Research Report DFE-RR187

High Need Families Project: Development and piloting a new parenting intervention (The Helping Families Programme) for children with severe and persistent conduct problems.

Final report

Dr Crispin Day, Ms Megan Ellis, Dr Lucy Harris

Department for Education

The Authors

Dr Crispin Day, Assistant Director of Research, National Academy for Parenting Research, King's College, London, Institute of Psychiatry, UK/ Head, Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust

Ms Megan Ellis, Project Co-ordinator, High Need Families Programme, National Academy for Parenting Research, King's College, London, Institute of Psychiatry, UK.

Dr Lucy Harris, Post Doctoral Researcher, High Need Families Programme, National Academy for Parenting Research, King's College, London, Institute of Psychiatry, UK.

In association with

Professor Stephen Scott, Director of the National Academy for Parenting Research, King's College, London, Institute of Psychiatry, UK.

Professor Sharon Dawe, School of Psychology, Griffith University, Mt Gravatt, Queensland, Australia

Dr Paul Harnett, Senior Lecturer, Director of the University of Queensland Psychology Clinic, School of Psychology, University of Queensland, St Lucia, Queensland, Australia

Contents

Acknowledgements

We would like to thank the various project staff for their cooperation with, and support of, the development and piloting of the Helping Families Programme. Thank you also to our colleagues at the National Academy for Parenting Research, King's College, London and the Department of Education for their generous funding.

We would also like to thank Camden Families in Focus & Southwark Youth Offending service, who welcomed us into their teams and helped us to see how we could be best useful at the coalface and supported us to both develop and begin to evaluate the Helping Families Programme.

A special and heartfelt thank you goes to all the families who helped us develop this intervention. Your trust, truth, wisdom and strength to participate in and contribute to the Helping Families Programme are an inspiration and a gift to us and to all parents who love their kids and struggle.

Executive Summary

The High Need Families Project was one of a suite of projects funded by the Department for Education until March 2011.

Using a conceptual map and existing interventions, the Helping Families Programme was developed. The Helping Families Programme is targeted specifically at the small but significant number of families with multiple problems, where chaotic parenting is likely to give rise to disruptive antisocial behaviour. The Helping Families Programme is a manualised intervention, which improves the outcomes of children who live in some of the most complex and disadvantaged families in the UK. Children and families with such difficulties offer significant challenges to service providers and are the least likely to benefit from existing parenting programmes. Multi-stressed, high need families are particularly difficult to engage, retain and treat.

The Helping Families Programme was developed and evaluated through pre-pilot and pilot phases working with a team of clinical researchers based in two inner London services. Following this a mixed method study design was used. A sample of 14 families were exposed to the Helping Families intervention, pre and post measures were taken and 10 completing families participated in a semi structured interview. The results were very positive, with high levels of acceptability and genuine engagement from families who do not typically engage with health, education and social care services willingly. Services collaborating with us have been enthusiastic and have endorsed the ongoing implementation of the Helping Families Programme. With these early positive evaluation results and feedback, further dissemination and a more definitive evaluation are indicated.

This report provides an overview of the phases of the High Need Families Project, drawing together the lessons learned and describing dissemination of the Helping Families Programme to date.

Background

Severe and persistent conduct problems during the middle and later stages of childhood are characterised by frequent and serious non-compliance, aggression, destructiveness and violation of social rules such as lying and bullying. Their severity and persistence is associated with the enduring presence of key child, family and social risk factors (Ferguson et al., 2005), which lead to highly problematic outcomes affecting emotional and social development, family functioning and peer relationships. They have a detrimental effect on academic achievement and increase the risk of school exclusion. As a result, children with severe and persistent conduct problems living in complex family circumstances are exposed to significantly elevated risk of future negative outcomes such as criminal activity, substance misuse and unemployment (Broidy et al., 2003) and are more likely to be responsible for the significant social and economic costs associated with conduct disorder (Scott et al., 2001).

Numerous efficacious interventions are available to both prevent and treat conduct problems as they manifest during childhood through to adolescence (for a review see National Institute for Health and Clinical Excellence, 2006). However, a small but significant group of children and their parents, particularly those with severe and persistent difficulties living in complex family circumstances, do not participate in, or respond as expected to these interventions (Nock & Ferriter, 2005). With the aim of improving outcomes for this group of families, a research collaboration led by the National Academy for Parenting Research (NAPR), UK, and involving the University of Queensland and Griffith University, Brisbane, Australia, has developed an innovative intervention for families with children aged 5 to 11 years old demonstrating severe and complex conduct problems that place them at risk of being excluded from school.

Project Milestones

We have organised this report into four phases which reflect the division of the milestone tasks for the project:

Phase 1- Intervention Development (Oct 2008-Jun 2009)

Phase 2 - Pre-pilot testing (Feb-Jun2009)

Phase 3 - Pilot trial (Jul 2009-Mar 2010)

Phase 4 - Case-control study (Apr 2010 – Mar 2011)

This report details the life of the project from intervention development to the evaluation in service settings. Dissemination was a significant aspect of the project and occurred frequently throughout its duration (Appendix 1). Dissemination included providing feedback on each phase of the project to all stakeholders from service sites to Department of Education. We have also presented to a number of international clinical and research conferences. A paper documenting Phase 1 has been published (Appendix 2) and papers from Phases 3 and 4 are in the process of submission. The learning gained and challenges faced have been discussed where relevant.

Phase 1 Intervention Development

The development of the *Helping Families Programme* has been guided by the Medical Research Council (MRC) framework for the development and evaluation of complex interventions (Campbell et al., 2007). Figure 1 illustrates the framework as applied to the High Need Families project.

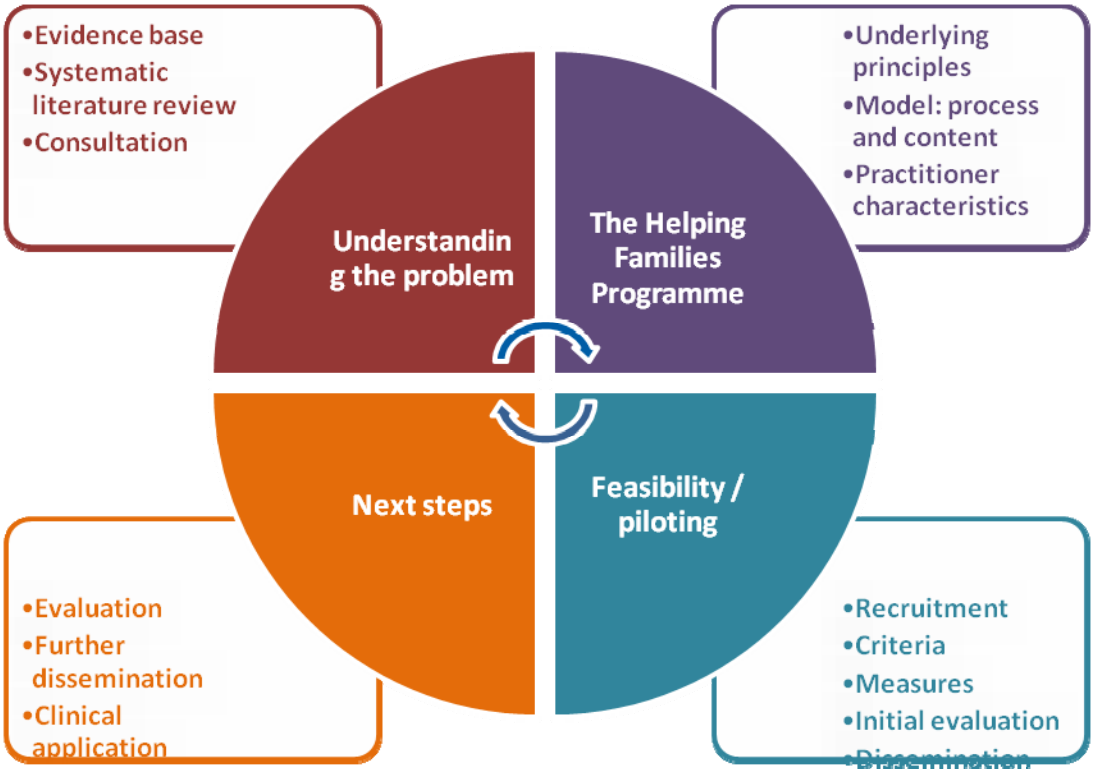


Figure 1 High Need Families Developmental Framework

Systematic Literature Review (see Appendix 1)

Literature searches of *MEDLINE, PsychINFO* and other databases were conducted using key search terms. Combined with further consultation with experts, we developed a thorough and current understanding of:

(i) The pathways that lead to severe and persistent conduct problems/disorder, and factors associated with their persistence and their amenability to change; and

(ii) Effective therapeutic methods used to optimise families' participation and bring about change.

(i) Pathways to severe and persistent problems

Key findings indicate:

- Factors intrinsic to the child or present in the family environment appear to be more influential in moderating outcomes than factors in the wider environment
- No single causal pathway inevitably leads to, nor maintains, severe and persistent conduct problems (Figure 2)
- Persistence associated with enduring presence of key child, family and social risk factors (eg. Ferguson et al., 2005).
- The interplay between factors is dynamic, the outcomes individually determined and difficult to predict (Cicchetti & Toth, 1997).

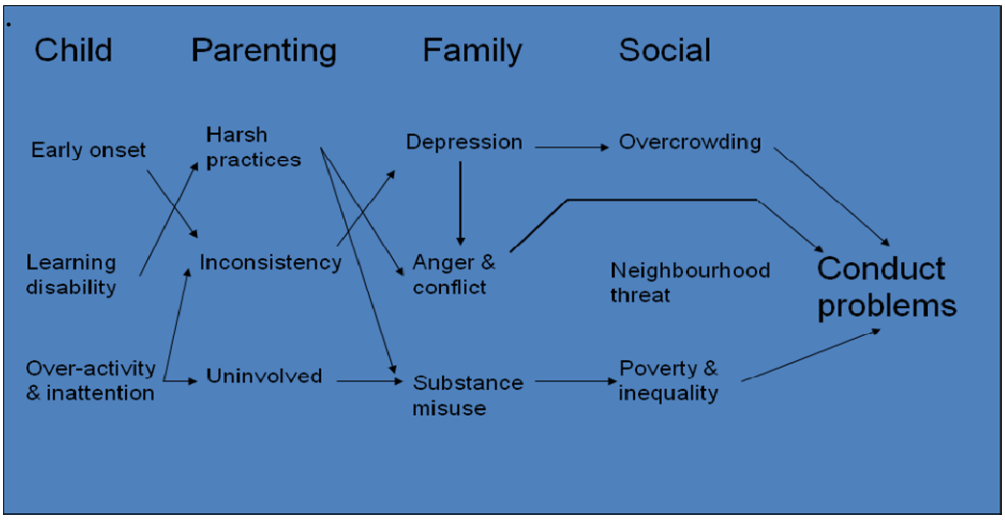


Figure 2 Understanding the causal pathway

Our reviews indicated that effective interventions for children experiencing persistent conduct disorder living in complex circumstances need to:

- Be multimodal in nature
- Address key risk factors
- Be systematically adjusted to the particular circumstances of individual children and families.

(ii) Current evidence on effective interventions

We identified a number of promising manualised approaches for other age groups:

- Parents under Pressure (PUP), Multi-systemic Therapy (MST) and Functional Family Therapy (FFT).
- Individualised and indicated components of the US Fast Track program (Slough et al., 2008) – in addition this is a complex and resource intensive programme
- Group-based Incredible Years (IY) Advanced/Pathfinder programmes – however there is little evidence currently available about its outcomes for parents of older children.

The efficacy of treatments specifically designed for older children with complex and persistent difficulties is not well documented.

Effective Engagement and Change

Literature in this area indicated:

- Key risk and protective factors not only have a fundamental impact on children's behavioural difficulties but also parents' ability to affect change, particularly due to the detrimental effect certain risk factors can have on parental engagement and participation (Nock & Ferriter, 2005).
- Some risk factors are not amenable to change through psychological interventions such as, socioeconomic status and poor living conditions.
- Others barriers are potentially changeable, for example, access, treatment expectancies, intervention format and the quality of the therapeutic alliance (Lundahl, Risser & Lovejoy, 2006).
- The quality of the therapeutic alliance is particularly important as many families with complex psychosocial difficulties often feel highly suspicious of, and alienated from, services and practitioners (Barlow et al., 2005).

We concluded that programmes aiming to work with potentially alienated and disaffected families need to incorporate *explicit* models for developing and maintaining effective relationships with marginalised families, such as the Family Partnership Model (Davis & Day 2010).

Developing the Helping Families Programme (Appendix 3)

As a result of the systematic literature review and consultation processes the research collaboration agreed that the Helping Families Programme should seek to:

(i) Address the complex multi-determination of severe conduct problems and associated problems in school attendance

(ii) Reduce, or at least stabilise, the compounding influence of specific risk factors

(iii) Reinforce the presence of specific protective factors.

Developing a better understanding of the problem also facilitated a clear specification of both the population for which the Programme was to be initially aimed (see Box 1) and a set of evidence based principles underpinning the Programme.

Box 1: Criteria for the Helping Families Programme

Inclusion criteria

- Child aged 5-11 years, with severe conduct disorder, at risk/currently school excluded.
- Child lives with participant parent.
- Family is subjected to at least one of the following risk factors:
  - Harmful substance use
  - Lack of satisfying and pleasurable activities with child/family
  - Inability to maintain a tolerant, stable and regulated mood
  - Lack of supportive family/social networks
  - Frequent family crises and events.

Exclusion criteria:

- Principal presenting problem of sexual abuse, pervasive developmental disorder or severe mental disability.
- Acute parental mental illness.
- Insufficient parental spoken English.
- Consent for school attendance records refused.

The Helping Families Programme aims to help multi-stressed parents to address their children's immediate behavioural and school attendance difficulties and in doing so help parents to bring up their children safely, lovingly and with confidence that they are doing the best by their children. The Helping Families Programme is based on a clear set of principles, and is based on an explicit model of the intervention process (Davis & Day 2010); it uses a clear range of strategies for helping families to achieve their desired goals. Parents' behaviour, cognition and emotional regulation are the direct targets of the intervention.

A snapshot of the Helping Families Programme in practice:

- An intensive 20 session (possibility of multiple contact per week) programme delivered over a maximum of 6 months
- Assertive and proactive outreach – Reaching Out
- Individualised, working in partnership with the family
- Addresses risk factors inhibiting effective parenting
- Goal driven, strengths-based, future-focused
- Supports change in the context of chaotic family environments
- Empowers parents to help themselves and look after their families
- Parent tool kit to help parents sustain changes

The Helping Families Programme is organised into core practice modules and intervention modules (see Figure 3).

Figure 3: Helping Families Core Practice and Intervention Modules

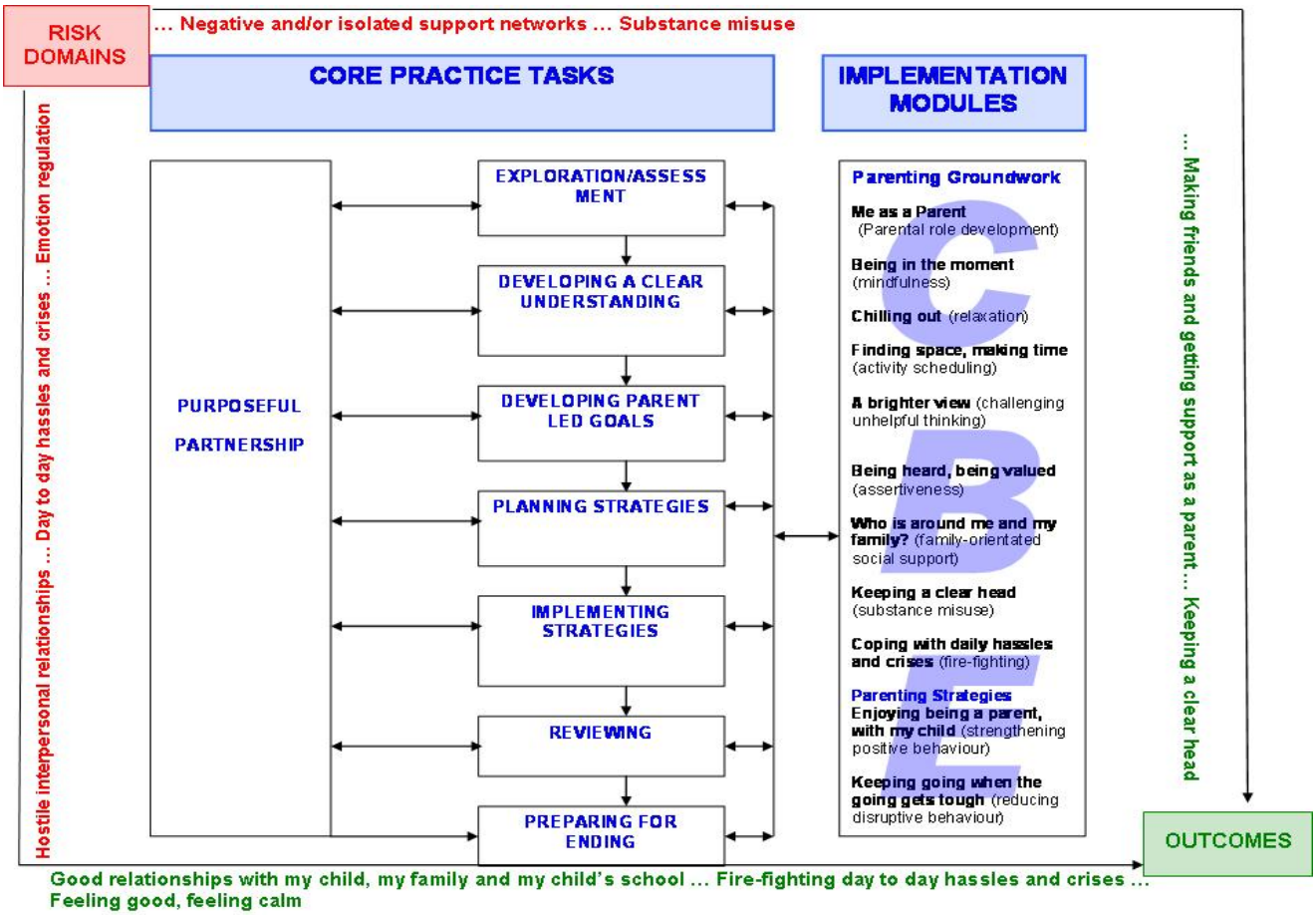


Figure 3: The Helping Families Programme model

The content and methods of the core practice and intervention modules is multimodal and uses a range of evidence-based strategies and techniques, derived from cognitive, behavioural, social learning, relational, attachment and systems theories to develop individualised implementation plans, that are structured but non-sequential

(Dawe & Harnett, 2007), accommodating the complexity and individual variation in families' needs and allowing for additional problems to be addressed as they emerge during the course of the intervention.

The core practice module requires practitioners to continually demonstrate an explicit set of characteristics (Day, Ellis et al 2010) and procedures to engage and maintain goal-orientated partnerships with parents(Davis & Day 2010)

Helping Families Programme Core Practice Modules:

- Building a Purposeful Partnership Relationship and Making First Contact
- Exploring and Assessing
- Developing a Clear Understanding with Parents
- Developing Parent Led Goals
- Planning Strategies and Implementation
- Reviewing the Goals and the Relationship

Helping Families Programme Implementation Modules:

The strategy modules that follow form the basis by which the goals and outcomes of the Helping Families Programme are achieved. The strategy modules improve outcomes across 5 key risk domain areas, not all of which will be relevant to each family. Parents' behaviour, cognition and emotional regulation are the direct targets of the intervention. The Programme's intervention modules (see Figure 3) focus on specific risk and resilience factors that will increase parents' capacity to:

1. Increase positive relationships and conflict management skills
2. Increase skills to maintain a tolerant, stable and regulated mood
3. Increase positive and supportive family and social networks
4. Reduce harmful substance use
5. Increase adaptive instrumental and emotional coping

The five risk factors outlined above are addressed through the structured yet non-sequential use of both parenting groundwork and parenting strategies (see implementation modules in Figure 3). The implementation modules offered within the Helping Families Programme are summarised below

The strategies are organised into Parenting Groundwork & Parenting Strategies, a menu is developed with the parents to address their goals to reduce their risk factors and increase their family resilience:

A) Parenting Groundwork (Cognitive, emotional & behavioural strategies to address parent risk factors)

1. Constructs of self as a parent & child (The parent I want to be)
2. Mindfulness (Being in the Moment)
3. Relaxation (Chilling Out)
4. Activity Scheduling (Finding Space/ Making Time)
5. Challenging Unhelpful thinking (A Brighter view…)
6. Assertiveness (Being heard, being valued)
7. Family Orientated Social Support (Who's around me and my family)
8. Substance Misuse (Keeping a Clear Head)
9. Instrumental & Emotional Coping (Fire Fighting –managing daily crises and hassles)

B) Parenting Strategies (Evidence based grounded in social learning theory)

1. Strengthening Positive Behaviour (Enjoying being a parent with my child)

(e.g. child centred play, connecting with your child, modelling, praise.)

2. Reducing Disruptive Behaviour (Keeping going when the going gets tough)

(e.g. punishment vs. discipline, giving clear instructions, setting limits…)

Practitioners and parents agree on goals for treatment and then formulate a strategy plan based on the equation: ***OUTCOME*** = *Goal x (A1+A2-9)) + (B1+B2)* this is then implemented over the course of the programme.

Intervention materials: Practitioner manual - principles and core references, core practice and strategy content (including practice guides, tools and communicators) and a parent workbook

Outcomes for Families

- Reduced frequency and severity of child conduct problems
- Improvement in parents' reports of their ability to monitor, regulate and control their emotions
- Reduction in parents' negative beliefs
- Improvement in parenting behaviours and access to universal parenting resources e.g. parenting programmes
- Improved school attendance

Phase 2 – Pre-pilot testing

Consultation (Appendix 4)

From March to September 2009 a consultation and liaison commenced. Department for Children Schools and Families(DCSF) confirmed a fit between Family Intervention Projects (FIP's) and High Need Families Project and provided guidance and introduction to potential FIP sites:

- Five FIP's were identified by DCSF for potential consultation – all of whom were sent a brief overview of the High Need Families project calling for interest was sent to potential FIP's between January and March 2009.

- A series of scoping meetings commenced with 4 of the 5 FIP's- Newham, Stoke on Trent, Southwark and Camden.

- Southwark Youth Offending Service and Camden Families In Focus agreed to collaborate. They agreed to act as a source of referrals, to nominate interested FIP practitioners to co-work with a Helping Families Programme (HFP) practitioner, to use the HFP as part of the FIP toolkit, and to receive supervision from Project Lead.

- Stoke and Newham were enthusiastic about the intervention and wanted to use the HFP with training and supervision, however a sustainable working model was not established due to resource limitations. Both sites were sent draft manuals and agreed to provide feedback to the project team – this was not received.

- We consulted with the DCSF to identify potential additional FIPs to collaborate with manual development. Unfortunately this was not possible and additional FIP's were not recommended to project.

- Discussions with London School of Economics commenced, followed by the development of the CSRI-adapted (Appendix 5).

Identifying and developing the processes and procedures required to undertake the pilot study occurred simultaneously with consultation. This included the assimilation of site personnel and project practitioners' feedback, ensuring that both were fully equipped to carry out the piloting of the intervention and appropriate use of the associated materials. The processes undertaken and procedures developed are as follows:

- Protocol completed and Risk Indices developed (Appendices 6 and 7).
- Ethics application completed and approved following two rounds of amendments (Appendix 8).
- Clinical Researchers recruited and training provided. This involved individual 'apprentice training' following orientation to the manual and tools as well as training in the research processes such as recruitment and the administration of measures, once practitioners felt competent with both the manual and research processes they were imbedded in pilot sites.
- Research recruitment processes developed and training provided
- Practitioner Information Packs developed and distributed to sites (Appendix 9)
- Clinical Researchers, once settled at the pilot sites, commenced recruitment into the pilot, co-working with site practitioners. The identification of families' proved difficult; practitioners at both sites could identify families but there were several exclusion criteria that made them unsuitable. To illustrate, the majority of FIP families had older children, but both practitioners and families repeatedly requested the intervention be delivered to these families. Recruitment issues were resolved when for suitable families were recruited through wider services in the teams, (Southwark referred from the Early Intervention team and Camden from the wider Families In Focus team).

Manual development and implementation (Appendix 10)

The intervention manual, associated materials and their implementation were considered to be 'in development' throughout the life of the project, consistent with the MRC framework's principle of continuum of increasing evidence, ensured that feedback from practitioners and families was discussed and incorporated into the manual and associated materials, establishing a feedback and review process that was to see the intervention develop extensively.

Key developments in Phase 2 included:

- Feedback from HFP practitioners and site practitioners indicated a review of the language used, to ensure the manual was culturally appropriate.
- An intervention fidelity review was undertaken which informed the development of fidelity tools for use in practice and supervision (Appendix 11).
- Manual restructure and re-formatting commenced as a result of feedback from sites and practitioners providing feedback that density and size were cumbersome. Additionally it was identified that tools e.g. Goal Star (Appendix 5) were required to assist practitioner implementation. Work commenced and continued over the next twelve months.
- Strategy modules were analysed and development commenced to ensure the cognitive, behavioural and emotional aspects of parenting were attended to.

Phase 3 - Pilot trial

A team of 3.5wte Clinical Researchers were recruited and trained to pilot the Programme with a case series of 15 families in action research. The team of Clinical Researchers successfully embedded itself within two services, the Southwark Youth Offending and Camden Families in Focus. Practitioners within these services continued to offer routine support alongside the Programme. As the pilot progressed, these services increasingly endorsed the value of the Programme's manualised approach. Below is an overview of the pilot methodology:

- 15 children and their families were recruited in Southwark and Camden. Suitable families were identified by the Youth offending Team and Camden Families in Focus.
- Children in the families were aged 5 -11 with severe conduct problems, at risk of or currently excluded from school. Families were chaotic with at least one severe risk factor (substance misuse, frequent family crises, inability to maintain a stable and regulated mood, interpersonal conflict with the child, close family or school)
- Data collection began in June 2009 (Appendix 12). Standard pre and post measures for conduct disorders and parenting were used (Parent Report Versions of the Strengths and Difficulties Questionnaire and, Alabama Parenting Questionnaire, school attendance records). Data was collected at the start, week 10 and week 20. All parents were consented to participate in a semi-structured interview post intervention.
- Data was collected throughout on Goal Achievement, Family wellbeing and parent/ practitioner relationship.

The international ratio of positive outcomes with multi-stressed families is 1/3 get better, 1/3 stay the same and 1/3 get worse. Of the 15 recruited, within the first 2-4 weeks, 1 family had the target child removed by social services, 1 family with 2 target children moved out of London, 1 family with 2 children did not meet the criteria this was not evident at the time of recruitment, 2 families dropped out within the first 4 weeks of starting the programme. Of the 8 remaining families all

remained engaged in the programme, 5 children and their parents had clinically significant changes, 62% of the completing families almost double what would be expected when working with multi-stressed families.

Key findings

Below is a summary of our findings from Phase 3:

- Multistressed families are notoriously difficult to engage and sustain in a programme requiring step by step disciplined change. Normally their attendance and participation in interventions is very poor and hence successful outcomes are limited. This attendance pattern is in stark contrast with what was achieved in the pilot - the worst family had 4 cancellations and 1 did not attend in 20 weeks.
- Engagement was authentic and sustained, after the initial 4 weeks no other families dropped out. To achieve this the Helping Families practitioner had to consistently and continuously demonstrate a specific set of characteristics, in at times incredibly stressful and chaotic circumstances in the community, where both parents, children and other family members were highly aroused or in crisis. These characteristics included genuine respect, humility about what HFP could achieve strength and integrity, intellectual and emotional attunement, resolute and quiet enthusiasm, technical expertise and high levels communication skills in particular listening.
- All parents consistently rated the relationship with their Helping Families Programme very highly.
- The manualised approach was found to be accessible and acceptable to both the families and the practitioners
- Overall as goals were achieved, small and broader core goals, parents reported an improvement in their overall sense of wellbeing.
- There were significant improvements for all families in the goal achievement, an example of the improvements see chart below:

Goals	How close I am to my goals at the beginning of HFP	Following the completion of HFP
To manage my mood so that I can parent my children more consistently	40%	91%
To get my child back into school 5 days a week	61%	91%
To be calm when people are rude out and about	7%	97%
To have a positive relationship with my child	16%	53%

- All families except 1 showed an improvement in terms of risk on the Strengths and Difficulties Questionnaire.
- Alabama Parenting Questionnaire scores showed improvement across the board.
- A paper reporting the findings from this phase is currently in the process of submission

A case example

The following example provides a summary of a typical family who would participate in the Helping Families Programme. The 2 boys both had the highest SDQ scores possible at commencement of the intervention in the pilot. For more detail about this family and their progress through the Helping Families Programme please see the Case Study presentation attached. All names have been anonymised.

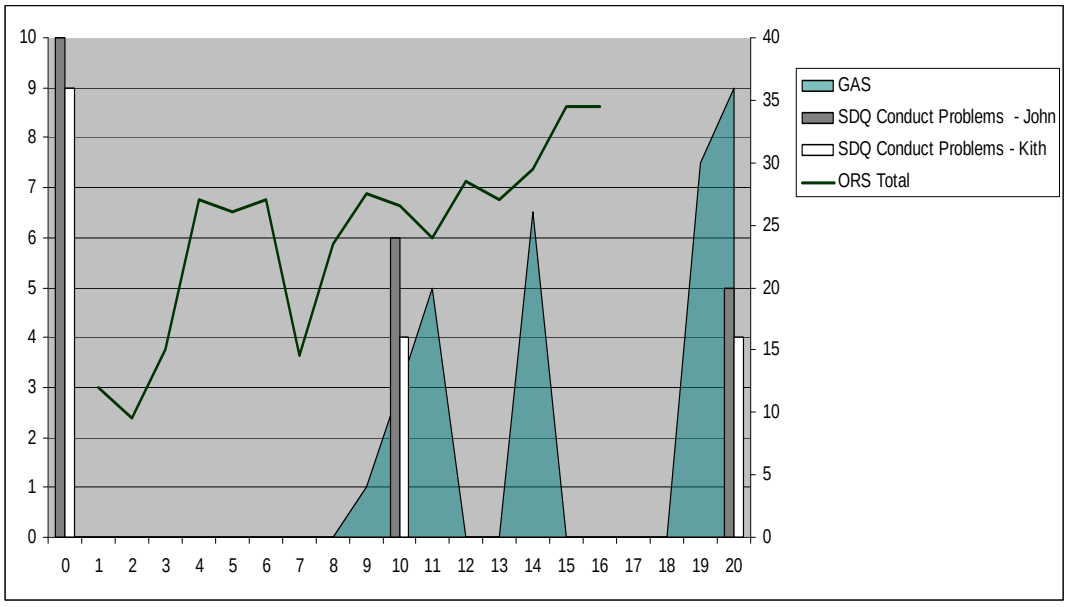
The Matthews Family: Sue (Mum, 46 years), Caine (Dad, 63 years) and their sons John (9 years), Kith (11 years), Keate (14 years), James (16 years). The target children were John & Kith.

- **Home & Community** - the boys were fighting every day, they were threatening each other with weapons (knives) and fire lighting both inside the house and on the estate where they lived. They were disrespectful towards their parents, used abusive language and were defiant. They stole from the home and regularly absconded without parental permission. The parents were separated but cohabiting in a small flat with the estranged father sleeping on the couch. The relationship had been violent and continued to be acrimonious.
- **School** - John had received a three-day exclusion for stealing a teacher's phone and had one internal exclusion (that was reported). John was generally disruptive,

goading other pupils, he was inattentive during class, showed spontaneous unprovoked behaviour (kicking chair), poor literacy and was awaiting an ADHD assessment. Kith had not received any exclusions (that were reported) but was involved in three incidents of bullying a vulnerable child and was regularly involved in minor behavioural incidents in the class and playground.

- **Parent/s** - Sue reported that 'so many people had been to help the family but there'd been no change'. Sue described feeling hopeless and depressed and unable to parent her children. Both parents described them as being out of control and neither parent thought there was anything that could be done. Sue had previously attended two parenting groups. Although she reported finding some aspects of this helpful she struggled to maintain the implementation of strategies.
- **Post HFP intervention** - Kith and John's school attendance was **100%** two months after completing HFP intervention. Police checks undertaken by the FIP Manager on 12.10.10 indicated that neither boy had come to police notice since closure. Nor had there been any reported incidents of antisocial behaviour at the family address.

The chart below provides a more detailed overview of the measures collected from the Matthews family. This shows how the different aspects of the Programme interrelate to produce positive outcomes for both the parents and their children.



- The chart shows that as the weeks progressed Sue's (Mum) scores on the Outcome Rating Scale increased. This is a weekly measure charting overall, individual, interpersonal and social well-being.
- The turquoise indicates that as the weeks progressed Sue rated herself as closer to reaching her identified goal of 'managing her mood so that she can parent her children more consistently'.
- Both John and Kith's SDQ Conduct Problems scores reduced over the 20 weeks.

The chart shows that as Sue's overall sense of well-being increased as did her perception that she was able to parent more effectively and achieve her goal. There appears to be a positive impact of parental well-being on her ability to parent effectively and, as can be seen above, this led to an increase in prosocial behaviour and a decrease in antisocial behaviour in the two boys.

All parents were interviewed following their completion of the intervention again Sue is representative of what parents said.

"The Helping Families Programme) does make a difference to me and a lot to my family, especially my kids and their behaviour. It helped me a lot. It helped me how to calm down, helped me with the depression, helped me to set boundaries for them and helped me how to cope with some of the behaviour and not to give up in certain situations cause you know it really gets to you and you want to give up"

"When I first started I thought „oh no, this is gonna be the same. I've done the family programme before so I thought it was all about children „cause lots of the family programmes are about what to do with the children… but with Jess it was more like with me."

"I can remember when Jess started the kids were controlling me instead of me controlling them and it's like they were all doing what they wanted to do instead of me telling them what to do, so I take back control now… before I used to give up and didn't want to have trouble."

"It was very difficult to do these things, very difficult, she (Jess) was sticking in there and she didn't give up"

Learning to inform Phase 4

- Families who meet the criteria to receive the Helping Families Programme have been involved with multiple services over long periods of time, with little or no effect. E.g. One family had 28 workers involved across 14 agencies. Therefore service use and involvement data to be collected in next phase.
- The Helping Families Programme practitioner actively collaborated and worked alongside all agencies in the professional network, which was attributed to reductions in child protection concerns as reported by social care.
- The planned 2-3 contacts per week to facilitate engagement and change was neither always necessary, nor acceptable for families at the early stages of engagement. One or less of face to face contact per week plus active multi-agency working, text and email contact was more helpful to facilitate engagement and change
- It is difficult to maintain focus and a methodical approach with chaotic, multi problem, crises driven families. The process of 'Fire-fighting' was central to building stability and to facilitate the tasks of the helping families process and increase instrumental and emotional coping with families.
- The development of a process to establish 'Quick wins' (the rapid achievement of small manageable goals) is essential to assess the families readiness to both engage in the Helping Families Programme and instil hope for change.
- It was helpful to use an example parent folder to assist parents to engage in the programme.
- Materials and tools used with parents were more accessible when these incorporated visual aids and activities.
- Fidelity tools were effective in facilitating practice reflection and structuring the supervision conversations. This was essential in enabling practitioners to work with families in persistently chaotic and stressful environments, while maintaining fidelity to the programme and retaining hope and integrity for the work being undertaken.
- Clinical Researchers provided feedback that they required more guidance in relation to recruitment and the use of evaluation measures. Therefore the research process was refined and a researcher resource pack was developed (Appendices 13 and 5)

Phase 4 – Case control study

Original Phase 4 Plan

Phase 4 involved a number of hypotheses as described in the protocol and ethics application (Appendix 14 and 15). Using a quasi-experimental design in which outcomes of a group of children (n=15) whose parents are receiving the Helping Families Programme (intervention group) would be compared with those of a group of similar children (n=15) whose parents were receiving routine intervention and care (comparison group). The sample size was nominated as it was considered appropriate to conduct a feasibility pilot.

Participants in the Intervention group were recruited from Southwark Youth Offending Service and Camden Families in Focus and associated services. Several similarly operated services in London were identified as potential comparison sites.

Revised Phase 4

14 families were recruited to the intervention group of the case control study. However, significant challenges were faced by the team.

For various personal reasons the entire clinical research team left the project at the beginning of Phase 4. This posed several challenges and ethical issues:

1. Retaining participants in the study was extremely difficult as we were not able to provide information about when they would receive the programme and by whom. This was a challenge particularly with these families due to the engagement issues highlighted earlier.
2. There were significant recruitment issues requiring several rounds of advertising and human resource processing.
3. Recruitment and training in the clinical intervention and the research functions of the post was required for three new members of staff. This was a staggered process as recruitment and notice dates occurred at different time points over seven months
4. This disruption had significant implications on the ability to develop networks to with potential from which the control group could be recruited.

5. Preliminary conversations and correspondence that did occur did not result in any sites willing to participate. There were two main reasons for this, firstly services approached said that there were no established referral pathways for primary school aged children. Secondly, for those children that did meet the criteria , services were reluctant to provide referrals when the families would not receive the intervention due to the high needs of the sample population.

A decision was taken to manage these challenges internally and continue to work with the sites where we had well established referral pathways and good relationships and apply the rigorous frame and measurements that had been developed from the piloting with a single case series, only consisting of families receiving the intervention.

Using our learning from Phase 3 a number of research procedures, processes and pathways were refined. These included Recruitment for the Research Clinicians and the site practitioners (Appendices 13 and 5). A number of educational and promotional materials were developed to assist with both the research and the understanding and dissemination of the Helping Families Programme. These included an updated practitioner information pack, guidance on explaining the intervention to other professionals and agencies and a promotional leaflet (Appendices 16, 17 and 18).

Quantitative and qualitative results for 10 families who completed the Helping Families Programme, and for whom we have pre and post intervention data, are presented below. We do not have post intervention data for 4 families who did not complete. They all engaged with practitioners but were unable to make time and space (both practically and psychologically) to actively engage with the work required of them during the Helping Families Programme. In all cases, ending the work early was negotiated between and agreed by practitioners and parents. Below is a summary of the quantitative and qualitative data for the 10 completing families.

Quantitative results

A range of standardised measures were administered to participating parents and the identified child's teacher. See the table below for descriptions of the measures used:

Measure	Description
Strengths & Difficulties Questionnaire (SDQ) (Goodman *et al.*, 1998)	The SDQ is a behavioural screening questionnaire. We report on the Child Conduct Problems subscale of the SDQ.
Behaviour for Learning Questionnaire (BfL) (Day, unpublished)	The BfL is a measure of a child's behaviour at school, in relation to learning. We report total scores, comprised of the following subscales: managing feelings and behaviours, motivation and educational achievement, social skills, attendance, and home-school relationship.
Adapted Goal Attainment Scale (GAS) (Day & Ellis, unpublished)	The GAS is a visual analogue scale used to rate parent goal attainment in relation to the parenting risk factor/s identified as the focus of the intervention.
Overall Rating Scale (ORS) (Miller *et al.*, 2003)	The ORS is a visual analogue scale that measures parent wellbeing across four areas: overall, individual, interpersonal and social wellbeing.
Session Rating Scale (SRS) (Duncan *et al.*, 2003)	The SRS is a visual analogue scale measuring session and parent-practitioner relationship quality across four areas: relationship, goals and topics, approach or method and overall satisfaction.

Key findings

The key findings from Phase 3 are as follows:

- 80% of parents and 70% of teachers reported improvements in their child's conduct problems.
- 100% of parents and 80% of teachers reported improvements in their child's skills and behaviour at school.
- 100% of participating parents reported that their overall wellbeing and their goal achievement improved over the course of the intervention.
- 90% of parents reported a consistently high or improved partnership relationship with their practitioner.
- Levels of engagement were high, given the multi-stressed contexts families were operating in. None of the parents failed to attend a session without prior arrangement.

The graphs below show the pre and post results for the 10 completing families for each research measure:

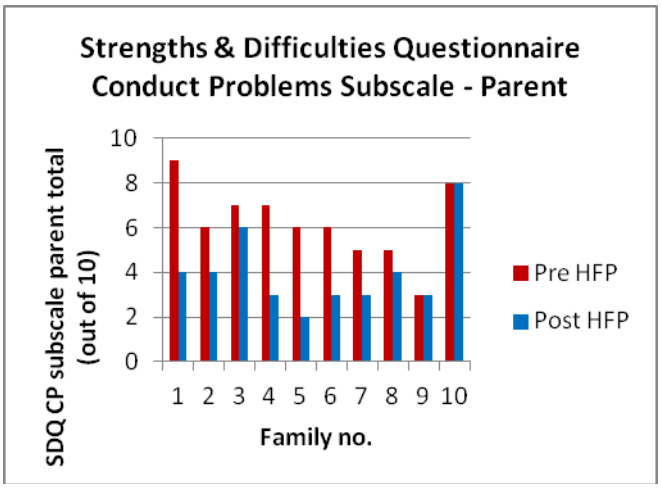


Figure 4: Pre and post intervention scores from the parent-rated SDQ Conduct Problems subscale for the 10 completing families

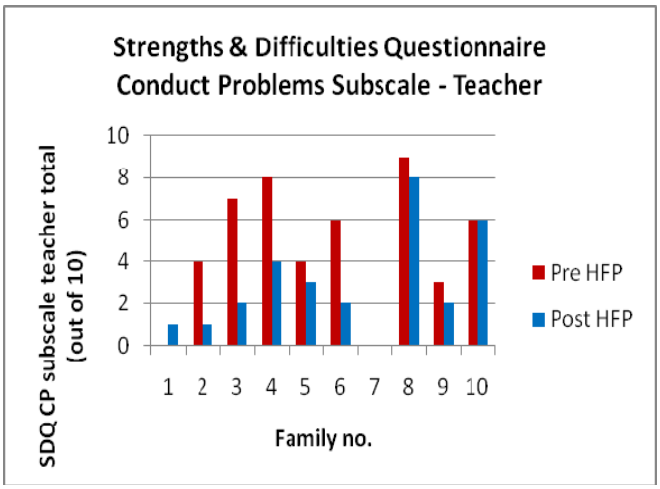


Figure 5: Pre and post intervention scores from the teacher-rated SDQ Conduct Problems subscale for the 10 completing families

Figures 4 and 5 show that 80% of parents and 70% of teachers reported improvements in child conduct problems over the course of the Helping Families Programme.

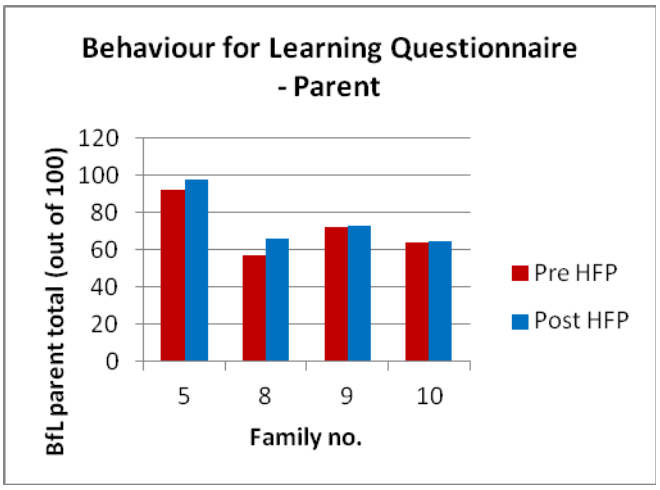


Figure 6: Pre and post intervention scores from the parent-rated BfL for 4 of the 10 completing families (the BfL was not originally administered to parents)

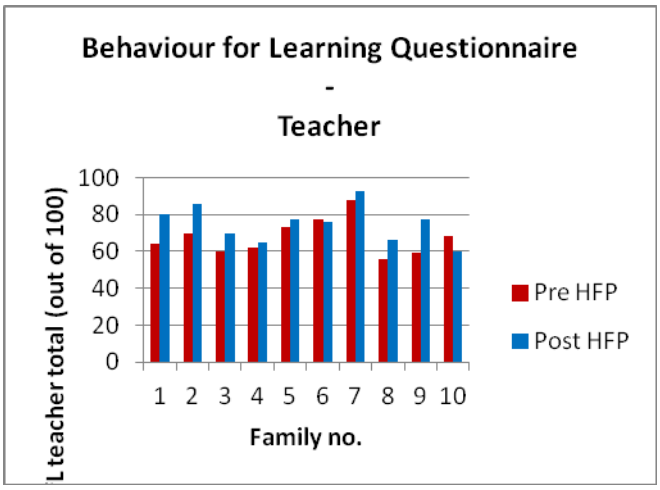


Figure 7: Pre and post intervention scores from the teacher-rated BfL for the 10 completing families

Figures 6 and 7 show that, where administered, 100% of parents and 80% of teachers reported improvements in their child's skills and behaviour at school.

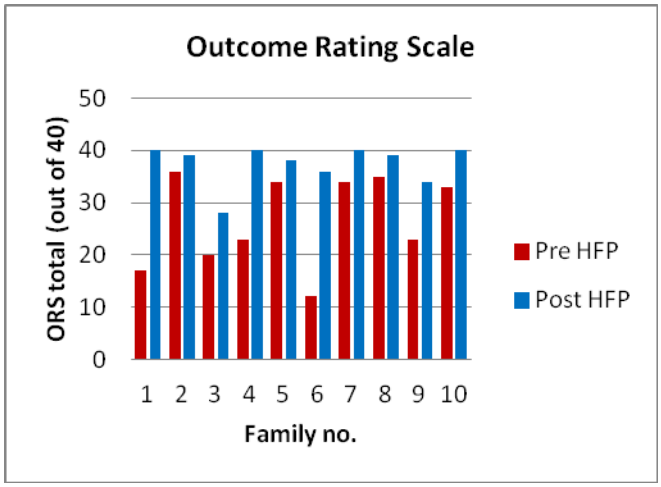


Figure 8: Pre and post intervention scores from the parent-rated ORS for the 10 completing families

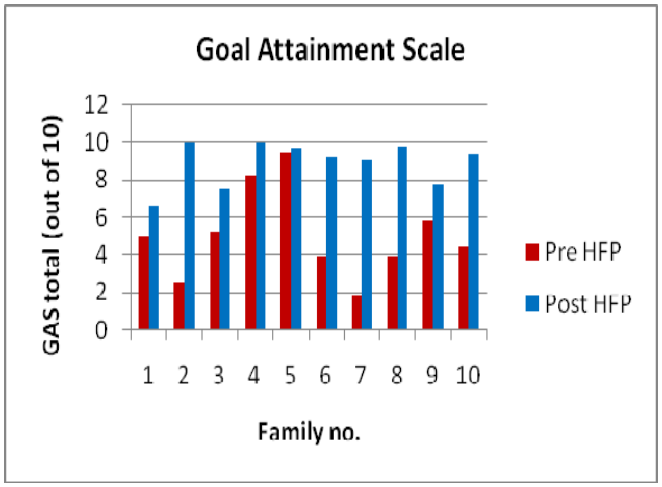


Figure 9: Pre and post intervention scores from the parent-rated GAS for the 10 completing families

Figure 8 shows 100% of participating parents reported that their overall wellbeing increased over the course of the intervention.

Figure 9 shows 100% of parents reported improvements in their intervention goal achievement over the course of the intervention.

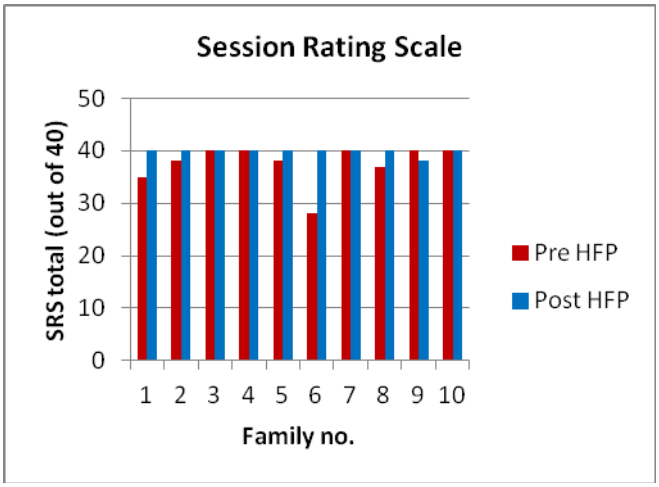


Figure 10: Pre and post intervention scores from the parent-rated SRS for the 10 completing families

Figure 10 shows 90% of parents reported a consistently high or improved partnership relationship with their practitioner.

Clinical activity and service use data

Clinical activity data:

- The total number of pre-arranged cancellations over the course of a parent's engagement with the Helping Families Programme ranged from 1 to 16
- None of the participating parents failed to attend a session without prior arrangement

Service use:
The Client Service Receipt Inventory (CSRI; Beecham and Knapp, 2001) was used to evaluate family service use pre and post the Helping Families Programme (Stevens *et al.*, 2011). Findings are tentative but suggest that:

- The mean costs of service use was similar at baseline and follow-up
- There is an indication of change in the types of services used at follow-up
- There is tentative yet initial support for a shift to potentially more effective and preventative services e.g. findings show a higher use of school-based support and lower use of social workers' time

Qualitative results

All participating parents volunteered to take part in a semi-structured evaluative interview (Appendix 19) at the end of the Helping Families Programme, these are yet to be analysed.

Below is a selection of comments from these interviews:

"Hope started after I saw little changes start to happen … is this the same child?!"
"You feel as though the practitioners are still there for you even though they're not physically there."
"The most important thing is being listened to. If you listen to the parent about their child then the strategies will work."
"I am much calmer around C. "I don't go C! [scream his name] as soon as there is a fight."
"In the beginning I thought he was the devil child, turned into a demon. I couldn't stand him. If social services came to take him I'd go 'yeah, take him' … I couldn't be bothered with L [child]. Now we have a better love and we are more connected."

Feedback

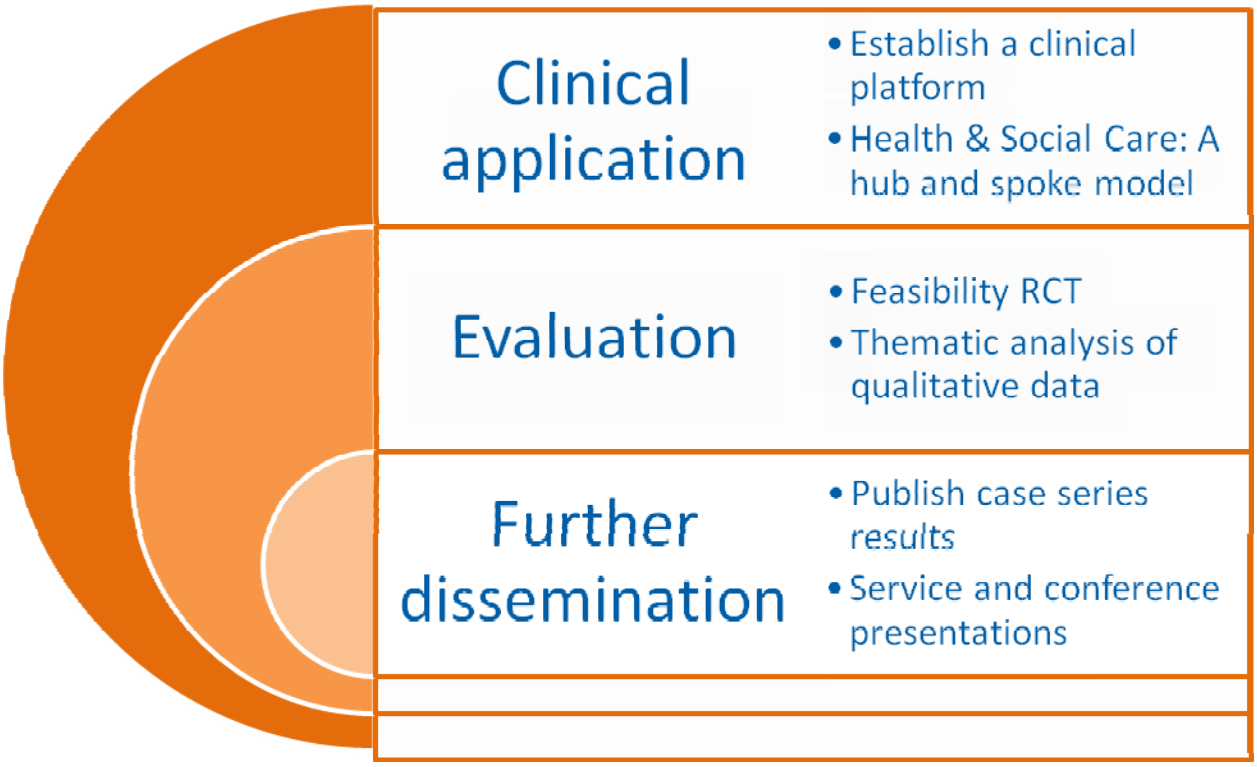
Consistent with principles of the Helping Families Programme, processes were developed to ensure all families, the professionals involved in their care, the service sites and the schools were provided with feedback that was collated in partnership with the families about progress through the intervention and outcomes achieved. Appendices 20, 21 and 22 provide examples of the documents developed to facilitate feedback. These include case summaries, school feedback and clinical site summaries of participant families.

Summary

The data presented above provides initial positive support for the effectiveness of the innovative, systematic intervention provided by the Helping Families Programme. In standard interventions with complex families 33% improve with 66% staying the same or deteriorating. Preliminary findings indicate that in the Helping Families Programme 70-100% of parents and teachers show improvements in children's behaviour, emotional wellbeing, parents goals and over all sense of well-being. We also demonstrated very high levels of genuine engagement and retention with zero parents

failing to attend appointments arranged in their home or where they chose over a 6 month period.

Next Steps



As indicated above we are in negotiation with commissioners to provide the Helping Families Programme as part of their suite of services offered. We have prepared a further research proposal to conduct a cohort study to build the evidence base for this programme and continue to make a fundamental difference to child and family outcomes.

Bibliography

Al-Halabi, D. S., Secades-Villa, R., Perez, J. M., et al (2006) Family predictors of parent participation in an adolescent drug abuse prevention program. Drug & Alcohol Review, 25, 327-331.

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (4th edn). Washington DC: American Psychiatric Association.

Armbruster, P. & Kazdin, A. E. (1994) Attrition in child psychotherapy. Advances in Clinical Child Psychology, 16, 81-108.

Baer, J., Ball, S., Campbell, B., et al (2007) Training and fidelity monitoring of behavioral interventions in multi-site addictions research. Drug and Alcohol Dependence, 87, 107-118.

Barber, J., Sharpless, B., Klostermann, S., et al (2007) Assessing intervention competence and its relation to therapy outcome: a selected review dervied from the outcome literature. Professional Psychology: Research and Practice, 38, 493-500.

Barber, J. P., Mercer, D., Krakauer, I., et al (1996) Development of an adherence/competence rating scale for individual drug counseling. Drug and Alcohol Dependence, 43, 125-132.

Belsky, J. (1984) The determinants of parenting: a process model. Child Development, 55, 83-96.

Bronfenbrenner, U. (1979) The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press.

Browne, A. & Finkelhor, D. (1986) Initial and long-term effects: A review of the research. In A sourcebook on child sexual abuse (ed D. Finkelhor), pp. 143-179. London: Sage.

Campbell, N., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths., F., Guthrie, B., Lester, H., Wilson., P., Kinmonth, A.L. (2007). Designing and evaluating complex interventions to improve health care. British Medical Journal, 334, 445-459

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A.L., Sandercock, P., Spiegelhalter, D., et al. (2000). Framework for the design and evaluation of complex interventions to improve health. British Medical Journal, 321, 694-6.

Capaldi, D. & Patterson, G. R. (1987) An approach to the problem of recruitment and retention rates for longitudinal research: Behavioral Assessment Vol 9(2) Spr 1987, 169-177.

Castonguay, L., Goldfried, M., Goldfried, M., et al (1996) Predicting outcome in cognitive therapy for depression: A comparison of unique and common factors. Journal of Consulting and Clinical Psychology, 64, 497-504.

Chamberlain, P. & Patterson, G. (1995) Discipline and child compliance in parenting. In Handbook of parenting: Applied and practical parenting (ed M. H. Bornstein). Mahwah, N.J: Lawrence Erlbaum Associates.

Cicchetti, D. (1989) How research on child maltreatment has informed the study of child development: Perspectives from developmental psychopathology. New York, NY: Cambridge University Press.

Barlow J, Kirkpatrick S, Stewart-Brown S, Davis H (2005) 'Hard-to-reach or out-of-reach? Reasons why women refuse to take part in early interventions.', Children And Society, 19 (3), 199 - 210

Broidy, L.M., Nagin, D.S., Tremblay, R.E., et al. (2003). Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: a six-site, cross-national study. Developmental Psychology, 39(2), 222-45.

Cicchetti, D. & Rizley, R. (1981) Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. New Directions for Child Development, 11, 31-55.

Cicchetti, D. & Toth, S. L. (1995) A developmental psychopathology perspective on child abuse and neglect. Journal of American Academy of Child & Adolescent Psychiatry.

---- (1997) Transactional ecological systems in developmental psychopathology. New York, NY: Cambridge University Press.

Claussen, A. H. & Crittenden, P. M. (1991) Physical and psychological maltreatment: Relations among types of maltreatment. Child Abuse & Neglect, 15, 5-18.

Conger, K. J., Rueter, M. A. & Conger, R. D. (2000) The role of economic pressure in the lives of parents and their adolescents: The family stress model. In Negotiating adolescence in times of social change (ed L. J. C. R. K. Silbereisen), pp. 201-223. New York: Cambridge University Press.

Connell, A. M., Dishion, T. J., Connell, A. M., et al (2008) Reducing depression among at-risk early adolescents: three-year effects of a family-centered intervention embedded within schools. Journal of Family Psychology, 22, 574-585.

Davis, H &, Day, C.(2010). *Working in Partnership: The Family Partnership Model.* London: Pearsons

Dawe, S., & Harnett, P. H. (2007). Improving family functioning in methadone maintained families: results from a randomised controlled trial. Journal of Substance Abuse Treatment, 32, 381-390.

Day, C., Kowalenko, S., Ellis, M., Dawe, S., Harnett, P. & Scott, S. (2011). The Helping Families Programme: a new parenting intervention for children with severe and persistent conduct problems. Child and Adolescent Mental Health, 16, 167-171.

Dobson, K. & Singer, A. (2005) Definitional and Practical Issues in the Assessment of Treatment Integrity. Clinical Psychology: Science and Practice, 12, 384-387.

Dodge, K. A. & Pettit, G. S. (2003) A biopsychosocial model of the development of chronic conduct problems in adolescence. Developmental Psychology, 39, 349-371.

Dumas, J., Gibson, J. & Albin, J. (1989) Behavioral correlates of maternal depressive symptomatology in conduct-disorder children. Journal of Consulting and Clinical Psychology, 57, 516-521.

Egeland, B. & Sroufe, L. A. (1981) Developmental sequelae of maltreatment in infancy. In New directions for child development: Developmental perspectives in child maltreatment (eds R. Rizley & D. Cicchetti), pp. 77-92. San Francisco: Jossey Bass, Inc.

Feeley, M., DeRubeis, R. & Gelfand, L. (1999) The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. Journal of Consulting and Clinical Psychology, 67, 578-582.

Fergusson, D.M., Horwood, L.J., & Ridder, E.M. (2005). Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. Journal of Child Psychology & Psychiatry & Allied Disciplines, 46(8), 837-49.

Finkelhor, D. (1994) Current information on the scope and nature of child sexual abuse. The Future of Children, 4, 31-53.

Fonagy, P. & Target, M. (1994) The efficacy of psychoanalysis for children with disruptive disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 45-55.

Giovannoni, J. (1991) Social policy considerations in defining psychological maltreatment. Development and Psychopathology, 3, 51-59.

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1337-1345

Hansen, D. J. & Warner, J. E. (1994) Treatment Adherence of maltreating Families: A survey of professional regarding prevalence and engagement strategies. Journal of Family Violence, 9, 1-19.

Harnett, P. H., & Dawe, S. (2008). Reducing Child Abuse Potential in Families Identified by Social Services: Implications for Assessment and Treatment. Brief Treatment and Crisis Intervention, 8, 226–235.

Hart, S. N. & Brassard, M. R. (1987) A major threat to children's mental health: psychological maltreatment. American Psychologist, 42, 161-165.

Henggeler, S., Melton, G., Brondino, M., et al (1997) Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65, 821-833.

Henggeler, S., Pickrel, S. & Brondino, M. (1999) Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. . Mental Health Services Research, 1, 171-184.

Hill, J. (2002) Biological, psychological and social processes in the conduct disorders. Journal of Child Psychiatry and Psychology, 43, 133-164.

Hogue, A., Dauber, S., Chinchilla, P., et al (2008) Assessing fidelity in individual and family therapy for adolescent substance abuse. Journal of Substance Abuse Treatment, 35, 137-147.

Hogue, A., Henderson, C., Dauber, S., et al (2008) Treatment adherence, competence, and outcome in individual and family therapy for adolescent behavior problems. Journal of Consulting & Clinical Psychology, 76, 544-555.

Hutchings, J., Bywater, T., Williams, M.E., Shakespeare, M.K., & Whitaker, C., (2009). Evidence for the extended school aged incredible years parent programme with parents of high-risk 8 to 16 year olds. Retrieved October 30, 2009 from: http://www.incredibleyears.com/library/paper.asp?nMode=1&nLibraryID=599.

Huey, S., Henggeler, S., Brondino, M., et al (2000) Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. Journal of Consulting & Clinical Psychology, 68, 451-467.

Iwaniec, D. (2006) The Emotionally Abused and Neglected Child: Identification, Assessment and Intervention: A Practice Handbook (2nd edn). Chichester: John Wiley & Sons.

Jones, L. M., Finkelhor, D. & Halter, S. (2006) Child maltreatment trends in the 1990's: Why does neglect differ from sexual and physical abuse. Child Maltreatment, 11, 107-120.

Kaufman, J. & Cicchetti, D. (1989) Effects of maltreatment on school-aged children's socio-emotional development: Assessments in a day camp setting. Developmental Psychology, 25, 516-524.

Kazdin, A. & Wassell, G. (2000) Predictors of barriers to treatment and therapeutic change in outpatient therapy for antisocial children and their families. Mental Health Services Research, 2, 27-40.

Kazdin, A. E. (1995) Conduct disorder in childhood and adolescence (2nd edn). Thousand Oaks, CA: Sage.

---- (1997) Practitioner review: Psychosocial treatments for conduct disorder in children. Journal of Child Psychology and Psychiatry, 38, 161-178.

---- (2004) Evidence-based treatments: Challenges and priorities for practice and research. Child and Adolescent Psychiatric Clinics of North America, 13, 923-940.

Kazdin, A. E., Bass, D., Ayers, W., et al (1990) Empirical and clinical focus of child and adolescent psychotherapy research. Journal of Consulting & Clinical Psychology, 58, 729-740.

Kazdin, A. E., Holland, L. & Crowley, M. (1997) Family experience of barriers to treatment and premature termination from child therapy. Journal of Consulting and Clinical Psychology, 65, 453-463.

Kazdin, A. E., Mazurick, J. L. & Bass, D. (1993) Risk for attrition in treatment of antisocial children and families. Journal of Clinical Child Psychology 22, 2-16.

Kazdin, A. E. & Weisz, J. R. (2003) Evidence-based psychotherapies for children and adolescents. New York: Guilford Press.

Kazdin, A. E. & Whitley, M. K. (2003) Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behavior. Journal of Consulting & Clinical Psychology, 71, 504-515.

Kendall, P., Gosch, E., Furr, J., et al (2008) Flexibility within fidelity. Journal of the American Academy of Child & Adolescent Psychiatry, 47, 987-993.

Lundahl, B., Risser, H. & Lovejoy, C. (2006) A meta-analysis of parent training: moderators and follow-up effects. Clinical Psychology Review, 26, 86-104.

Luntz, B. K. & Widom, C. S. (1994) Antisocial personality disorder in abused and neglected children grown up. American Journal of Psychiatry, 151, 670–674.

Maughan, B., Brock, A. & Ladva, G. (2004) The Health of Children and Young People. London: Office for National Statistics.

McGee, R. A. & Wolfe, D. A. (1991) Psychological maltreatment: Toward an operational definition. Development and Psychopathology, 3, 3-18.

McKay, M (2004) Engaging families in child mental health services
Child and Adolescent Psychiatric Clinics of North America, 13, 905-921

McKay, M., Stoewe, J., McCadam, K., et al (1998) Increasing access to child mental health services for urban children and their care givers. Health and Social Work, 23, 9-15.

McLeer, S. V., Callaghan, M., Henry, D., et al (1994) Psychiatric disorders in sexually abused children. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 313-319.

McMahon, R. J. & Wells, K. C. (1998) Conduct problems. New York, NY: Guilford Press.

Medical Research Council (2000) A framework for the development and evaluation of RCTs for complex interventions to improve health. London: Medical Research Council.

Miller, W. R. & Rollnick, S. (1991) Motivational Interviewing:Preparing people to change addictive behaviour. New York: Guilford Press.

---- (2002) Motivational Interviewing: Preparing People for Change (2nd edn). New York: Guilford Press.

Moffit, T. E. & Caspi, A. (1996) Childhood predictors differentiate life-course persistent and adolescence-limited antisocial pathways among males and females. Development and Psychopathology, 13, 355-375.

Morgenstern, J., Morgan, T., McCrady, B., et al (2001) Manual-guided cognitive-behavioral therapy training: A promising method for disseminating empirically supported substance abuse treatments to the practice community. Psychology of Addictive Behaviors, 15, 83-88.

Navarre, E. L. (1987) Psychological maltreatment: The core component of child abuse. In Psychological Maltreatment of Children and Youth (eds M. R. Brassard, R. Germain & S. N. Hart). New York: Pergamon.

National Institute for Health and Clinical Excellence (2006). Parent-training/education programmes in the management of children with conduct disorders. www.nice.org.uk/page.aspx? o=TA102.

Nock, M. K. & Ferriter, C. (2005) Parent management of attendance and adherence in child and adolescent therapy: a conceptual and empirical review. Clinical Child & Family Psychology Review, 8, 149-166.

O'Hagan, K. P. (1995) Emotional and psychological abuse: problems of definition. Child Abuse and Neglect, 19, 449-461.

Patterson, G. & Chamberlain, P. (1994) A functional analysis of resistance during parent training therapy. Clinical Psychology: Science and Practice, 1, 53-70.

Perepletchikova, F. & Kazdin, A. (2005) Treatment integrity and therapeutic change: issues and research recommendations. Clinical Psychology: Science and Practice, 12, 365-383.

Perrino, T., Coatsworth, D., Briones, E., et al (2001) Initial Engagement in Parent-Centered Preventive Interventions: A Family Systems Perspective. The Journal of Primary Prevention, 22, 21-44.

Prinz, R. J. & Miller, G. E. (1994) Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. Journal of Consulting and Clinical Psychology, 62, 645-650.

Sanders, M., Markie-Dadds, C. & Turner, K. (2000) Practitioner's Manual for Standard Triple P. Brisbane: Families International Publishing.

Santisteban, D. A., Coatsworth, J., Perez-Vidal, A., et al (2003) Efficacy of brief strategic family therapy in modifying Hispanic adolescent behavior problems and substance use. Journal of Family Psychology, 17, 121-133.

Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., et al (1996) Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. Journal of Family Psychology, 10, 35-44.

Scott, S., O'Connor, T. & Futh, A. (2006) What makes parenting programmes work in disadvantaged areas? The PALS trial. York: Joseph Rowntree Foundation.

Scott, S., Knapp, M., Henderson, J., & Maughan, B. (2001), Financial cost of social exclusion: follow up study of antisocial children into adulthood. British Medical Journal, 323, 191-194.

Sexton, T. L., & Alexander, J. F., (1999). Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation. Henderson, NV: RCH Enterprises.

Shaw, D. S., Dishion, T. J., Supplee, L., et al (2006) Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-year effects of the family check-up in early childhood. Journal of Consulting and Clinical Psychology, 74, 1-9.

Shelton, K.K., Frick, P.J., & Wootton, J. (1996). Assessment of parenting practices in the families of school-aged children. Journal of Clinical Child Psychology, 25, 317-329.

Shivack, I. M. & Sullivan, C. W. (1989) Use of telephone prompts at an inner-city outpatient clinic. Hospital & Community Psychiatry, 40, 851-853.

Slep, A. (1997). Parental Attributions Coding System (unpublished manuscript).

Slough, N.M., & McMahon, R.J. et al. (2008). Preventing serious conduct problems in school aged youth: The Fast Track Program. Cognitive and Behavioral Practice, 15, 3-17.

Society for the Prevention of Cruelty to Children (2006) Prevalence and incidence of child abuse and neglect. London.

Spoth, R., Redmond, C., Hockaday, C., et al (1996) Barriers to participation in family skills preventive interventions and their evaluations: A replication and extension. Family Relations, 45, 247-254.

Staudt, M. (2007) Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. Journal of Child and Family Studies, 16, 183-196.

Szapocznik, J., Perez-Vidal, A., Brickman, A. L., et al (1988) Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. Journal of Consulting and Clinical Psychology, 56, 552-557.

Tomison, A. M. (1997) Overcoming Structural Barriers to the Prevention of Child Abuse and Neglect - A Discussion Paper. Australian Institute of Family Studies.

Waltz, J., Addis, M., Koerner, K., et al (1993) Testing the integrity of a psychotherapy protocol: assessment of adherence and competence. Journal of Consulting & Clinical Psychology, 61, 620-630.

Webster-Stratton, C. (1990) Long-term follow-up of families with young conduct problem children: from preschool to grade school. Journal of Clinical Child & Adolescent Psychology, 19, 144-149.

---- (2005) The Incredible Years: A Training Series for the Prevention and Treatment of Conduct Problems in Young Children. Washington, DC: American Psychological Association.

Webster-Stratton, C. & Hammond, M. (1999) Marital conflict management skills, parenting style, and early-onset conduct problems: Processes and pathways. Journal of Child Psychology and Psychiatry, 40, 917-927.

White, C., Warrener, M., Reeves, A., La Valle, I. (2008). Family Intervention Projects: Design, Set-up and Early Outcomes. Research Report No DCSF-RW047. National Centre for Social Research (for the Department of Children, Schools and Families).

Widom, C., DuMont, K. & Czaja, S. (2007) A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. Archives of General Psychiatry, 64, 49-56.

Zahner, G. E., Pawelkiewicz, W., DeFrancesco, J. J., et al (1992) Children's mental health service needs and utilization patterns in an urban community: An epidemiological assessment. Journal of the American Academy of Child & Adolescent Psychiatry, 31, 951-960.

Zoccolillo, M., Pickles, A., Quinton, D., et al (1992) The outcome of childhood conduct disorder: implications for defining adult personality disorder and conduct disorder. Psychological Medicine, 4, 971-986.

Appendices

Appendix 1 – Example of Helping Families Programme dissemination

Appendix 2 – Day, C., Kowalenko, S., Ellis, M., Dawe, S., Harnett, P. & Scott, S. (2011). The Helping Families Programme: a new parenting intervention for children with severe and persistent conduct problems. Child and Adolescent Mental Health, 16, 167-171.

Appendix 3 – Overview of manual structure and contents

Appendix 4 – Examples of consultation meetings with FIPs March-Sept 2009

Appendix 5 – Camden example of 2010 recruitment stages 2 & 3

Appendix 6 – 2009 protocol

Appendix 7 – The 5 risk indices of the Helping Families Programme

Appendix 8 – 2009 ethics application

Appendix 9 – 2009 practitioner information package

Appendix 10 – 2009 manual contents

Appendix 11 – Reflective practice fidelity tools

Appendix 12 – 2009 research measures: Questionnaire battery and topic guide for qualitative interviews

Appendix 13 – 2010 recruitment stage 1

Appendix 14 – 2010 protocol

Appendix 15 – 2010 ethics application

Appendix 16 – 2010 practitioner information package

Appendix 17 – Explaining the Helping Families Programme to other professionals

Appendix 18 – Helping Families Programme promotional leaflet

Appendix 19 – Parent qualitative interview schedule

Appendix 20 – Example case summary

Appendix 21 – Example of school feedback document

Appendix 22 – 2011 example feedback to the Camden clinical site

Ref: DFE-RR187

ISBN: 978-1-78105-061-3

February 2012