A PROFESSIONAL SUBMISSION OF EVIDENCE ON BEHALF OF THE COMMUNITY PRACTITIONERS AND HEALTH VISITORS ASSOCIATION (CPHVA)

To the National Institute for Clinical Excellence for the appraisal of the clinical and cost effectiveness of parent-training/educational programmes for the treatment of conduct disorders in children.

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1. Introduction

In view of the swift moves to address family and in particular child health needs within currently proposed policy (Department of Health, 2003; Department for Education & Skills, 2003) it is timely and right that a review of parenting programmes is made. Parenting support activities exist within mainstream NHS services via the activities of Health Visitors and School Nurses, professional groups who make up the majority of the Community Practitioners and Health Visitors Association (CPHVA) membership. It is common for these professional groups to work alongside other community workers in the provision of parent-training/education programmes for all parents wishing to learn new ways of caring for their children. By contrast, it is less common for these parenting programmes to be specifically offered for the treatment of child conduct disorder. Within this report the CPHVA seeks to explain the background to parenting services and illustrate why preventative services in this area, must not be underestimated. In keeping with the guidance received from NICE, the contents of this professional submission have been organised under the headings of: literature searched, clinical effectiveness, cost-effectiveness and implications for the NHS. The submission concludes with some recommendations to the committee.

2. Background

2.1 The Context and Value of Parenting

The context for parenting is determined by both family circumstances (economic prosperity, educational opportunity) and family function (cohesion, accord and positive regard, parental self-esteem), which collectively impact on child educational attainment and opportunity to develop self-control and skills in managing one's own behaviour (Wadsworth, 1999). Wadsworth (1999) explains that these features of a child's social life are part of an individual's 'social programming' that generates vulnerability or resilience to subsequent life stressors. He likens this with 'biological programming' for foetuses in utero, infants and children (Barker, 1998) when exposed to biological hazards such as parental smoking, poor nutrition or early infection, interfere with subsequent maturation of cells and organs, and create vulnerability in adults exposed to biological stressors, such as a high fat, sugar and salt diet, smoking or infectious disease.

The significance of parenting as a social programming activity can be realised in evidence that illustrates the relationship between the quality of nurturing and nourishment provided during childhood years and the development of coping and competence skills in adult life (Bartley et al., 1999). Indeed childhood social experiences can influence a trajectory for life, impacting on child growth (Montgomery et al., 1997) educational attainment (Sweeting and West, 1995; Hertzman and Wiens, 1996) and adult
physical health (Lundberg, 1993), mental well being (Wadsworth, 1996), propensity to crime and violence (West and Farrington, 1973; Farrington and Welsh, 1999) and future parenting practices (Polansky et al., 1981). The sum total of such experiences, not least educational disadvantage, is the risk of long term unemployment in adult life which predisposes individuals to both physical and mental ill-health (Montgomery et al., 1996), which in turn creates economic disadvantage and limited opportunity to redress life circumstances. Wilkinson (1999) identifies this cyclical situation as a disastrous recipe for health which, when combined with weakened social bonds raises stress experiences and chronic anxiety. These states then act as precursors to other health limiting behaviours such as smoking, alcohol consumption coronary heart disease. The task then is to help children and young people become resilient to such life risks, by improving early social experiences in order that they can increase their competencies, self-esteem and ability to seek out help when needed (Werner, 1995). Programmes of intervention therefore need to understand the breadth of early years experiences and, in Werner’s (1995:84) terms, “support children in the context of the family, and the family in the context of the community”.

2.2 The context of service provision

The provision of support for parents via individual and community wide action has traditionally been the cornerstone of health visitor practice (Malone, 2000). Contemporary health visitors have continued to show foresight and realise that parents living within disadvantaged communities could benefit from targeted help (Angeli et al., 1994; Hareendran, 1998; Dawson et al., 1998; Kilgour and Fleming, 2000; Emond et al., 2002). Unfortunately much of this has persisted as silent work owing to the difficulty in quantifying benefits, particularly when involving home visiting approaches to care. More recently however a shift in attention to population based approaches to health care has encouraged health visitors and school nurses to rethink how they spend time supporting parents and young people (Department of Health, 2001; Rowley et al., 2002). Alongside this, increased political attention on the family (Home Office, 1998; Department for Education & Employment, 1999) has led to a growth in the adoption of various parenting training programmes for health visitors, school nurses and many other community practitioners, in order that they can facilitate parenting education classes and groups (see Appendix 1., Table 1.). This alone creates considerable variation across service providers and the methods employed to support families facing parenting challenges, as does also the reality of family life and the contexts within which parenting takes place. Indeed it should be acknowledged that parenting is a complex activity and as such any intervention rarely operates in isolation of other potential sources for change. To explain the multi-faceted nature of generic parenting education/training and support, Figure 1. illustrates the range services. Here the relationship with statutory services, different formal
(examples listed in left hand side boxes) and informal support systems (examples in the right hand side boxes) and the various contexts within which they operate, is mapped out.

**Figure 1. Formal and Informal Facilities for Parenting Education and Support**

With consideration of the above it is evident that parenting training/education groups operate within various locations where there is the opportunity for exposure to additional informal systems of support.

2.3 **Responding to Parenting Support Needs**

Health visitors are guided in their work with families by four principles:

1. The search for health needs
2. The raising of the awareness of health needs
3. The facilitation of health enhancing activities
4. Influencing policies affecting health.

These were originally identified by the Council for the Training of Health Visitors in 1977 and have since been reaffirmed by Twinn and Cowley (1992) and the Nursing and Midwifery Council (2002). A greater part of their work therefore, will be in a promotional and preventative role with all families rather than that of treatment with a specific few. The resulting universal parenting support is largely operated via
contact in the home, community NHS clinics and through facilitation of informal community activities such as drop-in groups and parent led schemes/events (see Figure 2, tiers 1 & 1a). However with the overriding public health implications of children with conduct disorder going untreated, there is some pressure on health visitors to join in providing a service for treating this major cause of stress in families.

Figure 2. A Tiered Model of Service Working in Partnership.

2.3i A Tiered Service Framework The above model (Figure 2.) is based on a framework recommended by the NHS Health Advisory Service (1995), but contains the additional tier (1a) to highlight the role informal care providers play. Important features of the model are that it assumes:

- Different levels of need in terms of the number type and complexity of problems in children and their families.
- A requirement for different degrees of mental health specialisms.
- A psychological role for all people working with children and families and hence the need for interagency partnership and co-operation.
- An emphasis on promotional and preventive work (Davis et al 2002).
The inclusion of tier 1a. emphasises the close partnership between informal and formal systems and the foundational role that informal care providers have in maintaining universal preventative and promotional services for parents. From this basis other services can emerge, with tier 1 and 2 practitioners collaborating to provide targeted parenting support delivered in groups. Similarly tier 2 and 3 practitioners work together to provide one-to-one services for ‘harder to reach’ families. Health Visiting is thus largely concerned with influencing the quality of parenting generally within the population and by doing so make a major contribution to the prevention of conduct disorder by working with families from infancy onwards.

The Child and Adolescent Mental Health teams (CAMHs) are more likely to be working closely with tier 1 when more serious difficulties are encountered and the programme sets out to treat conduct disorder. However, in spite of the Health Advisory Service (1995) recommendations, there still remain a considerable number of areas where CAMHs teams do not seem to be supporting Tier 1 workers. It appears that this is linked to the poor development of parenting services across the levels of need.

3. Literature Searched

3.1. Published Literature

Acknowledgment, within the scoping document (NICE, 2003a), for the potential different outcomes from parenting education/training programmes is reassuring, as is also the intention to access a variety of electronic databases (NICE, 2003b). Outcomes can be understood from both the parent and child’s perspective and are likely to exist at both short and long term levels. Suggested outcomes are listed in Table 1. The search strategy will therefore need to be extended to accommodate the wide range of outcomes and resulting facets.

Table 1. Short and long term outcomes resulting from parenting training/education programme.

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<td>↓ Child abuse/neglect</td>
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<td><strong>Parent centred</strong></td>
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<td>↑ Parental self esteem</td>
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<td>Interaction with child</td>
<td>↑ Parental self-efficacy</td>
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<td>Realistic expectations</td>
<td>↓ Depression</td>
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<td>Emotional/mental well-being</td>
<td>Stress/Anger Management</td>
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<td>Parental perceptions</td>
<td>Involvement in child’s education</td>
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3.2 Unpublished research

In an attempt to locate unpublished work or papers undergoing review, a number of practitioners and academics have been contacted. The review team may wish to follow-up these contacts.

3.2i Professor Edmund Sonuga-Barke (Dept of Psychology) and Dr Margaret Thompson (Dept of Psychiatry) at Southampton University have worked with a number of South West NHS Primary Care Trusts and teams of Health Visitors developing programmes of parenting support. Contact: ejb3@soton.ac.uk

3.2ii Professor Eric Emerson, (Institute for Health Research, Lancaster University), has completed work in the field of learning disabilities and parenting, considering the mental health needs of children with intellectual disability. Contact: eric.emerson@lancaster.ac.uk

3.2iii Dr Francis Bunn at University of Hertfordshire has prepared a systematic review protocol reviewing the effectiveness of parenting programmes in minimising risk taking behaviours in children under 18 years (Bunn, 2003). As one of the symptoms of conduct disorder, risk taking (such as early age smoking, alcohol and drug use), presents a real concern for parents and whole communities. The NHS then becomes the recipient of escalating costs incurred to treat mixed pathologies (e.g. respiratory disease, major systems failure and accidents) associated with these risky behaviours. This review by Bunn could illustrate the far-reaching effects of the both the consequences of conduct disorder and the possible gains from investing in programmes that may counter these difficulties.

3.3 Theses

A search of the CPHVA and the RCN Steinberg Collection of Theses using the search terms, parenting training, parenting education, conduct disorder, parenting support generated no results. When repeating this search with the UK University Library COPAC database, two relevant theses (Jones, 1999; Lee, 2001) were identified. Unfortunately it has not been possible, to date, to access and review these theses.

4. Clinical Effectiveness

4.1 Understanding effective parent/child interactions

To understand the impact of parenting programmes it is first helpful to appreciate how parents and children interact. In a detailed discussion of the Parent Advisor Model, Davis et al. (2002) highlight how a cycle of monitoring, construing and responding develops during parent/child interactions. Here the relationship is mutual, with the parent's behaviour being determined by their own constructions of what they monitor in the child. Similarly the child monitors the parent's responses, construes this and responds accordingly, stimulating further patterns of construing and responding. Whilst Davis et al
(2002:152) illustrate this as a cycle of interaction, it is feasible for the cycle to take-on either an upward or downward trend, depending on each participant's response, but particularly the parent's, ability to make adaptive and empathetic responses to their child. A maladaptive response could arise when parent constructions are inappropriate or unreasonable; stimulating repeated challenging child behaviour and a parent/child interaction that is dysfunctional with respect to child conduct. By contrast adaptive parental responses are more likely when a parent is able to make reasonable, empathetic and realistic constructions and this in turn stands a greater chance of evoking more manageable and appropriate child behaviours.

4.2 Understanding effective parenting programmes

Parenting programmes clearly have a part to play in shaping how parents monitor and construe their children. Factors affecting parental constructions including self-esteem and self-efficacy have been key areas of attention for parenting interventions (Cutrona and Troutman, 1986; Teti and Gelfand, 1991; Conrad et al, 1992; Coleman and Karraker, 1997; Miller-Heyl et al, 1998; Coleman and Karraker, 2000; Markiewicz et al, 2001; Coleman and Karraker, 2003).

4.2i Parental Self-Efficacy. A programme stands the chance of being effective if parents are exposed and are receptive to different positive sources of self-efficacy (Bandura, 1995). This will enable them to more appropriately construe and empathise with their child and via modelling opportunities and verbal support, practice more positive and appropriate responses to their child. The important element here is the receptiveness of the parent, or the extent to which the parent is ‘tuned-in’ to what the programme is about. To aid receptiveness to social models or verbal persuasion the parent needs to be able to identify with those delivering the message; that is they need to be significant others (Bandura, 1997). The relationship established with the programme facilitator is therefore of paramount importance.

Self-efficacy theory is thus useful in helping generate an understanding of whether parenting programmes can be effective. To explain this further, figure 3. shows pathways a parent may take through a programme. Here the programme exposes parents to social role models and verbal messages of support and reassurance, which if readily accepted and trusted by the parent, encourage them to practice adaptive and positive responses to their child (e.g. uses engaging language, demonstrates empathy and praises achievements). This provokes more pro-social child behaviour, which impacts on the parent’s sense of success in their parenting role and influences future behaviour. Equally however, another parent within the same session may not identify with group members or the modelling examples given. This parent will be less receptive to the sources of self-efficacy and more inclined to continue with existing modes of response to the child, which if low in praise will negatively
affect the child’s constructions of parental behaviour and hence child responses. These responses reinforce a low sense of parental success and poor mastery of parenting skills.

Figure 3. Pathways through a parenting programme.

4.2ii. The Facilitator. Given that the facilitator or programme leader takes the primary role in engaging course or group members, the pathways described above indicate the crucial role parenting facilitators have in shaping outcomes for each parent. In support of this position Crowley (2002) has argued that the priority should be the correct choice of facilitator, as opposed to the choice of parenting package. Fundamentally the education-training package will only be as good or useful as the person able to deliver it. An effective programme is therefore reliant on the careful recruitment and training of the facilitator, specific to the needs of the target group.

4.2iii. Parental Engagement. A key ingredient of an effective programme is undoubtedly the ability of the programme to attract and engage the very people it aims to serve. Recruitment difficulties are acknowledged by Jack (2001) in his discussion of services offered by family centres, but there is evidence of some families recognising the value of compulsory requirements to attend parenting education sessions when parenting orders are in place (Braun, 2001). Generally however the business of getting parents there is a very real concern for those in the thick of service provision. Those seeking to address this issue (Dumka et al, 1997; Orrell-Valente et al, 1999; Perrino, 2001; Haggerty, 2001) argue that service providers need to be sensitive to parental perceptions of what constitutes child behavioural problems, family organisation and culture. More specifically Prinz and Miller (1996) have considered how to engage parents when conduct disorder has been identified as a particular risk. Here the key areas of concern are the: interpersonal relationships between parents and all those associated
with service provision, (facilitators, support staff and receptionists), expectations between parents and facilitators and the ability of the intervention to address situational demands and constraints. With all three elements it is clear how the facilitator is indeed an essential programme component, who will need to be adept at communicating effectively, assessing needs and expectations and working creatively and flexibly to customise programmes with respect of the former. Parenting programmes only have the potential to positively impact on child conduct disorder if those in most need of them attend. Attendance and retention is longstanding difficulty with these types of programmes. Any review of evidence should therefore take parent attrition seriously and consider which strategies appear to minimise this risk.

4.2iv Length of Programme. Successful engagement of parents is not only important for sustaining change in parenting practices but also for avoiding parental rejection of support systems. As highlighted in Figure 3, parents may engage with a parenting programme in different ways and this is not surprising given the complexity of the context within which both family life and the programmes themselves take place (Section 2.2). Some, despite identification with positive role models within the programme, may outside of the programme, face criticism from significant others. If resilience to such criticism has not been developed the effect is undermining and interferes with chances of successful mastery when practicing new skills/techniques at home. Failure to achieve success early on in a programme may dishearten parents and cause them to withdraw (Cunningham, 1996). Equally during the early stages of a programme parents become more self-aware and begin to recognise their personal behavioural limitations. If not coupled with appropriate verbal persuasion and guidance on alternatives, this self-identification, can generate despondency and parents can ‘feel worse before they feel better’ (Whittaker et al, 2003). Implications of this include the need for facilitators to be perceptive to parental responses as the course progresses and for those planning parenting training-education to ensure the programme runs sufficiently long enough to allow parents time to overcome sometimes difficult realisations. The danger otherwise is that parents will feel guilty about their previous practices and will respond by rejecting further contact with a programme that has induced such negative feelings.

4.3 Outcomes measures used within research and practice

Many of the outcome measures previously used have been developed either in the US or Australia. The resulting choice of language and sometimes lengthiness can negatively affect their value and utility within UK clinical situations. In response to this limitation researchers at Hertfordshire University have been developing an outcome measure of parental self-efficacy for use within the UK and an unpublished report is available from these authors (Bloomfield and Kendall, 2003).
It can also be argued that outcomes measures have generally been designed for use in research and experimental situations as opposed to clinical practice and the real world of service provision. The artificial nature of the experiment within social situations is shown in some studies where financial payments are given to parents to encourage ongoing participation (Nixon and Singer, 1993; Anastopoulos et al., 1993; Black and Teti, 1997; Taylor et al., 1998; Lagges and Gordon, 1999). Rarely would this be feasible if the same programme was offered as part of NHS services. Few studies take a pragmatic approach to study design as many fail to observe the intention-to-treat principle or maximise opportunities for blinding (Whittaker et al., 2004). Examples of these studies include: Cunningham et al. (1995) using the Parenting Sense of Competence Scale (PSCS), Webster-Stratton et al. (1988), Gross et al. (1995) and Greaves (1997) using the Parenting Stress Index (PSI), Zimmerman et al. (1996) using the Family Skills Inventory (PSI) and Webster-Stratton et al. (1988) using the Child Behavior Checklist (CBCL).

4.4 Professional opinion regarding the value of different programmes

A small survey of CPHVA Parenting Special Interest Group members (37) was completed in November 2003 to identify common practice and views with respect to parent programme use (see Appendix 1.). Despite its small size, the survey is a snapshot of parenting work involving many health visitors across the UK. It is common for health visitors to work in partnership with others to deliver universal parenting support frequently characterised by promotional and preventative activities and often using Family Caring Trust Parenting Programmes. A third of respondents were directly involved in treating conduct disordered children. These Health Visitors tended to use Webster-Stratton or Triple-P, although for the reasons cited below, there was some resistance within the profession to both of these programmes.

- Webster-Stratton videos are of poor quality using dated and American examples.
- Caroline Webster-Stratton, the author, carried out majority of research in America. There was concern that this does not transfer well to UK culture.
- The Australian developed Triple-P uses directive methods and middle-class family situations within videos. This latter feature makes them unsuitable for culturally diverse populations.
- Again much of the evidence for Triple-P is based on findings from research conducted in Australia by its author, Matt Sanders.

There was a strong feeling amongst the profession that UK developed programmes were likely to be more acceptable and culturally relevant to parents served by the NHS. This is perhaps why the Tameside and Glossop Positive Parenting programme appeared to be a popular choice. Evidence for this programme comes from an evaluation of home-visiting support for mothers, although the positive parenting training was primarily intended for use with groups of parents (Whittaker et al., 2003).
5. Cost Effectiveness

5.1 Economic influences

There is a growing appreciation that the experience of disadvantage within single households impacts not only on individuals but indeed whole societies (Cowley, 1999). Mustard (1996) illustrates this economically, by explaining the existence of primary and secondary wealth-creating sectors. The primary sector being the engine of economic growth generates income for the whole of society, whereas the secondary sector affects the quality of the social environment within which the primary sector operates. The two are reliant on one another and the faltering of one automatically has consequences for the other. Accordingly if the primary wealth-creating sector declines within a region, then the capacity to support the secondary wealth-creating sector is reduced. Secondary sector activities, which include aspects of education or support for children, can be identified as key parts of an infrastructure supporting an economy. Simplistic examples include the availability of educational courses that prepare individuals for employment, or equally the availability of childcare provision that allows individuals to firstly attend educational courses and or be employed. A less obvious but nevertheless fundamentally important secondary wealth creating activity is that of parenting.

The financial costs to health services from treating behaviourally disordered children are highlighted in recent published research by Guevara et al. (2003). Here children with behaviour disorders, like children with physical conditions such as asthma, diabetes and epilepsy, made greater use of office-based consultations, prescribed medication and accident and emergency (A & E) services, than control group children did. Medicine prescription costs were particularly high for children categorised with disruptive disorders and were greater than those with physical disorders.

5.2 Cost effectiveness of implementing programmes

Treatment of Behaviour disorders does therefore present a significant financial burden to the NHS, indicating good reasoning for use of preventive strategies. Examples of these would include visiting and parenting support group by health visitors both in the ante and post-natal periods. An American example of a home visiting scheme for adolescent mothers who were judged as high risk for child abuse and neglect, illustrated how child and maternal health outcomes could be improved and that the programme was a cheaper course of action than provision county foster care (Sterling Honig, 2001). It was thus a cost-effective means of boosting family mental health and preventing child abuse in high-risk families. These outcomes are beneficial not just to individuals but also to communities within which they reside (Mustard, 1996). Cunningham (1996) argues that cost-effectiveness of parenting programmes should be considered not just in terms money required to organise, administer and deliver parenting services, but also in terms of potential reductions in costs to public services created by antisocial
behaviour. Certainly in view of Guevara et al's findings programme costs need to be compared to those incurred from ongoing A & E attendance, when behaviour disorders are not actively managed. Additionally the real implications to NHS of not dealing with conduct disorder are illuminated by Scott et al. (2001) in their follow-up of children with anti-social behaviour, the existence of conduct disorder was the greatest predictor of future costs. This research is referred to within the recent Every child matters, government green paper (Department for Education & Skills, 2003) and the pathway of consequences from not dealing with childhood oppositional and defiant disorders is clearly illustrated (see Appendix 2.).

5.3 Training Costs
Finally it is worth noting that cost will vary depending on the programme being delivered. Initially these will be dependent on the cost for training the required number of practitioners to deliver the programme of choice. Training costs are likely to be an ongoing concern with staff turnover and programme development. Different programmes of training are likely to vary in price whilst they operate within a business model and as such should be compared with the costs of current modes of training offered within the NHS, amongst others the Tameside and Glossop Positive Parenting training provided across North West NHS Primary Care Trusts is one example.

6. Implications for the NHS
6.1 Implications of formal delivery across NHS
There are numerous implications for the NHS that would result from formal delivery of parenting programmes specifically for conduct disorder. These include: service access, delivery by whom, training, supervision, programme length, marketing and monitoring.

6.1i Service Access. Typically where treatment for conduct disorder is currently offered, access to the parenting group is by referral only and practitioners who are able to make referrals will vary across health districts. Most other parenting groups are open access with self-referral being the most usual option. To assist with equitable access to services there needs to be national agreement about whether access is referral restricted and if so which professional groups are eligible to make referrals.

6.1ii Delivery by Whom. Evidence and experience from the delivery of generic parenting services indicate that multi-disciplinary approaches are a sensible move forward, since rarely can a single professional group respond comprehensively to the complex needs of families. Where conduct disorders are present, there is often a complex family situation, which would require those involved to
posses a professional qualification and knowledge of normal and disordered family functioning as a baseline. In addition individual professionals need to possess particular attributes and skills which include amongst others; the ability to engage parents, deal with confidential issues, assess needs, facilitate groups and work flexibly with a programme in accordance with parents’ needs.

6.1.iii Training and Education. Training needs will differ depending on the discipline under consideration and the purpose of the parenting programme being delivered. Programmes of training to deliver parent-training/education services should be developed as part of work force development plans. To optimise training potential local NHS Trusts should develop plans alongside Local Education Authorities, Social Services Departments, Sure Starts and other providers to develop comprehensive training packages. This strategy would assist practitioners to work in a complementary manner and should help maximize limited resources. Differentiation must be made between training and education since the latter may come in the form of University accredited modules that address knowledge needs, but may not address or assess skills required for delivering parent-training/education programmes. Training, may attempt to address both knowledge and skills needs, but assess neither. In reality practitioners being prepared for roles delivering parent-training/education programmes need to be both educated, trained and assessed for competence to execute this role.

6.1.iv Supervision. All health visitors responding to the CPHVA survey (Appendix 1.) and who were providing groups for the treatment of conduct disorder received supervision either from a specialist health visitor or from a mental health professional. For those facilitating universal parenting groups, supervision was variable with some being supported by the CAMHs departments, others specialist health visitor or from other health visitors during peer supervision sessions. A sizeable proportion (n=7, 19%) still received no supervision. It is clear that the model set out in the Health Advisory Service document is still far from being a reality in many areas of the country. This issue is very important and may act as a barrier to the implementation of services in some areas. Supervision is important for ensuring service quality, particularly when practitioners are dealing with the often complex family situations associated with established conduct disorder. It requires commitment, time and funding if it is to be useful to practitioners.

6.1v Programme Length. Programmes aimed at treating conduct disorder typically last longer than other open access programmes. This clearly has implications for the NHS in terms of the availability of appropriately qualified personnel and the additional resources needed for supporting longer programmes.
6.1vi  Marketing. Marketing and parent recruitment are important elements of any parent-training/education service, to maximise cost efficiency and minimize participant attrition. To assist with this these topics should be included within the curriculum of any training programme for professionals.

7. Conclusions

7.1 Support for parents who care for children with conduct disorder is an important need area of the health service. Failure to address the needs of these parents and children will result in not just a spiralling cycle of deprivation, antisocial behaviour and poor mental health, but also in an escalating use of expensive pharmacological interventions and consultations within specialised clinics. In addition to this A & E services will continue to respond to the fallout that results from risk-taking behaviours common to conduct disordered children and adolescents.

7.2 Conduct disorder does present a different level of need than that usually catered for by generic parenting support services. Figure 2. highlights the need to determine the thresholds at which different forms of parenting support/interventions are indicated.

7.3 The existing evidence base to support parenting interventions is not strong, due to limitations of study design, availability of culturally relevant outcome measures and in many instances a failure to sufficiently follow dropouts from programmes. Currently further research within UK care contexts is needed. With this in mind there is a clear indication for the appraisal committee to take seriously the professional judgements of those currently working in the field of parenting support. Health Visitors have a clear history and breadth of professional practice within this field.

7.4 In the view of the CPHVA, those working with parents and carers of conduct disordered children need to be professionally qualified, and have an ability to understand and work with families experiencing a high level of dysfunction. This body of people would differ from those typically identified to facilitate the generic parenting support groups; where there is a positive move to encourage lay involvement in service planning and delivery.

7.5 It is recommended that all professionals working with programmes to prevent and treat conduct disorder undergo appropriate training in addition to their general professional education. In addition a package of clinical supervision should be agreed nationally and adopted by all health care trusts.
7.6 There is a need to move away from ideas about ‘one size fitting all’. That is that providers of health care services must recognise that different parent-training/education programmes will meet different needs. Competent professionals will need to be able to recognise what best suits the needs of the population they are serving.

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