), as well as White Americans, mixed heritage and African immigrant populations. In addition, SFSC has been implemented in both rural and urban populations, with mothers as well as fathers, offenders and parents with physical disabilities.

Sure Start

Programme description: Sure Start is the very large government initiative launched in July 1998 aimed at preventing the social exclusion of disadvantaged children, from conception to age fourteen years (and older for those with special education needs). Rather than providing one specific service, Sure Start attempts to change and add to existing services by reshaping and enhancing these services, providing new services, and increasing and improving co-ordination between agencies (Sure Start, 2003). More specifically, Sure Start aims to promote physical, emotional, intellectual and social development in pre-school children by increasing childcare availability, supporting parents in employment and in developing their careers, providing parent skills training and education on child development, health and family support services (Sure Start, 2003).

Sure Start services include childcare, children's centres, children's information services (information on nursery education and childcare availability), early excellence centres (a range of educational and care services for parents and children), extended schools (co-ordinating childcare services), health and family support (parental education on child development, promoting awareness of healthy living, early identification of difficulties), neighbourhood nurseries, out-of-school childcare, local programmes (including family support, advice on nurturing, health services, and early learning opportunities) (Sure Start, 2003). In addition, Sure Start is currently developing a comprehensive research programme, complementing research funded by the DfES and Department for Work and Pensions research programmes. It includes local programme evaluation, as well as research on early years and childcare, neighbourhood nurseries, and Early Excellence centres. A large-scale, well-designed six-year evaluation of all Sure Start programmes in England, led by the Institute for the Study of Children, Families and Social Issues, University of London, is currently underway to determine the impact of the programme.

Teenagers in Trouble: Skills for Parents

Programme description: Teenagers in Trouble is a video-based information package developed by the director of the Trust for Adolescence (TSA), Dr. John Coleman. The 45-minute video includes groups of parents talking about the problems they experience with their teenagers, with dramatised interactions of some of the issues raised during the group discussion, e.g. boundaries, negotiation, neighbourhood and peer influences, where to seek help and support. The video is accompanied by a 28-page booklet for parents; while for professionals, the video is accompanied by a 32-page facilitators' guide, purchasable from the TSA (Trust for the Study of Adolescence, 2003).

Appendix II: Grid details

Details of individual interventions and their evaluations are provided in an online grid that can be accessed at the Policy Research Bureau's website: www.prb.org.uk.

In this section we provide a general guide to how the information contained in the grid is organised. Information is organised into two broad categories:

1. descriptive information about the intervention itself
2. information about the quality of the evaluation study

The details given within each of these two broad categories are tabulated below. In some instances, certain items of information were missing, and 'N/I' (no information) is used within the grid to indicate the unavailability of a specific piece of information. [Please consult the guidance note provided online for detailed instructions about how to search and retrieve information contained within the grid.]

1. Descriptive information about interventions

This includes the implementation and process variables that describe each intervention: table 1.

Table 1. Grid categories for descriptive information about interventions

Grid category
Reference – including authors and date
Exemplar status of study. Where there are multiple trials of a given intervention, one to three 'exemplar' evaluations have been entered into the grid rather than numerous evaluations of the same intervention.
Beneficiary or target population/group • universal **or** targeted, including target group e.g. fathers, foster, grandparents, step parents, ethnic or cultural minority, low income, teenaged, other). • Parents, including whether couples, mothers, fathers etc.
Type/nature/format of the intervention • therapeutic/preventative • group work/individual work • format – different components or strands - ie: formal 'education' classes & courses,(incl. parent training and skills building/advice and information 'interventions')/helplines & web-based/home visitation by professionals/befriending and family aides/peer support/therapy or counselling for families and individuals
Age of child
Throughput - i.e. numbers using service and period used for (week, month, year, etc)
Intensity and duration (e.g 2 x 2 hrs sessions each week, for three months)

Referral routes – self-referral/agency referral, voluntary / agency referral, mandatory, etc
Delivery • funding sector: statutory/voluntary • providing agency (e.g. health, social services, education, youth or criminal justice, leisure services, voluntary organisation) • staffing – professionals /paraprofessional/peers
Overall aims or objectives/ Specific outcomes targeted within broader outcome category.
Risk/protective factors addressed - factors that the intervention aims to decrease or bolster
Cost - including cost effectiveness or cost-to-benefits ratio
Country • location of the intervention • urban/rural

2. Evaluative information

This category includes the scientific and evidential factors that relate to the methodological characteristics and quality of the evaluation and also the evidence regarding the effectiveness of the intervention. The details are listed under headings described below in table 2.

Table 2. Grid categories for evaluative information

Grid category
Methodological characteristics: Quantitative study methods including: • design: RCT/ quasi-experiment/uncontrolled study; • measurement points: (numbers of waves of data collection) in time including follow-ups • sample size: (*small* is <50; *medium* is 50-100; *large* is 100+) • mode of administration: self-report/investigator-based assessment/observation (e.g. by non-clinician) • measures: validated/unvalidated/combination
Methodological characteristics: Qualitative study methods including • Sample size • Depth interviews/group discussions/observations
Score on adapted version of Scientific Maryland Scale (Farrington, Gottfreson, Sherman and Welsh, 2000) - coded: **Level 1.** Association between a prevention program and an outcome measure at one point in time; **Level 2**. Includes pre- and post- intervention measures (i.e. measures at two points in time) , but with no control group; **Level 3**. Pre- and post-intervention measures (i.e. measures at two points in time) and also treatment and control group; **Level 4.** Pre- and post-intervention measures (i.e. measures at two points in time) and treatment and control group, and also control for other factors that influence outcome; **Level 5.** RCT i.e. Pre- and post-intervention measures (i.e. measures at two points in time) and treatment and control group, with participants randomized to treatment and control group).

Score on GAEQ (Global Assessment and Evaluation of Quality)
Scored from 0 to 6 for quantitative studies and 0 to 5 for qualitative studies, with higher scores indicating better methodological robustness. [Details of scoring system at given in table 3 below].

Implementation – negative indicators – comments on factors listed below, where details are provided:
- attendance & engagement
- cultural sensitivity/appropriateness
- successfully reached range of ethnic groups (where intended to be 'inclusive' programme)
- user satisfaction & perception of 'helpfulness'
- practical aspects (location & accessibility; cost to users; timing)
- continuity & appropriateness of staffing
- (inter)agency working issues (communication, shared values etc)
- cost effectiveness.

Implementation – positive indicators: **–** comments on factors listed above, where details are provided

Outcomes
- The outcomes reported are listed under one of four headings depending on the findings of the study:
  works, *promising*, *unknown*, *doesn't work* (and includes negative outcomes) in relation to <u>any</u> outcome reported in the evaluation, in addition to the main outcome that the study has been categorised under.
- The headings are adapted from Farrington et al (2000), and are defined as follows:
  What works: programs must have at least one level 3 to 5 SMS evaluations showing statistical significant and desirable results and the preponderance of all available evidence showing effectiveness.
  What doesn't work: programs must have at least one 3 to 5 level evaluations with statistical significance tests showing ineffectiveness and the preponderance of evidence support the same conclusion.
  What is promising: where level of certainty is too low to support generalisable conclusions, but where there is some empirical basis for predicting that further research could support such conclusions.
  What is unknown: any program not classified in one of the three above categories.
- Outcomes concern the *actual outcome* reported by the evaluators of the intervention rather than the *intended outcome*, as these can be quite different in practice.
- Numbers in brackets after outcomes refer to outcome commentaries of the main report where further discussion of the particular outcome can be found (e.g. 1b refers to educational outcomes).
- Where studies report on multiple outcomes, the various outcomes are listed.

Global assessment and evaluation of quality (GAEQ)

In addition to the SMS rating, another rating reflecting additional aspects of methodological robustness was also derived, namely the GAEG. Details of the GAEQ are set out below in table 3. This was derived by the research team at the Policy Research Bureau to reflect methodological aspects of evaluation studies that related to their robustness in our view.

To derive a score, each study was assessed on each of the dimensions below. The presence of each dimension scored a point on the scale. The total score was cumulative from zero to six for quantitative studies, and from zero to five for qualitative studies. A score of zero on an item implies low or poor rating on that dimension, or else that the dimension was not adequately documented. Higher scores imply greater methodological robustness.

Table 3. Details of Global Assessment and Evaluation of Quality (GAEQ) scoring

	Dimension	Quantitative studies	Qualitative studies
A	Measures/ data collection tools	Standardised (ie validated) or well-designed measures	Specified and standardised data collection tools (e.g. written topic guides, aide-memoirs etc.)
B	Sample representativeness	Response rate reported	Adequate representativeness of sample relative to analytic dimensions (in sense of cross-section, not statistical representativeness) e.g. not all 'volunteers'; not all one type of person when intervention is delivered to a range)
C	Sample size	Adequate sample size in relation to conclusions drawn	Adequate sample size in relation to conclusions drawn (especially re: sub groups: not less than n=5)
D	Analytic methods	Appropriate statistical methods	Proper data capture methods (tapes, notes) & appropriate and specified methods of analysis (e.g. grounded theory; content analysis; framework analysis; thematic etc)
E	Programme integrity	Programme integrity taken into account in conclusions	*(No qualitative equivalent)*
F	Type of evaluation	External or independent evaluation	External or independent evaluation

Abbreviations

Abbreviations used throughout the grid include the following:

- Include/ing = incl.
- Intervention = interv.
- Programme = prog.
- Population = pop.
- Years = yrs.
- Weeks = wks.
- Hours = hrs.

- Referral = ref.
- Significant = sig.
- Special populations = SP **-** including particular populations of social or policy interest as identified by the Family policy unit.   These include: fathers, foster parents, grandparents, step-parents, low income parents, ethnic minorities, refugees, asylum seekers, travellers, gifted children, children in transitions, children and parents with disabilities, teenage parents, parenting teenagers, children with SEN, parents in prison, drug using parents.

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An asterisk (*) in the first column indicates that further details of the individual programme and its evaluation are provided in the online grid that accompanies this report, accessible at the Policy Research Bureau's website: www.prb.org.uk. When a publication is a research review rather than an individual study, this is indicated in the first column by the word 'review'. All other items are articles, book chapters, or reports referred to within the text of the report.

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