

The Incredible Years

The Norwegian Webster-Stratton Programme

1998-2004

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Foreword

This report has been prepared to provide an account of the Norwegian *The Incredible Years* programme, in accessible form. Beside a description of the programme, it concentrates on the results of clinical trials carried out in Trondheim and Tromsø in 2001-2003, and presents material from a user evaluation carried out in 2003-2004. A brief examination of implementation issues is also included. Important project components in the programme seen as a whole have had to be omitted here, either because they are not yet complete or because space did not allow their inclusion. The treatment trial material presented here is based on work carried out by Bo Larsson, Willy-Tore Mørch, May Britt Drugli and Sturla Fossum. The user evaluation material is based on work carried out by Jim Lurie and the undersigned. Charlotte Reedtz, Jim Lurie and the undersigned have worked on collection of material to standardise instruments used in the research.

On a personal note, my role as editor of this report gives me the opportunity to record my gratitude and appreciation to the members of the original project team who planned *The Incredible Year* programme here in Norway: Willy Tore Mørch, Bo Larsson, Per Rypdal and Torill Tjelflaat. And in particular to Willy Tore, who has been the *primus motor* in the project and who has worked so hard to realise the plans and visions we had in 1998-99. All of us who have worked in the project owe a special debt of gratitude to the Directorate of Health in the Norwegian Ministry of Health and Social Affairs (now Ministry of Health) who have supported us so generously and given us constructive advice at every stage. Also we have to thank the Regional Centres for Child and Adolescent Mental Health in Trondheim and Tromsø, the two Regional Centres for Child Protection Research in Trondheim and Tromsø, and BUP St.Olav in Trondheim and BUP Tromsø (these two clinics were the base for the treatment trial). Our colleagues in all of these institutions have given us support and encouragement at every step, on what has proved to be an exciting, and very long journey.

All of us in the project are indebted to Carolyn Webster-Stratton, who has provided inspiration and guidance for so many. We hope that this first, summary presentation of our work and results can go some way to justify and reward the generosity she has unfailingly shown toward us.

Finally, thanks to Willy Tore Mørch, Bo Larsson, Jim Lurie and May Britt Drugli who have helped with the preparation of this report.

Graham Clifford

Trondheim
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1. Introducing a new approach for small children with behavioural difficulties

Introduction

Here we present in report form a summary of the results of the Norwegian programme *The Incredible Years* which was designed to introduce and test Carolyn Webster-Stratton's treatments for families who have young children affected by behavioural disturbances. Here is an approach which starts with the bold and apparently simple idea that children with severe behavioural disturbances can best be helped, if we train parents (and other adults) to help them, using everyday situations and problems as a starting point.

This introduction provides some background and explanatory material about the programme seen as a whole. The succeeding chapters deal with some of the main component projects, and there is a concluding discussion which deals with implementation issues.

"The Incredible Years" is a programme for children with severe behavioural disturbances, targeted at children in the 4-8 age range. It has been widely regarded as one of the best-documented and successful intervention approaches not only in the field of behavioural problems, but in clinical child psychology and child psychiatry in general. The programme consists of a number of different manual-based treatments, all of which are related, having basic principles in common. In addition to treatment based on parent groups, known as the Basic Programme, there is an Advanced Programme for parents which involves a larger number of sessions, allowing a focus on the parents' relationship and functioning. A treatment programme for groups of children - Dinosaur School - has been developed in two versions, one clinic-based and the other adapted for use in kindergarten or school. These children's programmes set out to improve social skills, which behaviourally disturbed children often have not acquired, and need very much. A Classroom Management Programme has also been developed to assist teachers and pre-school staff; in essential respects this is an adaptation of the Basic Programme. All these treatments have been tested extensively at the Parenting Clinic at the University of Washington, Seattle, using randomized group designs. Not least because of the stringent designs applied, Webster-Stratton's methods have been regarded as fulfilling the strictest criteria for evidence-based treatments. In addition, the Basic Programme has been evaluated in a few replication studies, in Canada (Taylor et al. 1998), in the United Kingdom (Scott et al. 2001), and most recently here in our programme in Norway.

The help that parents receive in this programme has a number of features that we find in other modern approaches to providing help for children and their families, whether mental health or child protection issues are involved. Whittaker (1997) has given these the collective appellation "family preservation services". The new service policies emerging in child psychiatry and child protection involve an effort to see the "problem child" not in isolation but as a member of his or her family and local environment, who necessarily also "own" the problem. Parents are seen as having both the right to

appropriate help *and* the responsibility for their child, so that it is reasonable to expect that they will cooperate with professionals to find solutions for problems that affect the child. This thinking has become embodied in the working of community services to an increasing extent, and in the new methods that are being introduced there. It is believed that parents usually will be highly motivated to find solutions to their problem. Of course, few who appreciate the problems involved from first-hand experience, will think that this offers any easy solutions. When dealing with behavioural problems among small children, we meet unhappy and confused children *and* adults. Few burdens are as heavy as those parents must bear when a child has an apparently intractable problem, and this is certainly so in the case of severe behavioural disturbances, which can lead to desperation, anger, demoralisation and disruption for the families concerned.

This Norwegian programme has included a number of component projects:

1. A treatment trial conducted at the University Child Psychiatric Clinics in Trondheim and Tromsø, using a three-group randomised design. This trial included 127 children and their families and was conducted in the period September 2001 - June 2003.
2. A recruitment project conducted in Trondheim and Tromsø, designed to facilitate referral of children for treatment at the two clinics.
3. Two epidemiological studies conducted in a variety of areas in north and central Norway, designed to standardise screening instruments used in the programme, and to estimate the prevalence of behavioural disorders among children in the age range 4-12.
4. A user study and evaluation designed to give a broad picture of families' situation before and after treatment, as well as their views about the help that the programme provided.
5. Development projects: (1) Introduction of modified parent group treatment designed as a preventive programme: (2) Development of clinical competence in Webster-Stratton's Classroom Management Programme for teachers and pre-school staff.
6. Three doctoral dissertation projects carried out within the programme, including meta-studies of research into treatment of behavioural disorders, characteristics of children with pervasive behaviour problems (home and school, gender differences), teachers' approach to behaviourally disturbed children, evaluation of a condensed version of parent training for preventive purposes etc.

Oppositional Defiant Disorder and Conduct Disorder

The DSM-IV classification system includes two severe behavioural disorders which can affect children. Oppositional defiant disorder (ODD) has the following symptoms, which have to present for at least six months:

The child often:

- Actively defies or refuses to comply with parent (adult) requests and argues
- Loses her/his temper, easily irritated, becomes angry
- Yells, screams
- Is spiteful and vindictive
- Blames others for his/her mistakes

Conduct disorder (CD) is characterised by the following symptoms.

- The child is aggressive toward people and animals, bullies, is involved in physical fights and shows cruelty
- Destroys property, may set fires
- Is deceitful, steals
- Commits serious violations of rules (stays out nights, runs away, truancy)

These symptoms must have persisted for the last 12 months.

Why treat ODD and CD in young children?

Early intervention is recommended because research in the last twenty years has established that behavioural disorders *can* be detected at an early age (from around four years) and because these problems, once they become evident, are relatively stable. They are likely to persist unless some form of treatment is provided. It has been shown that early onset in itself tends to predict more severe, long-lasting problems and a poorer outcome, with a substantial risk of anti-social behaviour in later childhood and adolescence, and in adult life. The severity and scope of symptoms at an early age are associated with outcome; the more problems early on, the poorer the outcome. Comorbidity of ODD and Attention Deficit Hyperactive Disorder (ADHD) gives a particularly unfavourable prognosis, and these two disorders frequently occur together. If problems are manifest in more than one setting, for example in the home and in day care/school, the prognosis is also less favourable.

Treatment approaches based on parent training were first developed in the USA in the 1980's (Forehand & McMahon 1981, Webster-Stratton 1981, Eyberg 1988). These treatments have a number of elements in common. Forehand's programme exists in a clinic and a home version. Two therapists work with the family for 10 sessions. The treatment is divided into two phases. (1) differentiated attention, reinforcement and attention to the child, and (2) a focus on the child's negative behaviour, appropriate commands and the use of "time-out". Forehand has developed other treatment packages: parent self-control training, social learning principles, and parent enhancement therapy (focussed on depression, marital problems etc.). Eyberg's programme is divided into two major phases: (1) play with a non-directive and positive approach, and (2) discipline skills, with a focus on clear commands and positive reinforcement. The treatment is available in individual and group formats and Eyberg's original trials have been replicated.¹

Webster-Stratton has carried out no fewer than nine controlled treatment outcome studies and three preventive studies. These include comparisons of the Basic Programme with waiting list controls, with the Advanced (parent training) Programme, and with a combination of Basic Programme and Dinosaur School. Cost-effectiveness studies include individual versus group format, and a self-administered version of the Basic Programme versus this programme in the nowadays usual group format. A school programme (Classroom Management), designed for teachers and similar to the Basic Programme, has also been evaluated. All these studies are controlled trials with one-year

¹ The preventive studies carried out in 1999-2003 were controlled trials among young children in day care in the USA, using a comparison with the Head Start programme and a combination of Head Start and the Basic Programme.

follow-up. There is also a comparison of the Basic Programme with the well-known Head Start programme, and this study has been replicated. These studies establish some predictors of outcome. For the Basic Programme there is a higher risk of relapse for single parents and families that lack social supports. For Dinosaur School negative parenting (over-critical, use of punishment) predicts a poorer outcome, but parental stress and ADHD diagnosis do not have a negative effect. Interestingly, none of these factors seem to exert a significant negative effect at one-year follow-up. An extensive study of moderators, mediators and predictors of treatment outcomes is now in preparation (Beauchaine, Webster-Stratton & Reid 2004).

The Norwegian programme

The decision to adopt Webster-Stratton's treatment methods for work with families of small children in Norway was influenced by recommendations made by a committee set up by the Norwegian Research Council (NFR). The results documented in her numerous studies are impressive. After parent training 70% of children showed reductions in behaviour problems that could be defined as clinically significant, using measurements based on questionnaires and observation. 60-70% had scores below the 90th percentile on behaviour questionnaires administered to parents, after treatment.

Until the mid-1990's, children and young people with severe behavioural disturbances, and their families, received little useful help from the health, social and educational services in Norway. There was general awareness of this, but little progress was made. In part this was due to the lack of promising methods which might serve as a basis for intervention. Responsibility for helping affected children and families was also divided between a number of different agencies and services. Help was difficult to obtain, and was poorly coordinated. Parents who were concerned about their children's behaviour, often became frustrated and demoralised, a state of affairs that made their already precarious and vulnerable situation even more unfavourable. There was also little awareness of the fact that children can show signs of severe behavioural difficulties at an early age, and no basis for early intervention could be said to exist. Child psychiatry received few referrals of children and young people with behavioural difficulties, and there seems to be agreement that the treatments offered at that time, were ineffective. Many of the worst affected children and young people did not get help at all. There is no systematic or research-based record of any of the actual results obtained from treatment before the late 1990's.

Research and method development, disseminated in international publications in the early 1990's, led to a situation in which there was some hope of better provision. The main difficulty for health, educational and social services here in Norway, was that a coordinated effort would be required to introduce such methods. From 1995, central government began to work towards this.

The researchers who developed proposals for a large-scale trial of Webster-Stratton's methods work at the universities in Trondheim and Tromsø. In 1998 the Norwegian research council (NFR) published the report from the expert committee, which provided a summary of available research dealing with severe behavioural problems among children and young people. The committee had been set up as a response to general concern about behavioural problems, and anti-social and delinquent behaviour among children and young people. It recommended adoption of certain methods (Parent

Management Training (PMT) and Multi-Systemic Therapy (MST) as well as trials of Webster-Stratton's treatment methods.²

PMT and MST have been introduced and disseminated in a programme supported by the Ministry for Child and Family, conducted by a group based at the University of Oslo. The group of researchers who initiated the Webster-Stratton trial was funded by the Ministry of Social Security and Health, and this was logical in the sense that their proposals involved a trial conducted in treatment facilities based in child psychiatric services. Both groups started their preparatory work in 1998.

The clinical trial which was set up was a three-group experimental design, in which effects of treatment (Basic Programme and combined Basic Programme and Dinosaur school) would be compared with non-treatment (waiting list control group). Planned group sizes, based on statistical calculations, were 60 for the two treatment groups, and 24 for the waiting list controls. Inclusion criteria were strict, only children scoring higher than the 90th percentile after screening with Eyberg Inventory (ECBI) *and* fulfilling diagnostic criteria (DSM IV) for oppositional defiant disorder or conduct disorder, were included in the trial material. Exclusion criteria were few: only children with gross learning difficulties, including autism, or with gross sensory deprivation, were to be excluded. Treatment was offered at two clinics (Trondheim and Tromsø). At the end of the projected two-year trial period, the trial material included 127 children.³

The rationale for a clinical trial of Webster-Stratton's methods reflected the project team's scepticism relating to adoption and dissemination of new methods, as this has traditionally been practised in Norway. All too often, new methods have been introduced without adequate investment in preparation and training. This has often meant that the version of a method that is introduced may not be particularly faithful to the original, and that evaluation procedures are neglected. The infrastructure and preparation involved in replication of randomised trials "from scratch" are considerable, and require funding and planning. In addition, many methods have been introduced and implemented without trials, so that the costs and benefits involved have not been properly assessed.

Even at the very start of our work, it was apparent that expertise in behavioural analysis and learning theory would be crucial in the project that was envisaged. It was appreciated too, that the project envisaged would be so large as to overstrain the resources available to one university clinic and its associated university department of child psychiatry. These considerations led to the establishment of close cooperation between the project group in Trondheim and a similar group at the University of Tromsø.

At a very early stage, it became apparent that a project would have to maintain a dual focus:

² Per Rypdal, a clinical psychologist working at the University of Trondheim, served on the expert committee, and it was his initiative which led to the decision to initiate project planning, designed to provide a platform for introduction of Webster-Stratton's methods in Norway.

³ The project involved treatment during the initial training period before the trial started, and a number of children who almost fulfilled the inclusion criteria also were treated, so that over 220 children had been treated before the end of the trial period (June 2003). All these have demonstrated positive effects for the Basic Programme, also at follow-up.

1. New and demanding manual-based treatment methods would have to be introduced, and such approaches were (and still are) novel in child psychiatry in Norway, as indeed they are in services for children and young people as a whole. In particular, the scope and intensity of training procedures involved would represent an innovation, which clinics might well find difficult to cope with. Personnel recruited for the trial would have to be selected on the basis of their suitability and their willingness to work in a manual-based treatment programme. A lengthy period of training (lasting one year before the clinical trial could begin) added to the overall cost of the project. We also found it imperative that maintenance of standards and programme/treatment fidelity in a clinical trial conducted at two sites (Trondheim and Tromsø) should be secured by giving overall direction and coordination of training and clinical work to one person.⁴

2. Much difficulty in developing programmes for helping families with young children suffering from behavioural disturbances has arisen from the fact that few of the affected children are identified before they have reached the age of eight or nine years, that is to say, at an age when severe disruption of family and peer relationships, and deterioration of school performance will often have developed. At this stage, much of the damage which behavioural disturbance leads to, will already be evident. Even if parents and community service professionals, including kindergarten and school, see that a child under the age of nine has difficulties, this may not be enough. It may take time for adults to accept that the problems are real and severe, and that the child will not "grow out" of them. To refer a child for psychiatric help is, quite reasonably, seen as a serious matter by professionals and parents alike; and referral procedures are often a barrier in themselves. We decided to make special efforts to reach affected families and children, by providing help and advice from independent coordinators in the areas where the clinical trial was conducted, and we also monitored referral. The coordinators would give assistance to community social work, nursing and teaching staff to facilitate referral, and provide information for parents. The coordinators also facilitated screening of children at an early stage.⁵ This was done with the intention of being able to compare referral data with material from a prevalence study which also was included in the project plan. No satisfactory epidemiological material has been available to assess the prevalence of severe behavioural disturbances (ODD and CD) among Norwegian children. So a standardisation project conducted in Tromsø and Trondheim where the projected trial would be conducted, as well as a project to

⁴ The team that initiated and planned the research consisted of Graham Clifford, Bo Larsson and Per Rypdal from the Department of Child Psychiatry in Trondheim, Willy-Tore Mørch from the Department of Child Psychiatry in Tromsø, and Torill Tjelflaat from The Regional Centre for Child Protection Research in Trondheim. Jim Lurie at the same centre worked in the project from January 2003. Sturla Fossum and Charlotte Reedtz (Tromsø), and May Britt Drugeli in Trondheim worked as doctoral students in the project. Graham Clifford was project leader in the planning phase (1998-2001) Willy-Tore Mørch took over as project leader in January 2001. Project planning, supported by funding from the Directorate of Health, began in 1999.

⁵ A report based on analysis of referrals in the first year of the clinical trial has been published. The purpose of the report was to provide a basis for decisions about what recruitment policy should be adopted for the second part of the trial. This proved to be a useful exercise, because recruitment of children to the project initially proved difficult. Recruitment issues seem in fact to be one of the main problems that must be addressed in implementing Webster-Stratton's programmes more generally in Norway.

provide material from a large sample (around 3000 children aged 4-12) were initiated. Projects aimed at securing referral of children to the clinical trial were carried out by the Child Protection Research Units in Tromsø and Trondheim.

The project (in its scope more a programme than a project) was far too large to be funded only with the support of the Norwegian Research Council. It involved the development of special treatment facilities with appropriate staffing in Trondheim and Tromsø, the work of a moderately large research team, the work we have briefly described above relating to referral and epidemiological study, training and the direction and coordination of treatment in two child psychiatric clinics, and not least, extensive preparation and planning which in fact took almost two-and-a-half years to complete, and which in itself represented a considerable outlay of resources and time. Almost a quarter of the funding resources we have used have been devoted to planning and preparation, including training. Though a project of this scope and size was very expensive and more or less unprecedented in Norwegian child psychiatry or child research (it is one of only two randomized treatment studies ever attempted in Norwegian child and adolescent psychiatry, and over and above this included other research components), government support and commitment was provided. The research centres that have worked on the project are set up to facilitate innovation and implementation, so that the legitimacy of the very considerable effort devoted to the project was hardly an issue. There have been some critics who doubted the wisdom of such large resources devoted to trials of a single group of methods, but the project on the whole has been well received.

At the present date, the clinical trial based on a three group design (Parent Training, Parent Training combined with Dinosaur School, and waiting list controls) has been completed, including one-year follow-up. Webster-Stratton parent groups have been introduced in a number of other clinics with guidance and training from our project staff, and a programme designed to assist teachers, and another to test preventive interventions (a variant of Webster-Stratton's parent groups), are being developed. Proposals for broader implementation of Webster-Stratton methods are under consideration, and many agencies and clinics have expressed an interest in the methods.

2. The treatment, the setting and the trial

Introduction

The Webster-Stratton programme in Norway was designed by a group of "outsiders" in the sense that most of the team had no or only limited clinical experience in child psychiatry. *The Incredible Years* has also been an interdisciplinary project: researchers have backgrounds in clinical psychology, child psychiatry, social work and education.

The programme was "researcher-initiated" to a considerable extent, and the team was on the whole sceptical about prevailing practice concerning innovation. Import of methods from abroad, approaches to organising research, stringency of design, attitudes to manual-based treatment, fidelity, and not least prevailing standards related to training in new methods, all gave cause for concern. The explicit aim was to secure high standards in all these areas. These high standards were in a sense the common philosophy the project was based upon. They were worth striving for, for their own sake, but were also seen as necessary to secure a valid base for the elaborate and complex research that was planned. The research team did not have altogether unanimous views about the scientific basis or emphasis of the treatment that was to be offered, though from the start all agreed that the behavioural analyst in the team should have the leading role in developing treatment and in training. Behavioural therapies have been controversial in Norway, and the sharp focus the project acquired by using these methods might have seemed something of a risk. For the research team, applying Webster-Stratton's methods properly and without modification seemed preferable to accepting a prolongation of the situation we had been in for so many years; that is having nothing to offer families afflicted by the severe behavioural problems of young children.

We emphasise these issues here because the project, like its counterparts developed to implement PMT and MST, was very much focussed on applying a method with considerable rigour and fidelity. The "therapists" (a term we abandoned in favour of "group leaders") whom we recruited were chosen largely because of their perceived suitability, that is to say, their willingness to work in a manual-based approach, with constant evaluation and supervision, and de-briefing by means of video analysis. In sum all this represented an innovation, since child psychiatry in Norway has characteristically allowed its practitioners a good deal of individual discretion, not much mitigated by supervision practices based on a one-to-one approach. The group leaders were by no means all recruited from child psychiatry in any case, and included clinical psychologists, social workers and educational specialists of various kinds, as well as milieu therapists. Many had worked in child protection or the school psychological and educational services. The research team saw breadth and variety of background as desirable. Treatment competence was seen as a matter of training and experience, rather than being the prerogative of any particular profession.

The Norwegian programmes set up to introduce new methods for helping children and young people with behavioural problems, have had a good deal in common. PMT and Webster-Stratton's methods in particular have had a good deal of common ground. The programme strategies were, however, dissimilar in that the PMT/MST was approached as an implementation programme (and has only relatively recently been enlarged to include full-scale testing of methods) while the Webster-Stratton group's strategy was to test the methods first, to provide a basis for decisions about implementation. Another difference was that the Webster-Stratton programme was carried out within child

psychiatry. This led to some research emphases that were not found in the original Webster-Stratton treatment studies - for example collection of diagnostic data and examination of co-morbidity patterns.

The clinical setting for the treatment trial

The Basic Programme and Dinosaur School are innovative in the context of child psychiatry in Norway. This is partly a matter of methods. Group work with parents is not altogether unknown in child psychiatric clinics, but it is not used frequently. Manual-based treatments with a strict, programmed sequential order have been very unusual. Group therapy for small children is also very unusual.

The clinical settings that were organised to offer Webster-Stratton treatment were very untypical of child psychiatry in some respects. As indicated, most of the group leaders were specially recruited from settings outside child psychiatry. Only a few had received the relatively lengthy training that is normally required for those who must qualify to work in Norwegian child psychiatric clinics. The trial teams were also organised as separate enclaves within their clinics, and especially so in Trondheim, where the majority of families involved in the trial live, and where the trial was conducted in a special research clinic set up for the purpose. Staff received specialised training, quite distinct from the usual training given in child psychiatry.

Prevailing expectations on the part of parents would still operate of course, since they probably would not appreciate that the Webster-Stratton service in effect had been set up in a special "customized" setting. We know very little about parents' preconceptions and expectations in relation to child psychiatry here in Norway. There is very little systematic research that deals with such questions, though government-sponsored research on a fairly large scale is under way.

In child psychiatry, relations with children and their families are of course seen in a clinical perspective. Child psychiatry has an explicitly multi-professional staff composition; outpatient clinics employ psychiatrists, psychologists, social workers and educational specialists (and in increasing numbers, family therapists). All these professionals are trained in clinical work, with an emphasis on self-insight and self-control in order to allow purposeful and focussed work on behalf of children and their families. It seems evident that clinics have a very different ethos from that of community services.

From our vantage point when designing our study, it seemed advisable not to be too much concerned with the self-perceptions of trained clinical staff in child psychiatry, simply because the trial project had a majority of staff *who had not received clinical training for child psychiatry*. This team composition to a great extent served to isolate the two Webster-Stratton treatment teams from the child psychiatry settings where they were located. Insofar as the host clinics could exert an influence, this would be transmitted to the treatment teams by their leaders, who had long experience of child psychiatry, or indirectly by means of procedures and structures imposed by the host clinics. It seems likely that the trial staff were most strongly influenced by the training and supervision which they received in the project, as was indeed intended: recruitment of staff without child psychiatric experience was a means to ensure that special training had as much impact as possible.

Content and Structure of the Basic Programme

Beyond these issues of general approach and background of the clinical staff, the treatment trial had a markedly innovative content seen in relation to child psychiatric practice in general here in Norway.

The Basic Programme can perhaps best be described as a composite of different methods and themes. This is quite explicit in the sense that the structure of the programme is sequential, with the early sessions devoted to helping parents understand how to strengthen their relationship with their child, and understand age-appropriate ways of relating to children, and not least what are age-appropriate expectations. The programme then moves on to deal with practical and everyday issues - what rules should be enforced, and what routines can be established - before dealing with methods parents can use to avoid reinforcing undesirable behaviour. Some of the devices taught are counter-intuitive, such as the necessity of ignoring annoying and irritating behaviours. Or culturally somewhat alien, such as the extensive use of rewards for children. An understanding of behavioural analysis principles on the part of group leaders is necessary: this is dealt with in a preliminary workshop before trainees study the manual, prepare sessions, and begin their work with groups of parents.

The groups consist of 12-14 parents (some other significant adults may be drawn in when this is considered appropriate) and sessions must be conducted so as to involve all participants. Group leaders (there are two in each group) have somewhat different roles. They must take care to respond to all the initiatives and questions that arise, as immediately as possible. A group session must not end with unresolved questions. The main devices the sessions are based on are video vignettes, which are used to introduce topics and illustrate points, and role play, in which group leaders are expected to take the lead. All sessions are videotaped and used in debriefing supervision afterwards. This is an important aid to supervision and programme fidelity, and is especially important in training. One group session will require about 12 hours' preparation and debriefing for group leaders in the training phase. It will be evident that group leaders need to develop considerable group work skills during their training.

On the whole, Webster-Stratton's policy has been that it is better for group leaders to specialise in one or other of the variety of treatment programmes, at least until considerable experience has been gained. Training, as elsewhere in clinical practice, is largely practical, and it is based on *working with parents*. There is relatively little theoretical or classroom training divorced from actual preparation for groups or de-briefing and supervision. Few of the staff recruited to the project had much experience of group work structured along these lines.

There are a number of features of the treatment that deserve special comment since they may have had some impact on the way parents perceived the sessions and indeed the treatment as a whole.

1. Group sessions are manual-based: each session of two hours (there are in all 12-14 sessions in a course of parent training) in the sequence must deal with particular topics. There must be no "run-over" between sessions. Group leaders must lead the group through the video vignettes that are specific to each session. Despite this structuring, it is imperative that sessions build on initiatives and contributions from the parents themselves. Conclusions in the form of principles and rules should be emphasised, but as far as is possible these should be identified with conclusions and

insights parents themselves have expressed. This is important because it is regarded as all-important that parents identify closely with the content of the training. Discussion and consideration of practical ways of helping children must be related to parents' own experience and problems. These guidelines are easy to state, but difficult to practice.

2. The group sessions constitute the whole of the treatment. As a rule, supplementary individual counselling is not provided, though the clinic might respond to an exceptional situation. The intention here too is to get parents to identify with the group, see that other parents have the same kind of difficulties as the ones they encounter, and see the "lessons" learnt in the group as their own "property". Other devices and strategies underline the socially rewarding aspect of belonging to the group. Sessions are arranged at times that are convenient for parents (after normal working hours). Personnel are provided to look after children if parents are unable to make their own arrangements. Coffee and tea and light meals are provided, and parents can have travel expenses reimbursed. All effort is devoted to ensuring that parents can attend each session, and non-attendance is always followed up. Parents are contacted and offers of assistance made if practical difficulties have arisen. All this underlines the message that each parent is important and valued as a member of the group. No structured follow-up after the completed course of sessions, is provided.
3. Parents have to engage in some activities that might be unfamiliar. For example they have to engage in role play, and it is expected that they will attempt to practice the principles developed in group sessions, at home. These "homework" tasks are followed up in the next session.
4. An explicit aim is that sessions should be enjoyable. Laughter and humour are seen as important, even though the sessions deal with serious and painful issues. A light tone reduces the threshold for learning and identifying with the group and the group process. Hesitant parents will be encouraged and reassured much more easily when the general atmosphere is lightened. This aspect of group management is also part of the group leaders' responsibility.

These features of the programme give rise to many questions about parents' response and own view of a highly structured programme. There are for example, questions about parents' identification with the group, and the extent to which they are able to learn from other parents. And we can ask whether the fact that the group sessions constitute the whole of the treatment, can lead to a situation in which parents miss whatever support the groups give, when the programme has terminated. It may seem rather strange to cultivate a relatively intense integration in and attachment to a group, and so terminate this after three months. There are also a whole series of questions relating to the actual content of the programme, and the methods used in the groups, especially the extensive use of role play and video.

Content and Structure of Dinosaur School

Dinosaur School is a group therapy for small children aged 4-8 years, and it was originally designed as a supplement to the Basic Programme. Its aim was to give children with severe behavioural problems a basis of social skills for relating to adults and other

children. The therapy uses elements and principles that the Basic Programme is based on, and was expressly designed to be complementary. In recent years, however, Dinosaur School has been put into use in schools in the USA, as a universal prevention intervention offered to whole schools, aiming to increase self-control and enhance peer acceptance. In this form it is adapted to classroom settings for the youngest children. Teachers lead sessions for all the children in their classes. In Norway, a similar implementation could take place in kindergarten and the first school year, though the challenges and costs associated with disseminating the method at first sight may seem considerable.

The therapy (14 weekly sessions) is led by two group leaders: a group includes 5-7 children. Its distinguishing feature is the use of large hand-held puppets, including Dinah the dinosaur who is the school "headmistress". Videos are used, and there is an extensive use of rewards in the form of stickers which via a points system, enable children to earn prizes of various kinds. Positive behaviour is promptly rewarded, and the puppets are used to convey the rules of behaviour children are encouraged to learn, relating to elementary principles for classroom behaviour.

Dinosaur School requires extensive skills on the part of group leaders. They must provide a structured and sequenced programme for a number of children who may be unruly or aggressive or both, and have difficulty in concentrating, are easily distracted, and lack age-appropriate social skills. It represented something of a challenge for our Norwegian programme in that group therapy with such young children has been very uncommon here.

In the randomised trial, parents tended to be disappointed if their children were not selected for inclusion in Dinosaur School. They correctly perceived that this might represent a somewhat inferior solution for their child. Combined Basic Programme /Dinosaur School has been shown to lead to somewhat larger improvements in behaviour in the home setting, though the additional "effect" is not very great seen in terms of the additional reduction in ECBI scores obtained. Assessment of the extent to which Dinosaur school improves children's behaviour in school or kindergarten settings is a complex issue, which will be dealt with in a subsequent section. For very young children, many of whom do not seem to be regarded as particularly "difficult" by pre-school staff even though parents report considerable difficulty, it may be difficult to draw conclusions. What does seem to emerge is that Dinosaur School is associated with some improvements in the home setting, which parents report and appreciate. Another issue that bears upon the interpretation of possible beneficial effects of Dinosaur School in a Norwegian setting, or non-response, is that children are introduced to classroom settings and the behavioural requirements these impose, much later than children in the USA or for that matter, in the UK. In reality, perhaps two to three years later. How this might affect the impact of Dinosaur school, seemed difficult to predict when we designed our project.

It is fair to say that these uncertainties did not at any point deter the project team from including Dinosaur School treatment in the programme design. Some of us saw the treatment as valuable because it was seen as being founded on learning theory, whilst some emphasised the importance of developing social skills among the in this respect very needful children that we anticipated would be recruited to the project. It is also a matter of record that the opportunity, rarely available, to offer a manual-based group

treatment for young children, seemed so intrinsically worthwhile and attractive that no consideration could have deterred us from introducing it.

Parents receive treatment in a specialised setting

Something that we had to take into account was that treatment not only had an innovative design and context, but that it also took place in a highly specialised setting. Children and families were assessed before admission to the treatment, but this assessment in most cases did not amount to a diagnostic assessment like that which is universal in normal practice in child psychiatry. As has been explained, the need to control the clinical setting in order to facilitate research produces and ensure fidelity, led to a setting which differed in some important respects from that which would be usual in a child psychiatric clinic. Parents encountered this when they entered the programme, the more so of course, because the already sequentially ordered treatment was complemented by quite elaborate measurement and assessment procedures. Parents were, to put it simply, placed in a situation that was initially more demanding than what would have been the case in a conventional approach in child psychiatric work with consultation and counselling. They had to fill in a large number of questionnaires and test instruments, undergo interviews dealing with many issues, some of them sensitive, and attend the clinic with the child so that observation-based tests could take place. Parents had to accept the uncertainty attendant upon a randomized waiting-list design, and a minority had to wait for some months before treatment could start, because their child was assigned to the waiting list control group.

Benefit for children and their parents is the justification for evidence-based methods. For the parents in the project, the reality of evidence-based treatment was in the first instance a burden in the form of assessment procedures that had to be completed before treatment could begin. Some parents had reservations about this and a few elected not to enter the programme for this reason. A few refused to complete follow-up assessments after treatment. Referral procedures too would tend to convey to parents that they were entering a "special" innovative programme. Information about the treatment in local and national media would have the same effect.

"Treatment" is a concept that implies a defined problem, defect or illness that has an established, systematically applied solution. Treatment may be based on a theoretically argued premise, and perhaps most often is, but the movement toward evidence-based methods in child psychiatry, reflects a weakening of allegiance to theoretical doctrines, and a more pragmatic, eclectic approach. "Treatment" rather than "therapy" is probably the correct term in the case of Webster-Stratton's methods: group leaders approach parents in an open fashion, there are no hidden agendas in the treatment and all the methods used can be discussed with parents, though abstract and generalised discussion is certainly not regarded as productive in this form of treatment. We have noted that group leaders in the Norwegian project, were at first called "therapists", but that this term gradually was used less often.

Our view of all this is that the demands imposed by evaluation of methods, and replication of these methods, as well as the organisation of the clinics, in effect would convey to parents that they were receiving a specially designed and innovative form of treatment. This might be expected to influence their opinions about the help they received, and maybe influence the actual impact of the treatment itself. But the effect upon parents of participating in a trial programme, with extensive assessment and

research going on, most of which requires that they answer questions that to some extent represent an intrusion into their privacy, including highly sensitive areas, is hard to predict. The issue is of some interest beyond this particular project and treatment, because the advent of evidence-based methods in services for children may result in an escalation of registration and assessment procedures. This has an ethical aspect, and a related question is whether parents in fact will tolerate these demands.

Pre-school and School Environment

A point of view that has gained much ground is that children who have behavioural difficulties will be helped far better if the same principles are applied to management of their behaviour, both at home and in these out-of-home settings. The importance of this is underlined by the fact that research seems to indicate that programmes and treatments aimed at dealing with behavioural difficulties in the home setting, very often do not lead to improved behaviour at pre-school or school. Most studies in fact find little evidence of such *generalisation*, though the extant research is rather varied in approach and methods and so hard to assess.

With the passage of time, the possibility of intervening in school and preschool has weighed more heavily in discussion about policy in this field. It seems to be imperative to develop school-based programmes for a number of reasons. Children at a very early stage in their schooling can be severely disadvantaged if their behaviour results in isolation from, or conflict with, the other children, and they will in effect be the first and most severely affected victims of their own disruptive behaviour. It seems very unlikely that they will be able to recover lost ground at a later stage. Social, emotional and intellectual development will be seriously affected and functioning impaired, probably before the behavioural problems involved reach a level that is intolerable for other pupils or the teachers involved. Other children involved will of course gradually suffer too, though it seems that these effects become so serious as to cause conflicts only after children have been in school for about 3-4 years. An equally important issue, however, is that teaching staff too are likely to be adversely affected by the presence of children with serious behavioural problems. Few are likely to cope with this in an entirely satisfactory way, for the obvious reason that they are not trained to deal with such problems. They may become partly de-motivated and demoralised, and they may even adopt strategies that isolate and stigmatise the child or children concerned. Little is known about the attitudes, expectations and resources of teachers placed in this situation.

A doctoral project incorporated in our programme addressed these issues. In addition, in 2001, we decided to initiate work with the Webster-Stratton Classroom Management Programme. This programme, in essence an adaptation of the Basic Programme, is designed to assist teachers. It is administered as a series of concentrated one-day sessions and uses specially adapted content including video vignettes. A relatively small-scale project in Trondheim was initiated in cooperation with the local authority, and later similar projects were started in Kirkenes and Tromsø in northern Norway. Although teachers' response to this has been more or less uniformly positive, we have no adequate research material to assess the substantive effects of this programme in a Norwegian setting. Evaluations are now being planned as part of the projected Webster-Stratton implementation programme. Use of Dinosaur School, preferably at pre-school level, has also been discussed. On the whole, our approach to intervention using these methods in school and in pre-school, has been rather circumspect. One reason is that it would be useful to have some evidence about generalisation from the Basic Programme and the

clinical version of Dinosaur School before making decisions about implementation. Another issue involved is the relatively restricted numbers of qualified supervisors (mentors) available, which will limit the scope of implementation that is possible for some time yet. And the Classroom Management Programme has only been in operation in the USA for a very few years and the first evaluation study from the Parenting Clinic in Seattle was only published recently (Webster-Stratton 2003).⁶

Avoiding stigma

As we have pointed out above, policy governing child and adolescent mental health in general is undergoing something of a transition in Norway at present. There is an emphasis on realignment of service provision to increase accessibility for users, and a desire for much greater attention to users' preferences. For young children, this means that parents to a much greater extent than formerly, should be active participants in treatment. This is seen as both their right and their responsibility. Central authorities would also like to see somewhat less emphasis on psychopathology and illness, and more emphasis on practical problem solving and cooperation, preventive work, and fluid and flexible approaches to demarcation between agencies at community and specialist levels.

One of the features of this realignment is a determination to reduce the stigma that can attach to families' use of services such as child protection and child and adolescent psychiatric services. Colton (1999), reporting an international comparative study, identified stigmatization as one of the main negative aspects of services for disadvantaged and vulnerable young people. The greater the difficulties and disadvantages children and young people confront, the greater the risk of them being stigmatised. Since education, health and social services are identifying more and more young people who need help, and since Norwegian policies have resulted in a rapid growth in the numbers of children and young people who are categorised as having special needs, the risk of stigmatisation is very real. Critics (Wyn & White 1995) have suggested that the growth in the numbers of children who are defined as having special needs exposes those concerned to the risk of marginalisation. The unintended stigmatising effect of specialised service provision can outweigh the benefits such services provide. Child psychiatry has always itself evinced a good deal of uneasiness about this. A very strong emphasis has been placed on the voluntary nature of parents' involvement with psychiatric services and the absolute nature of confidentiality. Present policy aims at a considerable enlargement of the numbers of children and young people receiving help from child psychiatry, in effect an increase of about 120% over an eight year period. Services have to be made more accessible and barriers, including constraints on cooperation between child psychiatry and other agencies, reduced or eliminated. But above all, government would like to see a stronger commitment to involving parents as active partners in treatment and preventive work.

⁶ PMT has a school programme which is about to be implemented in Norway. An evaluation is under way, but it will be some time before the results are available.

The ideals espoused by proponents of more thoroughgoing "decentred" approaches to professional-client relations are relevant in this contest. As an example we can refer to the often-cited principles advanced by Peyrot (1982) which it is claimed must be observed before clients can be said to "own" their problems. Clients must be able to:

- Decide whether a problem exists
- Define what the problem is
- Decide whether anything should be done
- Choose between alternative forms of help
- Initiate, regulate or terminate their contact with helpers

It's obvious that child psychiatry has always respected the first and third principles, and the last, since insistence that parents must choose to ask for help before referral implies this. Treatment is quite voluntary and depends on parents' assent, so it can be discontinued when they want. It is less easy to believe that parents whose children suffer from worrying difficulties will have found it easy to choose what form of help psychiatry might give, since they are under pressure, and probably most often do not have the offer of alternative forms of help anyway. The second principle can rarely have been observed in child psychiatry, since it by definition has operated as an expert consultative service. There are in any case some indications that parents prefer a situation where helpers have an expert role.⁷

Webster-Stratton's programmes were first offered in a "parenting clinic" at the School of Nursing at the University of Washington, Seattle. They were not designed to be used in psychiatry, and indeed the structure of child psychiatric services in the USA might make it seem unlikely that they would be offered in such a setting. But the operant assumptions in the programme fit fairly comfortably into the ethos of child psychiatry as it is practised in Norwegian settings. The Basic Programme does not differ much from practice elsewhere in child psychiatry in these respects, but very great efforts are made to persuade parents to complete the programme once they have entered it, and some maybe would feel that these amount to a strong or even untoward moral pressure. The Basic Programme seems to embody a very strong "expert position", though of a very positive kind. Parents are told that children's problems can be managed, they are reassured, and efforts are made to ensure that they feel that their own contributions are valuable. This positive reinforcement, and the will to communicate ideas concerning management of behaviourally disturbed children in terms that parents can grasp, are very much in tune with the policies being advocated by the Directorate of Health, but the Basic Programme must still be seen as an expert-led, if not expert-centred form of treatment.⁸

⁷ For example, a pilot study based on interviews with parents whose children attended a child and adolescent clinic in Molde. This suggests that parents value the staff's expertise and knowledge, and that they prefer to leave decisions about treatment to staff, although in general wanting to have as much information as possible about assessment, diagnosis and treatment.

⁸ Some of the viewpoints that are conveyed in the *Strategic Plan* of 2003, seem to rest on the conviction that child psychiatry is characterised by an often poor state of relations between parents and professionals. It is true that auditing by the County Public Health Officers in 2002-2003 revealed a number of serious lapses in procedures, and local practices that in some cases did not conform to the regulations laid down. Cooperation with community agencies was also found to be uneven in quality, and doctors in the community health services were often not involved in referral to child psychiatry. There is so little research material that bears directly upon professional-patient relations in child psychiatry that some of the viewpoints embedded in the *Strategic Plan* seem unreasonable. It seems that the plan, like a good deal else within current child and family policy, tends toward *dirigiste* rhetoric on occasion. Or perhaps the idea,

The team that led our project work did not want to make *a priori* judgements about how the *Incredible Years* programme ought to be implemented. Clearly, accessibility is a major consideration, and even with the relatively decentralised organisation of child psychiatric facilities in Norway, implementation only within child psychiatry might well limit accessibility.

3. Treatment Trial⁹

Introduction

The treatment trial that was conducted in the Norwegian Webster-Stratton project was a replication study.¹⁰ It attempted to reproduce as faithfully as possible the treatments devised by the originator, and the research design was set up on the basis of her work. Children's behaviour as assessed by parents and teachers was measured pre-post, and in a one-year follow up, after children had been randomly assigned to groups that (a) received Parent Training (Basic Programme), (b) received Child Training (Dinosaur School) plus Parent Training, and (c) were placed in waiting list control. Certain modifications and improvements concerning instruments and measurements were incorporated after suggestions made by Carolyn Webster-Stratton. These were not very extensive, and much of the original instrumentation and measurement was retained. The Norwegian project, in contrast to Webster-Stratton's work, also included diagnostic assessments based on DSM-IV criteria using the Kiddie-SADS interview methods. Inclusion criteria were slightly stricter than in the original study by Webster-Stratton since children included in the research material had to satisfy both screening (ECBI cut-off) criteria, and diagnostic criteria.^{11,12} Some children not fulfilling DSM-IV criteria were excluded from the research material, though they were as a matter of course provided with treatment.

The research material is extensive and includes:

1. Socio-demographic information.
2. Parent and teacher (day care and school) reports of emotional and behavioural problems among the children.
3. Child social competence and peer relations.
4. Child development and health.
5. Home and clinic observations, semi-structured admission interview, questionnaires.

The treatment trial, planned and executed to conform to standards for establishing evidence-based methods, represented a forbidding amount of preparation and organisation, and was a learning experience.

⁹ This chapter is based upon a presentation by Bo Larsson and Willy Tore Mørch, made at a conference in Auckland N.Z. in September 2004.

¹⁰ Previous replications: in Canada Taylor et al. (1998), Parent Training and Dinosaur School compared with eclectic outpatient therapy: and in the UK Scott et al. (2001) Parent Training and Dinosaur School compared with waiting list controls.

¹¹ Children had to have ECBI intensity scores above the 90th percentile using Norwegian normative data; and they had to satisfy DSM-IV criteria for either/or ODD/CD, the relevant information being elicited with a systematic diagnostic interview (Kiddie-SADS).

¹² Eyberg Child Behaviour Inventory is a 36 item questionnaire designed to elicit parental reports of behaviours relevant for ODD and CD. The items yield a problem score (is this a problem for you?) and intensity scores (problems assessed by parents on a 1-7 scale). ECBI has been standardised in the USA. A Norwegian standardisation study was carried out in Tromsø and Trondheim for the present study. 641 children were included (321 girls and 320 boys). Parent response rate was 77%. The 90th percentile was adopted as the cut-off point for inclusion in the treatment trial after scoring on ECBI: the actual ECBI scores are girls 119 and boys 126.

Parents are the source of most of the evidence that might show that treatment works

The Basic Programme has produced impressive and consistent results, judging by published research. Nearly 70% of the children whose parents participate, show a significant improvement by leaving the clinical group, defined by the 90th percentile on ECBI scores. This is as good a result as one could hope to obtain for any psychotherapeutic intervention. Replications have obtained very similar results. Follow-up studies, including a ten-year follow-up carried out by Webster-Stratton, show that improvements are maintained over time.

It has to be remembered, of course, that treatment effects can never be fully measured, and that there are always constraints upon validity. The screening instruments that have been used (Eyberg Inventory ECBI is the central example in our project) are based on parents' or teachers' and pre-school teachers' reports of the children's behaviour. The inclusion criteria for the original Webster-Stratton treatment study only admitted children with extremely high scores. Improvements effected by treatment are due to parents reporting fewer of the behaviours in the inventory. Since the trial designs involve parents filling out the inventory a number of times, there might be measurement (validity) problems attributable to parents "learning" the items and their significance. These problems are very difficult to assess.

ECBI yields continuous total problem scores that can be used in statistical analysis. Improvements among the treated groups, when averaged, typically amount to about one whole standard deviation, and since the children treated have on average scores at about two standard deviations from the Eyberg mean before treatment, the treatment effects obtained are statistically significant. The children, on average, have scores after treatment that lie at or just below the statistically "normal" demarcation border within one standard deviation about the mean. A relevant point, of course, is that these improvements are striking, but that we can still be left with children whose behaviour exhibits many problematical features.

Another approach to measuring the extent and character of changes in the children's behaviour, is to define what improvements can be regarded as clinically significant, that is improvements that are sufficient to remove children from the diagnostic categories ODD and CD, and bring them into the range of normal variation. Or a definition of what behavioural changes might be most crucial and desirable, given that behaviour will usually not change in all respects. Independent clinical assessments before and after treatment, were considered as an alternative in the Norwegian study, but had to be abandoned being very expensive. A diagnostic instrument, Kiddie-SADS, was used. This will go some way toward allowing a judgement as to whether significant clinical improvements have been obtained, though some authorities regard Kiddie-SADS as unsuitable for longitudinal study or measurement of treatment effects.

Convergent treatment effects, for example statistically significant changes on both parent and teacher reports, might serve to confirm significant treatment results, but not all children in the age range we are concerned with, will show serious behavioural impairment both in school/preschool and at home, and treatment effects obtained in the basic programme, as in other treatments with a broadly similar approach, have often not generalised particularly well to school settings. Observation of behaviour at home or in the clinic, such as was included in the treatment studies and the replications, can also corroborate findings obtained with measures based on parents' reports. Observation-

based measures might be thought best, since they can have greater consistency due to training of observers. But also these are not without limitations, since they may provide a poor guide to how children and parents interact in crucial situations that are not likely to be consistently reproduced in clinic or brief home observation sessions.

Generally, a problem in assessing the intrinsic, as opposed to statistical, significance of treatment results using these methods is that the treatment may lead to an altered, or increased tolerance of disturbed behaviour on the part of parents, or at least some of them. There will be disagreement about the likelihood of this occurring: the main point to be made here is that parent-based measurement of treatment effects has its ambiguities and problems.

Earlier evaluations have shown that parents respond very well to the basic programme. They enjoy the sessions and receive a considerable amount of reassurance and morale-boosting, by their own account. A three-year follow up, reported by Webster-Stratton & Spitzer (1996), one of the three qualitative studies included in their article, showed that this strong positive gain persisted, despite the fact that many parents still faced a good deal of difficulty due to the children's behaviour, and that they often received little encouragement, support or understanding from others.

In view of all this, a central question that has to be asked is whether the improvements obtained, which are considerable for many families, are in the main due to perceptual changes on the part of parents, and increased insight leading to greater tolerance of their children's' behaviour, or whether they reflect the continued application of methods and practical devices that the programme teaches. And we can ask whether changes in the children's' behaviour are involved, or whether improved morale and perceptual changes on the part of parents are the main mechanism involved in producing the very favourable results obtained. We must remember that all measures of effect have limitations. Beyond this lies the question of what mechanisms actually effect improvement. As Kazdin (2003) points out, much treatment research fails to throw light upon this.

It might be that placebo or "alternative" treatment designs could help to resolve some of these issues. Quasi-experimental designs like those described by Goldberg (1979) would at any rate be interesting to apply.¹³ It may be that group counselling given to parents might achieve some of the effects that have been ascribed to group treatment in Webster-Stratton programmes, and as a contrast to the full treatment programme, help to identify what other gains are secured. It seems likely that a kind of counselling effect is secured by the Basic Programme, and we should not forget that quite restricted counselling programmes have been shown to achieve considerable subjective improvements for a wide range of patients with various quite serious and threatening circumstances and problems. The problem the treatment presents for the evaluator is of course, that it is a composite of different elements, designed by a highly skilful yet pragmatic innovator. In this it resembles some other methods that are being introduced for work with families: the evaluation problems that the Basic Programme presents us with are perhaps generic for a wide range of the "new" methods.

Qualitative evaluation might throw some light on these issues. Indeed, an interest in the persistence of treatment effects, and what this actually consists of, was the motivation

¹³ A general finding in controlled studies of counselling, also in mental health settings, is that there are marked improvements in subjective terms for those treated, and a perception of enhanced quality of life. Such improvements often persisted despite little discernible improvement in underlying problems.

behind Webster-Stratton & Spitzer's qualitative study at three-year follow up. Our own user evaluation material was collected about one and a half years after the end of treatment, but parents' situation and their experience of managing the children's behaviour then, and the way their relationship with the children has developed, are of great interest. Webster-Stratton and Spitzer found that parents, despite maintained improvements in the children's behaviour, still faced a considerable challenge in dealing with their children on a daily basis.

Children included in the trial

As indicated, children included in the trial had to fulfil inclusion criteria as defined by both screening (ECBI) and diagnostic criteria. The great majority of those referred, and so included, were boys (see table 1 below). Children under the age of six amounted to 35% of those included. This was a rather smaller proportion than we had hoped for. Of course a large number of children were treated who were not included in the trial material, either being treated in the training period or treated but excluded from the trial material because they fulfilled screening but not diagnostic criteria.

Table 1 Children treated in trial: Age and gender

Age	3-5 years	6-8 years	Total
Girls	8 (31%)	18 (69%)	26 (20%)
Boys	36 (36%)	65 (64%)	101 (80%)
			127

Four families, two each in Trondheim and Tromsø, dropped out at the beginning of Parent Training. This amounts to a three percent dropout rate, which is low by usual standards. There were also a few drop-outs during initial assessment, after referral. Attendance at sessions, which has been a difficult problem in Webster-Stratton treatment in some settings abroad, was very good.

The strategy used to "recruit" children to the programme in Tromsø and Trondheim was based on dissemination of information to community services, and to some extent directly to parents. Much effort was expended to inform community services about the programme, and to provide information for parents. Recruiting families was not easy, and the information approach clearly had its limitations. Increasingly, the clinical teams themselves devoted time to direct contact with community service staff, and this proved fairly effective in Trondheim, where the treatment facility has a large population to serve. In Tromsø, recruitment proved especially difficult. At the outset, we probably overestimated the numbers of children in the target group, thinking that 3-5% of the 4-8 year age range would fall within the inclusion criteria. This in itself may account for the difficulty of recruiting children in Tromsø. Referral to the programme in the trial period was made more difficult because community service staff were hesitant at first. At the time of writing the now permanently established clinic department offering Webster-Stratton treatments in Trondheim has no difficulty in getting referrals sufficient to work

at full capacity, so it may well be that referral is getting easier because the programme is well-established. Throughout the trial, a number of families encouraged to approach the clinic by community service helpers, decided not to do so. Some hesitated because it seemed drastic to involve child psychiatry when a child is so young. A few (very few) felt that the programme was too demanding. On the whole, we have to conclude that there is a definite threshold that hinders referral to child psychiatry, even for these very seriously affected families.

Children with confirmed Oppositional Defiant Disorder diagnosis were naturally the majority among those treated, due to the inclusion criteria applied: 110 in the trial being confirmed and 15 possible, as opposed to 10 confirmed and 14 possible for Conduct Disorder. This was much as expected for a clinical sample of young children. The main co-morbid diagnosis for these children was ADHD, as shown in table 2 below. The very large number of ADHD diagnoses confirms that the treated children are a vulnerable group. Children affected with both ODD/CD and ADHD have been shown to have a poor prognosis.

Table 2 Children treated in trial: main co-morbid diagnoses

Diagnosis	Possible	Confirmed	%
ADHD	24	45	54
Enuresis	6	18	19
Encopresis	1	9	13
Anxiety	4	5	7
Separation Anxiety			
Generalised	5	-	4

N= 127

The three randomised groups in the trial were not altogether comparable in terms of problem profile when Child Behaviour Checklist (CBCL) measurements were applied. Both the Parent Training plus Dinosaur School (combined) group and the Waiting list group had higher scores for externalising problems, compared with the parent group (see table 3). This imbalance was a product of the randomising procedure and could not be corrected.

Table 3 Percentages of treated children with pre-treatment CBCL problem scores in clinical range (>90th percentile, based on Norwegian normative data)

	Internalising	Externalising	Total problem
Parent training	64	69	76
Parent training + Dinosaur School	53	87	91
Waiting list	62	81	89

Results (a) Post - treatment

Children’s behaviour and other problems as reported by parents

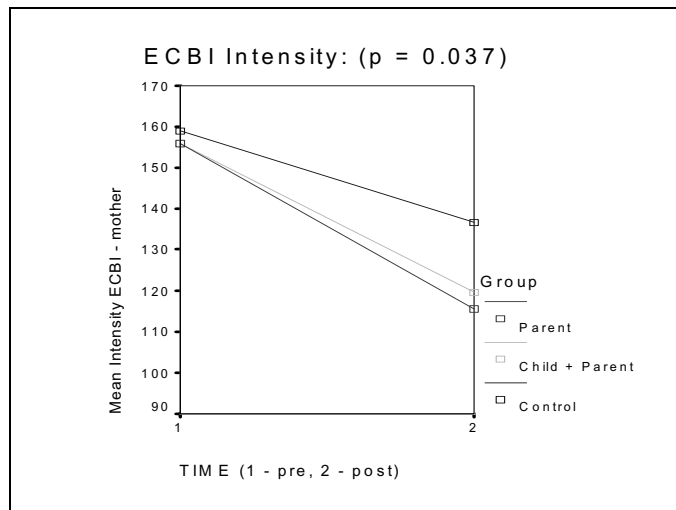
The design of the treatment trial involved measurements before treatment, after treatment, and at a follow-up one year after the end of treatment. In this section we present pre-post results. A later section will deal with pre-post plus follow-up. Parents scored their children using the ECBI before and after treatment, and the post-treatment scores, when averaged, showed a substantial and statistically significant reduction compared to the pre-treatment scores, which reflected inclusion criteria and were all above the cut-off point.

Table 4. Average of ECBI scores (intensity scores) pre-and post-treatment.

	Pre-treatment	Post treatment
Mothers	157	123
Fathers	147	121

Mothers scored their children’s behaviour higher (i.e. as more problematical) than fathers before treatment, but this difference had more or less disappeared when treatment was completed. It is not clear whether Parent Training can have contributed to this convergence. Analysed by treatment groups, the ECBI reductions are closely similar for Parent Training, and Parent Training plus Dinosaur School groups, while there is a moderate reduction for the waiting list control. The figure below shows these reductions (Note that the cut-off point for boys is 126, for girls 119.)

Fig.1 ECBI intensity scores (mothers) by treatment group, pre- and post-treatment



Another measure of the effectiveness of treatment is the extent to which ECBI scores for children lay below the 90th percentile on completion of treatment. Table 6 shows that the proportion of children with such reduced scores was considerable.

Table 5. Percentages of children with ECBI intensity scores below 90th percentile post treatment, Mother report.

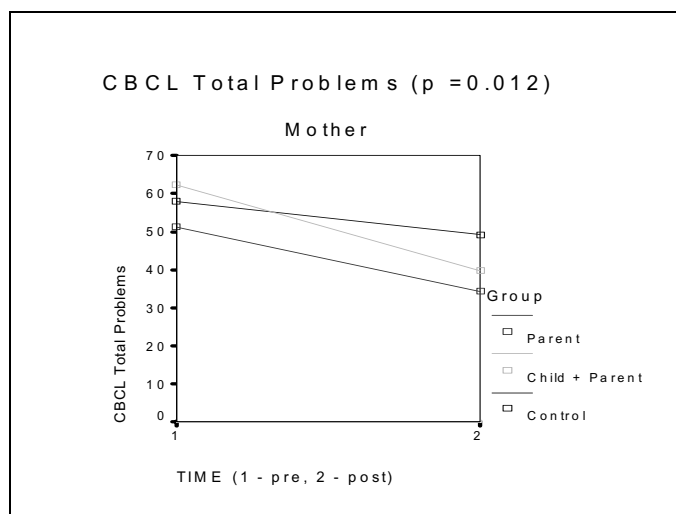
Treatment group	%
Parent Training	51
Parent Training + Dinosaur School	45
Waiting List	28

$X^2 = 3.24$. $p = 0.07$

$n=127$

CBCL scores showed statistically significant changes on sub-scales for total problems, externalising problems, aggressive behaviour, and internalising problems with $p < 0.05$. There was no significant change for delinquent behaviours. (See figs 2-4) In fig. 2 we see that total problem scores decreased somewhat more, and from a higher pre-treatment average, for the combined treatment group. This is a pattern that is repeated in results of CBCL pre-post treatment measurement, as illustrated in figs. 3-4.

Fig. 2. CBCL (Parent report) total problem scores for treatment groups. Pre- and post-treatment.



There is also a clear, and statistically significant improvement in internalising problem scores on mother report (fig.3 below)

Fig. 3 CBCL internalising problems (parent report) by treatment group. Pre-and post-treatment.

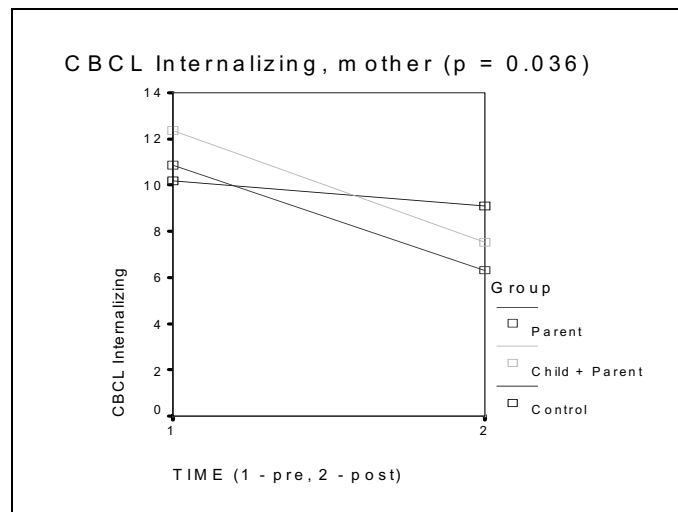
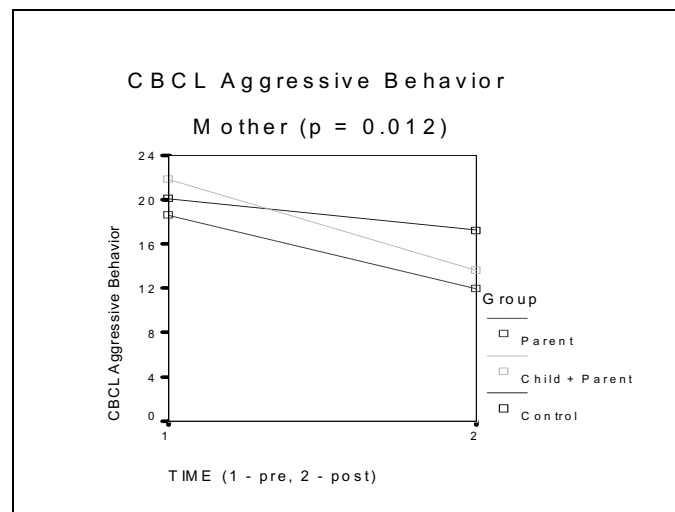


Fig. 4 CBCL Aggressive behaviour (parent report) by treatment group. Pre- and post-treatment



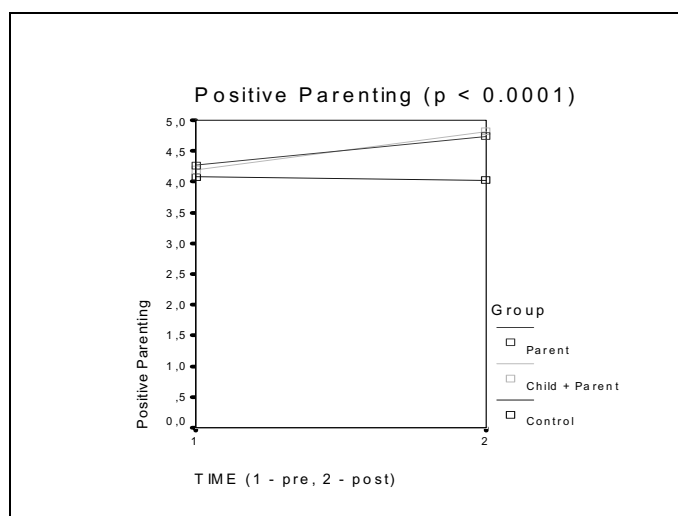
So CBCL results show that there is somewhat more improvement for the children who attend Dinosaur School. This is in tune with Webster-Stratton's own findings which

established that there were moderate additional gains for children who attended Dinosaur School while parents were attending Parent Training. It should be noted that the group who received this combined treatment had on average higher CBCL problem scores at the start of treatment, than the children in the Parent Training group. This in itself lends some support to the claim that combined treatment offers important advantages.

Parenting and Parental Stress

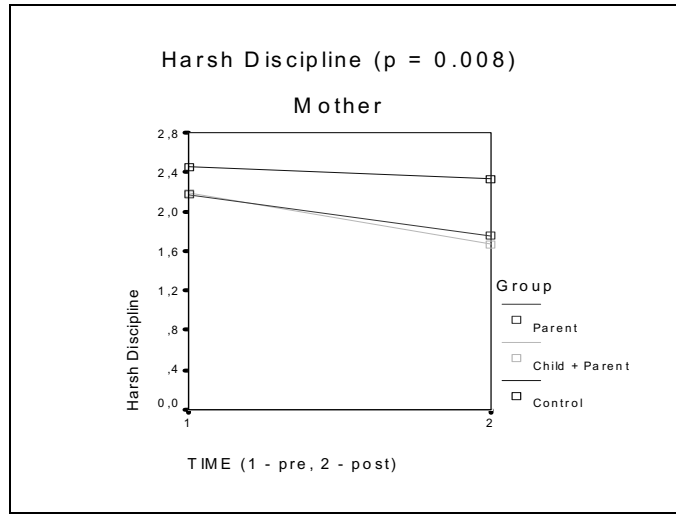
Our material also showed that a number of features of parenting also showed improvement during treatment.

Fig. 5. Positive parenting (parent report) by treatment group. Pre- and post-treatment.



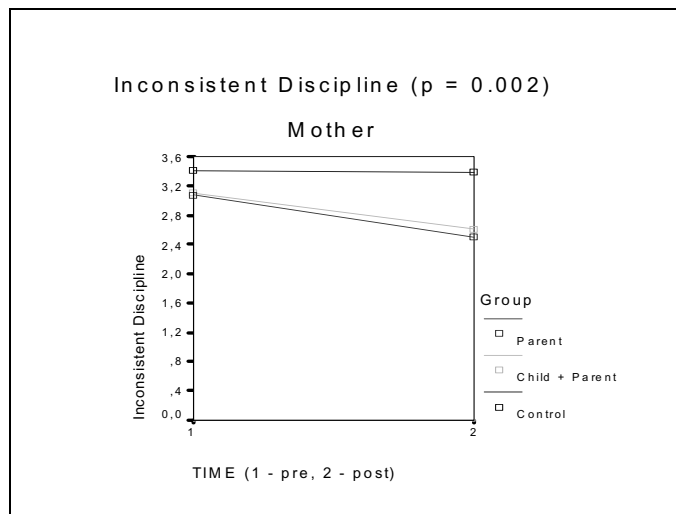
Here ascending scores indicate more positive features. Positive parenting denotes parental approaches to managing the child that build on positive reinforcement in a variety of forms. There is a distinct, and closely similar improvement for both treated groups, and a mild deterioration for the waiting list group. A similar tendency is revealed by the next figure which is based on a sub-scale indicating harsh discipline practices on the part of mother. These have also been reduced for both treatment groups.

Fig. 6. Harsh discipline (parent report) by treatment group. Pre- and Post-treatment.



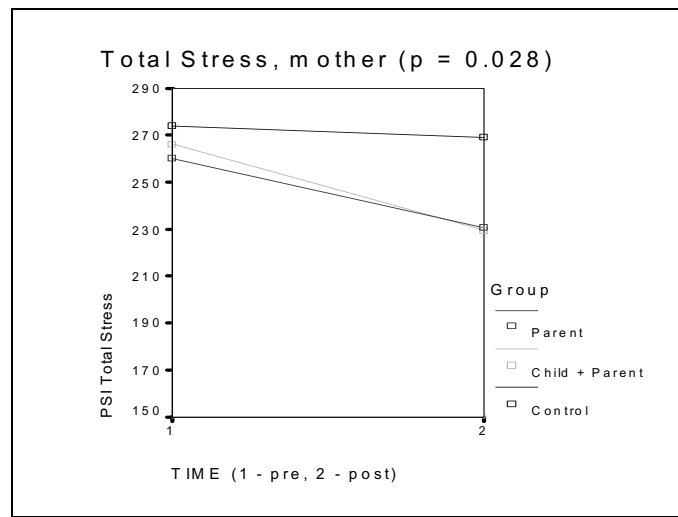
A similar effect is also seen in the case of inconsistent parenting practices, see fig. 7 below.

Fig. 7. Inconsistent discipline (parent report) by treatment group. Pre- And post-treatment.



The Parental Stress Index (PSI) questionnaire administered pre-post showed that stress levels among mothers declined quite sharply for both treatment groups, while remaining unchanged among mothers in the waiting-list groups.

Fig. 7. Parental Stress Index average scores for treatment groups. Pre-And post-treatment.



A sub-scale that measures stress directly associated with the behaviourally disturbed child (not shown) also showed significant stress reduction.

Children's behaviour at pre-school and school

Our findings, in line with those of many other studies, indicate that children's improved behaviour at home does not necessarily lead to any improvement in school or pre-school.

Table 7 below shows the percentages of children attending pre-school and school who were scored at a level above the cut-off point for aggressive behaviour (subscale derived from Teacher Report Form TRF for schoolchildren, and Pre-school behaviour Questionnaire PBQ, for children at pre-school) before and after treatment. The cut off-points demarcate a level of aggressive behaviour that is clinically significant, and have been established by using Norwegian standardisation data from the large scale prevalence study in our programme.¹⁴ The table shows that children of school age had only very limited improvement at school, as reported by teachers. There is no significant generalisation to school of behavioural improvements in the home, as reported by parents. There are however, signs of more substantial improvements in the pre-school setting, with a much larger reduction. There are signs of a differential generalisation effect. Unfortunately only one-sixth of the children in the sample were at pre-school, and the numbers involved are too modest for us to be able to draw any definitive conclusions.

¹⁴ The standardisation data have been provided by Barnevernets utviklingscenter i Midt-Norge, and are from a study (in preparation) by Jim Lurie and Graham Clifford.

Table 6. Percentages of treated children with aggression at clinical levels (PBQ and TRF) before and after treatment. Teacher report.

	Pre	Post
Pre-school	77	54
School	86	80
All children	83	63

n=120

Of equal if not greater importance is our finding that so many children had high scores for aggressive behaviour as reported by school and pre-school personnel *before treatment*. Comparison with Webster-Stratton's studies and the replications already cited, shows that, typically, around half of the children that were treated (with serious behavioural symptoms at home), had serious behavioural symptoms in the pre-school or school settings. In our study, nearly eight of ten of the preschool children and nearly nine out of ten of the schoolchildren, had such serious symptoms.

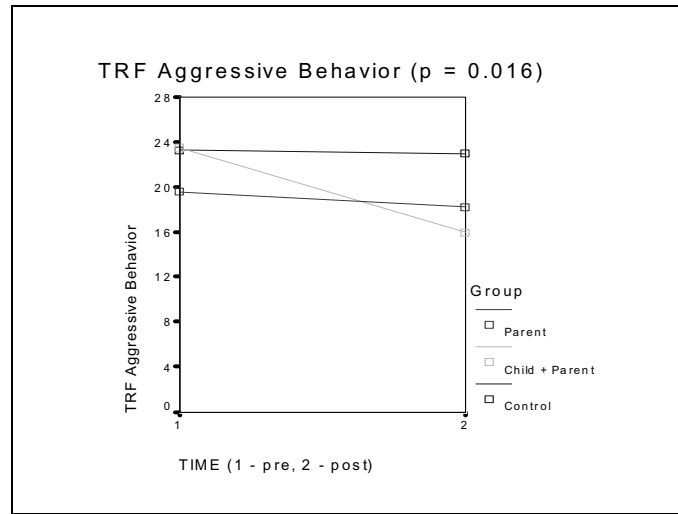
Table 7. Treated children below and above clinical level for aggression (PBQ and TRF) before treatment.

	Below cut-off	Above cut-off
Preschool	9	30
School	11	70

n=120

It is not easy to account for these very large proportions of children with serious behavioural symptoms in school and pre-school settings, so called *pervasive behavioural difficulties*. One possible explanation is the presence of some form of referral bias, since such a large proportion of the children that were treated were referred by community services whose interest in the children was prompted by referral from school and pre-school.

Fig. 8. TRF (teacher report) Aggressive Behaviour sub-scale scores by treatment group. Pre- and post-treatment.



Although there is little sign of generalisation in our material (and the evidence relating to pre-school children must be treated with reservation, there is an important exception in that the combined (Parent Training plus Dinosaur School group), displayed less aggressive behaviour after treatment, as measured using the Teacher Report Form (TRF) Aggressive Behaviour sub-scale as shown in fig. 8.

Note that there is no improvement for the children who have not attended Dinosaur School.

Summary pre-post

For the 127 children included in the trial, we can draw a number of conclusions about the effects of treatment:

1. There are significant reductions in the total intensity of behavioural problems after Parental Training and Dinosaur School, based on mothers' reports.
2. Internalising problems are also significantly reduced according to mothers' reports.
3. Children's social competence and problem solving are significantly improved after attending Dinosaur School.
4. There are significant reductions in parental stress levels both in relation to the child and more generally.
5. There is a reduction of aggressive behaviour problems in the pre-school and school setting for children who have attended Dinosaur School, but very little improvement for children in the Parent Training treatment group.

6. Attending Dinosaur School appears to enhance improvement in behaviour in the home (i.e. reported by parents).
7. Positive parenting practices are enhanced during treatment, and undesirable practices (harsh discipline and inconsistency) are reduced.

Results (b) at follow up; one year after treatment

The material presented here does not include children in the waiting list groups, who after their waiting period were provided with treatment. These were not included in the treatment groups in the research material. The results show that improvements secured during treatment are well maintained at follow-up. On the other hand there is little evidence of further improvement beyond the levels attained at the end of treatment, when averaged scores are used. There is also a consistent if slight trend toward somewhat better maintenance of improvements for the combined treatment group in the follow-up period. Fig. 9 below illustrates this general pattern.

Fig. 9. ECBI averaged scores (mothers), pre-, post and follow-up. Intensity scores.

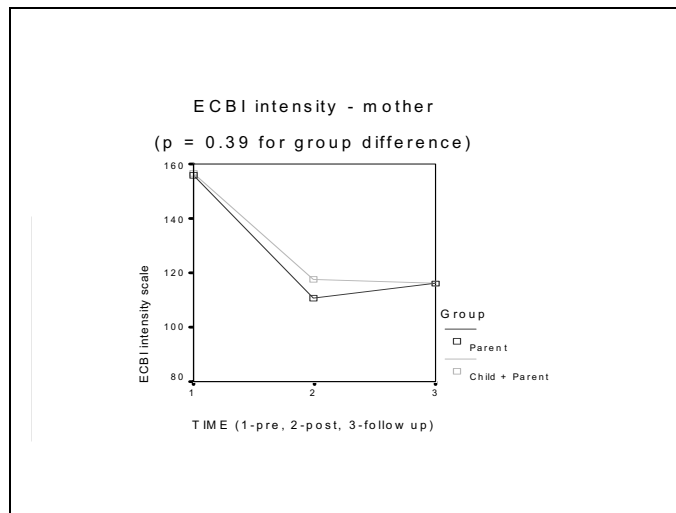
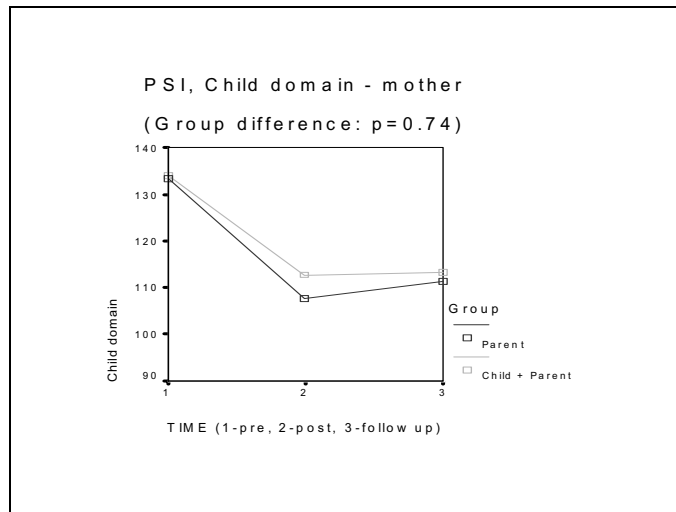


Figure 10. Parental stress levels, child domain (mothers, PSI). Pre-, post, and follow-up.



Parental total stress levels (not shown) display much the same trend. A lower level of stress is maintained, but there is no further improvement. Figure 10 above shows the level of stress in mothers derived from the child: total stress levels display the same pattern. Again the combined treatment group have a somewhat more favourable trend, suggesting that parents may benefit from the social skills children have acquired at Dinosaur school.

The proportion of children who left the clinically defined diagnostic categories actually increased during the follow-up period (see table 7 below). The changes are in fact considerable, suggesting that the impact of treatment as shown in post-treatment changes in diagnostic status, is not only maintained but has a continuing effect. Although relatively slight changes may produce much of this effect, this is a strong indication of an underlying long-term effect. Again, we should remember that the combined treatment group was the most seriously affected of the treatment groups using CBCL measures. CBCL seems to have differentiated the groups randomised for treatment in ways that ECBI did not. This may well account for the changes seen in diagnostic status at both post-treatment and follow up assessment points, when using CBCL.

Table 8. Numbers and percentages of treatment groups below and above ECBI clinical cut-off point at follow-up.

	Parent Training	Parent Training + Dinosaur School	Total
Below cut-off point	23 66% (post: 51%)	27 57% (post: 45%)	50 61%
Above cut-off point	12 34% (post: 49%)	20 43% (post: 35%)	32 39%
Total	35 100%	47 100%	82 100%

Use of a systematic diagnostic instrument (Kiddie-SADS) at follow-up provides a very similar picture (see table 8 below).

Table 9. Percentages of treated children with ODD/CD and ADHD Diagnoses at follow-up. (KSADS) Percentages in parenthesis Indicate diagnoses pre-treatment.

	ODD	CD	ADHD
Not present	68	97	60
Possible	12 (8)	1 (11)	15 (19)
Confirmed	21 (87)	2 (8)	25 (35)

Kiddie SADS is based on assessment using DSM-IV criteria, and so will tend to "disqualify" children for diagnostic status even though their overall behaviour as measured by for, example ECBI, has not improved very much. However, these assessment findings do resemble the overall pattern we have seen in the material. The numbers of children with behavioural disorders at diagnostic levels is greatly reduced. The effect is not so marked for ADHD, suggesting that the treatments are indeed more specific for ODD and CD.

CBCL measurements also confirm the stability of post-treatment reduction of reported behavioural difficulties. Continued improvement has occurred between the end of treatment and follow-up one year later. See Table 9 below.

Table 10. Percentages of children with clinical levels of CBCL externalising problems in treatment and control groups, before and after treatment and at one-year follow-up.

	Pre	Post	Follow-up
Parent Training	69	38	27
Parent Training plus Dinosaur School	87	45	40
Waiting List Control	81	62	-

70% of the parent training group, and 60% of the combined treatment group were scored as below the clinical cut-off point, and as within the normal variation range, at follow up.¹⁵

Something of the same pattern is evident for internalising problems (table 9) but the decrease evident in the follow-up period is rather slight, compared to a relatively dramatic reduction, in the treatment period, which only lasted 5-6 months (lapse of time between measurement points). Although these changes are statistically significant, the changes registered for the waiting list control group are so considerable that it might be wise to avoid too optimistic conclusions. Internalising problems in the age-groups we are concerned with here, and judged on the basis of parent reports, may be too unstable to allow definitive judgements.

Table 11. Percentages of children with clinical levels of CBCL internalising problems in treatment and control groups, after treatment and at one-year follow-up.

	Pre	Post	Follow-up
Parent Training	64	31	27
Parent Training and Dinosaur School	53	35	28
Waiting List Control	62	39	--

Conclusions

Substantial improvements in children's behaviour are reported by parents (ECBI) after Parent Training and Parent Training combined with Dinosaur School. CBCL measurements and diagnostic interviews (Kiddie SADS) present evidence of very similar changes. There are improvements in parenting practices in a number of areas, and

¹⁵ Based on Norwegian standardised data (Nøvik 2000)

reduced levels of parental stress. Children in the combined treatment group show rather more improvement than the Parent Training group, but the differences in outcome are not very large.

At follow-up, these improvements have been well maintained, but further improvement has not occurred for the averaged ECBI scores. The percentage of children who have left the group in the 90th percentile who were selected for treatment is 66% for Parent Training and 57% for the combined treatment group. The great majority of the children are below diagnostic levels for ODD and CD

Parental stress is maintained at a lower level after treatment, until follow-up.

The results are closely similar to those obtained in Webster-Stratton's original work, which attracted so much attention when published over a decade ago, and similar to the results obtained in replications in Canada and the UK.

These results are a satisfactory evidence base for Webster-Stratton's programme under Norwegian conditions.

4. Before, during and after Parent Training: parents' views¹⁶

Introduction

Brief questionnaires used in the original Webster-Stratton projects in Seattle were translated and used in treatment to provide information about parents' evaluation of the treatment. We have quite a large amount of such material but it has not so far been analysed, because other research components have had higher priority. Indeed, it might seem rather a waste of time to bother with this material, since it consists of overwhelmingly positive evaluations on the part of parents. However, it was always our intention to carry out a more substantial user evaluation based on in-depth interviews with parents. This was completed in the summer of 2004, and included 20 families interviewed after the one year follow-up assessment. All had completed the Basic programme, on average around 18 months before the time of interview. Some of the parents we interviewed had children who had completed the Dinosaur School programme. The interview sample was balanced (stratified), so that parents of children who had shown improvement after treatment, and of children who showed little or no improvement, were included. The sample was also constructed in such a way that parents of children under and over 6 years of age at the time of treatment, were included.

A qualitative study carried out Webster-Stratton & Spitzer (1996), focussed on some particular issues relevant to the situation of the families. It is an interesting element in the Webster-Stratton literature. Our evaluation was designed to be somewhat broader in scope, and not so sharply focussed on the issues in the earlier study. Originally we had intended to carry out an in-depth study of some families whose behaviourally disturbed children had not received treatment, but this proved impractical. So we supplemented the user evaluation of the treatment itself based on interviews with parents, with many questions relating to families' experience before they entered the programme, and their situation after treatment (that is, around one-and-a-half years after treatment ended). We wanted to see how the challenges parents face, develop after they have received help. And we were interested in the way in which parents perceive their situation at that stage, and judge the extent of the support and help they have received before, during and after treatment.

It has been evident for a long time that parents of children with behavioural difficulties have to bear a heavy burden. Stress and depression as well as familial and marital discord often develop. In the 1970's, when behavioural disorders and ADHD - "hyperactivity" - began to attract attention, community health and social workers as well as child psychiatric staff were well aware of such problems, which were perceived to be a precipitating factor for marital breakdowns, discord and poor family functioning. Campbell (1995) has provided a comprehensive summary of research which documents the difficulties parents face and the often very serious consequences that result. The advent of treatment programmes from the late 1980's onwards reflected this awareness. Great emphasis was placed on programmes which would address parents' situation and needs. Study of user perspectives upon treatment has to take account of the fact that parents and family members suffer considerable burdens and stresses even while the

¹⁶ This chapter is based on a presentation given at a conference in Auckland N.Z. by Jim Lurie and Graham Clifford.

behaviourally disturbed child is of pre-school or primary school age. A central issue relating to treatment is how it affects the family as a unit, and what kinds of benefit are obtained.

The design and the content of interviewing were determined by a desire to secure an *external assessment and evaluation based on parents' accounts and frames of reference*. None of the researchers involved, nor the interviewer, had training in the Incredible Years programme and methods. Neither group leaders, nor researchers associated with the treatment trial were invited to contribute ideas or interview content. Interviews were administered with the help of a specially designed interview guide which enabled parents to provide a basically narrative account. The interviewer was provided with a series of checklists to secure information about a range of issues. Particular emphasis was placed upon allowing time so that parent's accounts could be given without undue prompting. Some of those who have worked in the Incredible Years project felt that these interviews were too loosely structured and that they failed to focus on important issues in treatment, but the point is that these interviews were designed to elicit parents' own account of the entire process that began when they first experienced concern about their children's problems, through referral and treatment and beyond follow-up.

In-depth user evaluation material does not provide unambiguous findings. What parents tell us has to be interpreted, and there are a variety of problems of interpretation. In part these proceed from the fact that systematically organised qualitative material is highly specific and precise. It tells us a great deal about a limited number of subjects and their perceptions. Users of services rarely get the chance to describe their experiences: but when they are asked to contribute, they tell us a great deal, an account organised and structured around their perceptions and concerns. The material is of course not representative, and though it may display patterns, interpretation of these should be cautious. In our work with these interviews, we were above all reminded that each family is different. Treatment is often and quite justifiably based on assumptions about common characteristics that those affected by a problem, will share, but when families who share the same difficulty are studied in-depth, they prove to be very different, with different perceptions and concerns. On the other hand, we were also made aware that the structured and selective instruments used to assemble material in the treatment evaluation, involve a massive loss of information. This loss is likely to include material highly relevant to assess the impact of treatment upon families, and their situation after treatment.

The interview material does have some obvious limitations. The families were drawn from those who were treated in Trondheim in the first half of 2002. Referral patterns shifted somewhat during the course of the trial and these families may differ in some respects from those treated later. It is unfortunate that all are from Trondheim, but time constraints made it difficult to interview families treated in Tromsø. But over and above these limitations, it should be remembered that these parents have children with very pronounced behavioural disorders. All the children fulfilled screening and diagnostic criteria at the onset of treatment, and so they belong to a stringently defined clinical population. On that basis we would expect that many features of family life around seriously disturbed children, would occur in the sample.

Before treatment

It is no surprise that parents' descriptions of their children's behaviour before treatment correspond very closely to the description of symptoms specified for ODD and CD: anger and aggressive behaviour, uncontrolled and directed at parents, siblings and other children; high levels of activity and restlessness, poor concentration and a need for constant supervision, defiance and disobedience, and apparent inability to follow even the simplest instructions. Parents in most cases told us that they were the first to see these problems, sometimes in very early childhood and usually when the child was 3-4 years old.

Parents were always unsure about what the problems actually were and at a loss about what to do. This uncertainty lasted a long time, and in most cases was not resolved until the family entered the programme. Pre-school staff played the key role for most families in identifying and confirming behaviour that was problematic and abnormal, and to some extent providing an explanation of the children's difficulties. It emerged that these difficulties often became more apparent after changes affecting the family, as for example when a child started at pre-school (kindergarten), or the birth of a younger sister or brother, or the parents separating. This in some cases might have led parents to think that their child was reacting temporarily to circumstances or stress.

The impact upon the family and parents was very pronounced, in all cases. The child's behaviour invariably became worse. Nothing that parents attempted could arrest this deterioration. Parents struggled with feelings of guilt, responsibility and inadequacy. They felt trapped, frustrated, exhausted and as time went on, often resigned. Their relationship with the child became "gridlocked": there was a negative cycle of unacceptable behaviour, and ineffective parental responses. Mothers and fathers often began to disagree about how to deal with the situation, and their relationship suffered in a number of cases. Siblings were also adversely affected. Some parents said that it was impossible to give a sister or brother of the affected child enough attention. Siblings' relations with the disturbed child deteriorated, and their relationships with their parents were adversely affected too. Relations with grandparents and other relatives were often difficult and the child's behaviour often was embarrassing, and in time to led to withdrawal and isolation: It was, for example, difficult to make visits or receive visitors.

When asked about the help they had received before entering the Incredible Years programme, most parents singled out pre-school. All the children in the sample had attended pre-school and most parents were satisfied with the attention they and their child had received from pre-school staff. Other contacts that had been useful for some parents were community health services, and school including special education help, and school counselling. Some parents actively sought help to obtain a diagnosis or explanation of the child's difficulties. A few parents were dissatisfied with the help they were provided with, or dissatisfied because they had not obtained help when they wanted it. (This dissatisfaction is probably less widespread in the parents in our sample, than in parents with behaviourally disturbed children in the 4-8 age range in general, since they had all entered the programme after referral, often with the help of community service staff). Child protection and school counselling services were the main referral agents (about a third of the families), while pre-school and the community health services each provided only about one-fifth of the referrals. Some parents had taken the initiative themselves, and sought help from the programme, after obtaining information about it from the media or from friends.

The general picture of the families' situation before treatment corresponded closely to what we expected on the basis of available research. There are no real surprises. Although the children involved were young or relatively young, parents and siblings were already under severe pressure prior to referral. Families were showing signs of disruption, stress and isolation. Most parents tried to get help and an explanation of the problems they encountered. Pre-school is the best support for these parents, but pre-school does not refer many children. The more specialised community services channel referrals. It is easy to see the importance of pre-school in the light of the fact that children attend on a daily basis, so that their behaviour becomes impossible to ignore. At the start of our project, some of us expected that the health centre nursing staff would be the main source of referrals, but this did not prove to be the case. The health service personnel do not meet the children concerned very often. There seems to be some reluctance on the part of pre-school staff to refer directly, and this is understandable in view of the fact that they often hesitate to draw conclusions or make strong recommendations to parents. Pre-school is provided with its own community service specialists in the form of child protection and school counselling. This referral route no doubt takes time, and may partly explain why it proved difficult to recruit many children younger than six years, during the treatment trial.

There are indications here that the lapse of time between the first signs of serious behavioural disturbance, and referral, averages out at about three years. Most of the children are in pre-school for most of this period, and much valuable time would be saved if pre-school, in co-operation with parents, was able to refer directly, or was better supported by other agencies, so that referral could be discussed with parents at an earlier stage. There is no doubt that pre-school staff do become aware of these serious behavioural disturbances, even if they feel unable to draw definite conclusions about the problem, and that the situation most usually is discussed in a responsible way with parents. Of course some parents do not feel it is right to assent to referral to child psychiatry when a child is very young, and this has to be respected. But it is difficult to avoid the impression that pre-school is the key to early referral, the more so because parents have a great deal of confidence in the staff there. We have no material in this study that can throw direct light on how the more specialised community services deal with behaviourally disturbed children who are causing concern, but their role is clearly very important since they are the main source of referrals.

Parents' experience of the programme

The fundamental question here is how parents perceive the programme in retrospect. Post-treatment viewpoints are obviously a severe test of the acceptability of a treatment form seen from the users' perspective, if sufficient time has elapsed so that parents can have formed an impression of the *long-term value and effectiveness of the treatment, and its relevance to their situation and the child's problems*. Intuitively one might also expect that a "boost effect" due to enthusiasm generated by the attention and concern the programme directs at parents, would be less evident one-and-a-half years after the end of treatment.

Another important question relates to whether parents absorb and to an extent internalise the principles and techniques that the programme aims to provide them with. In-depth study provides an opportunity to investigate this issue, but there are validity constraints. In part these have to do with the fact that a successful treatment might well improve parents' understanding and perception of the problems the child faces, to such an extent that tolerance for deviant behaviour, on the parents' part, is extended. Parents

may also gain self-confidence and self-esteem in a programme like this, which deploys positive reinforcement as a pervasive strategy. This may affect their perception of the child's behaviour and their own responses. Other constraints arise because qualitative material, like any other research material, may be affected by reporting biases. A "good" programme (in the sense that parents want to conform to standards of parenting the programme advocates) may bias parents' reporting of how they approach parenting in research interviews, however careful we are to avoid leading questions. We were very careful and only asked questions about use of techniques taught in the programme, after parents had provided an account of the value of the programme as they saw it, in their own words. Lastly, qualitative research techniques tend to favour the articulate subject, particularly if researchers are predisposed to look for particular patterns or responses.

In spite of these reservations, it has to be said that the general picture of parents' evaluation of the treatment that we have obtained, is fairly clear. There is something approaching a consensus of views among parents on certain key issues.

A high level of parent satisfaction was evident about one-and a-half years after treatment. All parents told us that they had been satisfied with the programme, most being very positive indeed. A few were more reserved and/or less specific about why they were satisfied, but still expressed satisfaction.

Satisfaction was related to two distinct kinds of benefit that parents said they had derived from the programme:

1. Improved self-esteem and self-confidence, and reduced feelings of guilt and isolation.
2. Learning new parenting skills which enabled them to relate to the child in a more positive way.

Very nearly all parents reported the first of these benefits, while a clear majority reported the second. Those who reported both were more likely to report improvements in their child's behaviour. So the perception of having acquired skills was apparently related to perceived improvements in behaviour. Some parents reported quite dramatic changes in children's behaviour. A few parents, however, reported little or no improvement in the child's behaviour, despite having gained self-esteem and new skills. The conclusion to be drawn is that there are connections, but no unambiguous relationship, between how parents felt they had benefited from the programme, the results of treatment as indicated by perceptions of the child's behaviour, and parents' perceptions of what had contributed to these results.

Parents had generally similar views about which aspects of the programme had been most positive or most negative. The *group* was the most valuable aspect for most of them. Meeting parents in a similar situation to that they themselves experienced was very important for their morale and self-esteem. It helped to reduce feelings of stigmatisation, guilt and isolation. It was helpful to learn that others had apparently more serious difficulties. Most parents in fact concluded that the other parents in their group had more difficult challenges than those they themselves had to deal with, a logically impossible situation, but a telling indicator of the morale-boosting factor inherent in the group interaction. When parents with high social status or married couples talked about their difficulties, single parents and clients of social services or child protection felt considerable relief. Parents also found it very encouraging to meet other parents who

understood the problems they faced with their child. They had felt misunderstood for years when talking to parents of "normal" children, friends and relatives and others who gave them well-intentioned advice. It was a great benefit to be able to talk honestly and openly about the difficulties they had to deal with, in a supportive group environment. They gave and received useful tips about what might or might not work, from other group members. They spoke to other parents in the breaks during group sessions and during self-arranged get-togethers after the sessions: some of the best discussions they had occurred during these informal meetings.

The main message parents absorbed from the programme was according to them, *the importance of focussing on children's positive behaviour, and less on negative behaviour*. Parents' report of whether they had learned new parenting skills varied a good deal, as did the specificity of their description of what they had learned. Particular approaches and techniques which some parents described were playing with their child one-to-one, giving frequent praise, paying more attention, giving rewards for good behaviour, ignoring negative behaviour, timeouts, being more consistent and replacing scolding, physical punishment etc. with less confrontational responses such as the withholding of privileges. On the whole it seems that parents could learn and apply most of the techniques included in the programme, but not all seem to have done so: the degree to which the techniques were applied on a daily basis seemed very variable.

Parents were generally *very satisfied with group leaders*. They talked less, however, about interaction with group leaders than about their interaction with other parents in the group. Parents were most impressed with what they perceived as the leaders' positive personal qualities including warmth, optimism, enthusiasm, supportiveness, attentiveness and humour. Some parents told us that group leaders did a good job in demonstrating to parents the type of attitude they were teaching parents to adopt with their own children, such as optimism and praise. Group leaders supported parents' efforts to try out new approaches with their children.

Parents' opinions about the various elements the group sessions were based on were mixed. *Role play* was enjoyed most by mothers who found it a good way to break the ice, reduce tension, add an element of humour and stimulate discussion. Others (mostly fathers), found it intimidating, artificial, and felt it to be largely a waste of time. The *video clips* used extensively in the sessions were for some a useful way of presenting the principles the group sessions set out to establish, by illustrating concrete situations with successful and unsuccessful parental approaches to child-rearing. Others disliked the videos and found them old-fashioned,, unrealistic, too American in content and irrelevant for a contemporary Norwegian setting. *Home assignments* were seen by some as very useful; others found it difficult to devote time and energy to the assignments in addition to work and family demands including spending enough time with siblings.

Most parents disliked *filling out questionnaires*. They did it because it was a condition of participation in parent training. Objections included the amount of time required, the private and difficult nature of some of the questions (e.g. Do you hit your child?) and age-inappropriate questions (why should parents of a four-year old answer questions about their child's drug abuse or criminal activity?). Some parents, however, saw that there was a need for research that might help other families struggling with problems similar to those they experienced.

Dinosaur School was not a focus of our interviews with parents because they had only second-hand experience of it; children attend the sessions alone. Parents of children who had participated were nonetheless very positive, saying that children enjoyed the sessions, were proud of participating, and learned useful skills including how to control their tempers. Parents whose children had not been assigned to Dinosaur School were disappointed. Not all parents seemed aware that families had been randomly assigned to groups receiving parent training only, or parent training plus Dinosaur School.

After Treatment

Parents' view of their situation after 18 months varied a good deal. Many felt that the programme had been too short and wanted follow-up or "booster" courses, and continuing contact with other group members, and with child psychiatry. Some still sought further clarification about their child's problems.

The sample was deliberately chosen to reflect variation in outcome, i.e. children's response to treatment. So it is important to emphasise that the sample is not representative, in that it severely under-represents the proportion of parents in the programme, who experienced considerable improvements in their children's behaviour after treatment, improvements which were usually maintained at follow-up. "Non-responders" are correspondingly over-represented, and there are signs in our necessarily small sample that their parents, for whatever reasons, have not been so successful in adopting the techniques the programme sets out to teach.

Parents who have seen improvement in their children are, as might be expected, more optimistic about their child's future. They say that they have acquired tools that they can use to meet future problems and that they are confident of their own ability to cope with difficulties that might arise.

Others are less optimistic and saw a continuing need for help in the future. There is concern about what might happen to the child later and faces the challenges of adolescence and exposure to drugs, alcohol and criminality, as well as concern about job prospects.

Discussion

Before treatment

Interpretation of the findings of this qualitative study has to start from the recognition that the interview subjects were parents of young children with very serious levels of behavioural disturbance. Like similarly affected parents in other countries whose situation has been studied, they have felt the impact of their children's behaviour in many ways. Managing the child, and daily life in the family, very rapidly becomes difficult and exhausting. There is no respite, and family life and relationships in the family including the relationship between mother and father, deteriorate. This puts additional strain on everyone concerned. Disruption and frustration escalate. It takes quite a short time for secondary problems, such as the problem of giving enough attention to siblings, and disagreement about how to manage the child, to become an additional burden. Families also become isolated, and this too does not take long to develop.

Community health, social and educational services have not been able to help these parents effectively. They have not had structured programmes that might provide a

framework for managing the children's behaviour, and they have lacked the expertise or authority to define the problems affecting the child. The material we have obtained makes it clear that these parents affected by children's very severe problems, experience very real concern on the part of community service professionals and pre-school staff in particular. Service professionals care enough, but usually have not anything substantial to offer.

Pre-school is the arena of lost opportunity. Parents get a lot of useful support from pre-school staff, but most of the children in our material spent two or even three years in pre-school before they were referred, or were not referred while in pre-school. Those who were referred or whose parents contacted the clinic themselves (children under six) were fortunate. There was a programme available. They might well in many cases have spent their early years in primary school too in a steadily worsening cycle of disruptive behaviour and increasing isolation, before their behaviour placed such a strain on those around them that they were referred. This, after all, has been the usual career for many of even the most severely disturbed children.

There are quite clear indications in the interview material that parents and pre-school teachers have agreed that the children's behaviour was alarming and abnormal. A possible explanation for the very considerable numbers of children with *pervasive* behavioural difficulties that were treated in our programme is this congruence between parents' and teachers' views of the children concerned. This has, in effect, reinforced parents' concern. If this is so, it serves to emphasise even more the crucial significance of pre-school in implementing strategies for early intervention in this field.

It might be thought that parents underestimate the scale of the problems that gradually affect their children, and seek advice too late. Although some reservations have to be made in interpreting retrospective accounts, it does not seem that this played any part in the histories of the children in our study. Parents realised that something was wrong early on, and sought advice. But they were confused as well as alarmed. Naturally enough, and as parents often do, they blamed themselves or wondered whether they were managing the child's behaviour properly. Some looked for an answer to their questions and sought help. But no help could be obtained. There is no evidence here that informal support, network resources or relatives can provide really useful help. Parents become increasingly isolated as the children's problems escalate.

Our findings about the period before treatment suggest that much work needs to be done to lower referral thresholds for children in the target group. Child psychiatric services are perhaps more often than we care to admit, seen as intimidating and alarming, and referral routes are slow. The community health services and pre-school are the most important arenas for early identification of children who need help. Behavioural problems account for around 40% of all referrals to many child psychiatric clinics, and the great majority of these children are referred far too late. Much work needs to be done to create a proper framework for identifying children with severe behavioural disturbances, as early as possible. The accessibility of treatment would surely be much improved if child psychiatry could support treatment facilities developed in the community services themselves, or cooperate with community services to set up joint facilities.

Treatment

Our material describes a form of treatment which realises some of its major aims almost invariably. The group setting provides parents with a considerable boost in terms of self-esteem and confidence, and understanding of their situation. This effect is long-lasting, and it was clearly evident when we interviewed after follow-up. Parents also to a very great extent seem to have absorbed certain basic principles such as the importance of positive reinforcement, avoiding negative parenting and harsh discipline. Parents' morale receives a major boost, and their insight seems to be greatly enhanced. Parents' own accounts illustrate the impact of the programme, and so confirm findings from the treatment evaluation. Much has been learned.

But these findings must necessarily lead to other questions about the effectiveness of treatment. After all, parents whose children responded very poorly, or not at all, to treatment, also seem to have experienced most if not all of the beneficial effects of parent training mentioned here. One of the most impressive things about the treatment is, indeed, that it boosts morale for parents whose children do not respond well. How does this happen?

Parents' own view of the matter is that meeting others who share the same difficulties as themselves is very important. They feel understood, and much less isolated, and feelings of guilt and inadequacy are reduced. In an important sense, the therapeutic relationship as parents experience it, resides in the common experience and mutual identification of the parent group. As in some other research dealing with successful therapeutic settings and relationships, we see that the mechanics of the helping process are not really the main focus for clients. Group leaders are, like therapists or social workers in other research work where client perceptions have been studied, seen as persons with valuable and admirable *personal attributes*. But the morale booster is not, in parent's view, the relationship with the helpers. It is the mutual recognition and identification the group experiences. This reduces the stigmatising burden the abnormal child represents (some parents actually describe the effect in these terms). It is probably important not to underestimate the significance of this.

A majority of parents said that they used the techniques taught in the programme (some apparently with some considerable success) but some did not use them. And some of those who did use the techniques provided diffuse and equivocal descriptions that do not resolve the issue of whether the techniques were being applied regularly or with any consistency. On the whole, the balance is tilted toward some kind of association between use of techniques and behavioural progress by the children, but this finding is rather ambiguous. We have to conclude that many parents do learn techniques, and do apply them, but that the Basic Programme in this setting does not fully realise its aims. Not all parents use the techniques, and the extent to which they are applied is in many cases rather uncertain.

Mixed views about the actual devices used in parent training also seem to imply that the actual mechanics of group training are not the main issue. Parents have very varied and subjective views about homework, role play and video vignettes, but their views about these devices have little to do with their overall perception of the value of the treatment or its relevance for their situation.

Viewed as a whole, we have to conclude that the treatment is highly successful, also in parent's own terms. We have to remember that the results of treatment in the Norwegian

programme bear comparison with those attained elsewhere. It is possible to argue that better performance on the part of group leaders would have led to better acquisition of techniques on the part of parents, but the research material here cannot throw much light on this issue. Non-responders are found in much the same proportion in all Webster-Stratton programmes, and further analysis of our material is needed to see whether non-responders or their families have particular characteristics in common, that may predispose them to respond poorly to treatment. Whether poor acquisition of parenting techniques plays a major part in non-response, is something we are unable to clarify altogether. It seems, however, likely that it does play a role to some extent.

After treatment

Some interviews with parents provided particularly rich material dealing with the current situation, that is, the situation after follow-up. The treatment trial results showed that average ECBI scores that had improved markedly during treatment more or less maintained their lower levels in the post to follow-up period, but that no further improvement took place in averaged scores. What is striking about the families at follow-up is they vary a good deal, some parents being optimistic while others are worried about the future. Webster-Stratton's own qualitative follow-up study showed that parents still had to deal with a very difficult situation after treatment, with continual effort being needed to manage the behaviour of the affected child. Our material (treatment trial) showed that treatment reduces stress levels in parents, and this reduction is maintained: the qualitative interview material shows that parents are very much concerned about their children, including siblings in some families who are showing signs of problematical behaviour. Parents are worried and uneasy. They have made some effort to keep in contact with parents who were members of their group, and generally report that they are still isolated and that they lack support

The obvious implication is that parents are on the whole less vulnerable and have more control over their situation than before treatment, but that they *still are vulnerable* and that they need support. One very real gain which is evident in some of the interviews is that parents are able to reflect upon the child's needs and use the insights acquired in the programme. Community services and schools do not seem to be able to provide parents with the kind of support they would like. Many parents would like more training or some form of "booster" training.

For us the post-treatment situation the families are in leads to some sobering realisations. The general picture is one of families, in some cases parents alone or virtually alone with their children, who are isolated. Community or kin networks do not, according to parents' own accounts, provide any support. The current enthusiasm, for example in child protection, for network approaches, has to be tempered by the realisation that there are problems of child mental health that effectively isolate the family.

6. Implementation

Introduction

In 2003 The Norwegian ministries of Health and Child and Family Affairs decided to implement treatment provision for behaviourally disturbed children and young people on a broad basis. This decision was based on encouraging preliminary results from projects that introduced Parent Management Training and Multi-System Therapy, as well as from the programme using Webster-Stratton methods described here. The Webster-Stratton programme implementation seems likely to be the most restricted in scope of the three that are projected. But implementation of this programme raises a series of interesting and challenging questions, which we will discuss in this concluding chapter.

It is inevitable that perspectives on a problem change in the course of a lengthy project. At the start of the project, for example, we were concerned about the extent to which methods that to some degree show a North American cultural imprint, would prove acceptable to Norwegian parents, or for that matter Norwegian practitioners in child psychiatry. In the event we need not have worried. The methods, as we have seen, proved very acceptable to parents. Practitioners were very interested in the methods: over 100 people applied for six temporary group leader positions in Trondheim in 2000.

On one issue, however, our perspective has not changed. If anything, we have become more aware than ever that it is of overriding importance to provide effective help for families with behaviourally disturbed children. Norwegian families with such children, run much the same risks and suffer in much the same way as families in the USA, or in Great Britain or Canada where Webster-Stratton's programmes have been replicated under controlled conditions, and disseminated. Prospects for many of the affected children, without effective help, are just as bleak as elsewhere. It seems likely that the numbers of children affected here in Norway may be somewhat fewer than in other countries where epidemiological research into behaviour problems has been carried out. Possibly as few as one of thirty-five children aged 4-8 are affected. If so, that is very good news. But there will still be many thousands of affected children and families, which means that implementation and accessibility of services is a crucial issue.

The logistics of evaluation and implementation

In order to introduce up-to-date evidence-based methods in this area, it has been necessary to organise a kind of project structure which hardly has any precedent in health, social and education services for children, in Norway. MST and PMT were introduced in a project linked to the Institute of Psychology at the University of Oslo, but the government decided to establish a national centre devoted to development and implementation of these methods. Simply put, the scope of the effort needed to implement these programmes required the establishment of a dedicated centre. *The Incredible Years* has been a multi-centre project, with all the problems and benefits of coordination that necessarily follow. In Trondheim and Tromsø we felt (and still do feel) that it is necessary in a national context, to conduct treatment research and evaluation at the highest standards in very important and controversial problem areas. New methods cannot simply be imported (usually from the USA). They have to be “Norwegianised” in order to work properly in our settings. This is not so much a matter of adjusting the content of the methods to Norwegian conditions (we actually adjusted very little) but rather of setting up a foundation for thorough understanding of the methods, proper

evaluation, and quality control. The problem associated with introducing such methods is that this requires a level of competence that has not been available in child psychiatry or child protection. We had to work hard to be able to operate at the required level, and we have learned by trial and error. Local support for such programmes is quite understandably, conditional. Five-year treatment trials which absorb a large amount of senior research and clinical competence in planning and supervision are not necessarily popular among colleagues, or with university faculties who want a flow of published results and doctorates to secure funding for the future. They represent a burden for participating clinics. Research councils are quite unable to find adequate funding for projects of the kind we have described here, and central government funding of the kind we received is only provided in quite exceptional circumstances. So there are questions to be asked about the future of treatment research at the level of complexity that is needed to secure a viable evidence base, for expensive treatments that demand new infrastructure and training. Both funding and prioritisation of this kind of research in clinical settings, are in reality severely constrained. Randomised trials are expensive, and involve years of meticulous preparation, planning and execution. The result of all this is a few tables and figures, sufficient for a few articles, but hardly impressive as a product of many years of academic effort, judged by prevailing expectations. Implementation is likely to be even less rewarding as a route to academic qualification or status.

The other major type of constraint that operates upon innovative programmes of this kind, is that maintaining programme fidelity places limitations upon the pace of development. In *The Incredible Years*, group leaders need at least a year to qualify, and a good deal of supervision is required. Supervisors or *mentors* as they are called, have to practice much longer before they are qualified and accredited, and this has meant that the build-up of competence necessary to implement the methods, takes a long time. In fact, implementation has started on a basis of relatively slender resources in the form of supervisory competence. No-one in the project has wanted to challenge these limitations by changing standards, since there is agreement that it is important to maintain them. All the same, it is quite evident that programme fidelity has a very high cost in the form of relatively slow dissemination of the methods, particularly in the early stages of implementation that are taking place at the time of writing.

These constraints have also delayed the build-up of competence that will be necessary to disseminate the Webster-Stratton Classroom Management Programme. The first practical trials of this programme took place in Trondheim in 2002, but we had no funding to evaluate the work, and it now seems that such funding may be difficult to acquire.

Implementation plans

The provisional plans for implementation that were agreed in January 2004 can be summarised as follows:

1. An implementation plan with five years' duration was approved in principle.
2. The Regional Centres for Child and Adolescent Mental Health in Tromsø and Trondheim (RBUP) would provide 12 agencies with training (Basic Programme) each year.
3. The RBUPs in Bergen and Oslo would be prioritised for training.
4. A mentor (supervisor) training programme would be started.
5. Planning for evaluation and later implementation of the Classroom Management Programme would be initiated.

6. Dissemination of other methods (Dinosaur School in clinic and classroom versions, Advanced Programme, and the Preventive Programmes developed in Tromsø is to proceed as soon as qualified mentor resources permit.

The implementation programme is led by Professor Willy-Tore Mørch, and centralised in the sense that all decisions relating to which agencies will be offered training, are taken at RBUP in Tromsø. There are also implementation personnel working at RBUP in Trondheim. The project administration is divided between the two regional centres. Procedures for dealing with applications from agencies have been established, and implementation is coordinated with the implementation of PMT and MST conducted by the Norwegian Centre for Study of Conduct Problems and Innovative Practice, at the University of Oslo. The plans outlined here are likely to be revised and updated soon.

Implementation issues

The status of the Norwegian programme at the time of writing is that the effectiveness of the Basic Programme and Dinosaur School has been established. There is considerable demand for acquisition of competence by various agencies. The project team is in broad agreement upon the need for rapid build-up so that the Classroom Management programme can be evaluated and implemented. This seems to be urgently required because, as indeed was expected, Parent Training does not have broad generalising effects to children's behaviour in school settings. The tempo and logistics of introducing Classroom Management, and within a perhaps somewhat longer time scale, Dinosaur School in its pre-school/school versions, is the major issue in the project at the time of writing. On the other hand, the innovations introduced in Tromsø - the various preventive and proactive short Basic Programme variants - are very promising and it will be possible to disseminate them quite quickly, especially if community service agencies decide to offer them in large numbers.

In somewhat more detail, the implementation issues the project is working with include the following:

1. *Introducing Classroom Management as a curriculum supplement in pre-school and/or the first years of primary school.* Classroom Management would be adopted as a fixture for all groups or classes in schools or kindergarten. It would be important to secure evaluation material relating to the impact upon children with special behavioural problems and their peers in the school setting. Education research specialists in Norway are in agreement that programmes designed to influence children's behaviour in pre-school and primary school can have valuable preventive effects and will serve to enhance many children's adjustment to school and pre-school, and facilitate learning and socialisation.
2. *Using Classroom Management as a support in the school setting for children who have ODD and CD at diagnostic levels.* As our results have indicated, children who have responded well to Parent Training and Dinosaur School in its clinic version will often need support in school, where their behaviour will not necessarily improve without qualified behavioural management on the part of teachers. Following up children treated in the clinic, in their pre-school or school setting, is an important priority

3. *Developing preventive and proactive programmes for parents of young children (3-5 years).* A basis for developing and disseminating these short versions of Parent Training has been established, and evaluation has already started. The Norwegian innovations have perhaps yet to find their place in the overall implementation design.

Two other issues have been discussed in the light of our experience in introducing the programme and the evaluation results:

1. Problems associated with non-response to treatment. About a third of the children admitted to treatment fail to respond to treatment or show a very limited response. So far we are not ready to make specific proposals concerning these children, because a more thorough analysis of our results is required. But the problem of non-response does require attention, since it is a key to making the programme even more effective.
2. Most parents who have been in the programme have expressed a strong desire for follow-up or "booster" programmes. Our user evaluation showed that families are still quite isolated after treatment and that they generally lack good social supports. Support from community service agencies does not seem to be adequate either. A development project to explore this issue, and even a quite limited pilot study would be very useful, ought to be a priority.

Discussion

Evidence and Priorities

In discussing these issues, it has to be acknowledged that implementation has unavoidable political aspects which a group of researchers and clinicians cannot resolve. What the programme we have worked on has established, is the viability of the methods Carolyn Webster-Stratton has developed, *in a Norwegian setting*. There can no longer be any reasonable doubt that these methods work well here, with much the same striking rates of response as have led to widespread attention at international level. The programme has also developed a range of options for future development, and implementation raises the question of what choices have to be made in respect of these options.

Research that is now becoming available, concerned with predictors, mediators and moderators of outcome for children treated for early-onset conduct problems, makes it clear that parent training has the most durable effect of all the interventions developed by Webster-Stratton, when various factors that can impede or enhance the long-term effect of treatment, are taken into account (Beauchaine, Webster-Stratton & Reid, in preparation). This reinforces the impression that all the research dealing with these treatments conveys: parent training must be the core component in a strategy for implementing and disseminating the methods. Dinosaur School and Teacher Training should be offered as a supplement, since these methods so far as the present state of the evidence allows us to judge, have useful but lesser impacts upon children's behaviour (Op. cit.).

The cited research also strongly supports the view that early intervention is especially effective for children with other co-morbid conduct problems, for example ADHD, and

depression. Furthermore, it suggests that teacher training (Classroom Management) may be especially valuable as a supplement in treatment of children whose behaviour is disruptive in the school setting and who have poor impulse control.

The logistics of implementation dictate that the phase in which one builds up competence, should allow development of supervisory and training capacity in respect of several different types of treatment. If this is not possible, the range of options at a future date will be limited. This build-up takes time, and even given the considerable progress already made, involves a time-scale of 2-3 years from the present time (November 2004). When these resources are in fact available, the main priority has to be broad dissemination of Parent Training competence.

Broad dissemination in reality means that parent training facilities have to be available in local centres. Parents have in a few cases made journeys of up to three hours to attend parent training sessions in our programme, but this is beyond the usual practical distance limit for access to treatment. Accessible parent training in a Norwegian context would demand facilities in several centres within a region. In many areas, this can only be achieved by using models in which child psychiatry and community services cooperate to provide treatment. Practical experience in developing such collaborative provision is accordingly an important priority for the future development of the Norwegian programme.

The inescapable conclusion of this reasoning based on evidence about the effectiveness of programme components, is that broad implementation of Webster-Stratton methods will take some considerable time. The competence base for broad implementation will not be in place before 2006-2007 at the earliest.

Early intervention and prevention

The Incredible Years is the only available programme with an empirical basis, for children in the pre-school and early primary school age range. It may seem paradoxical to devote considerable resources to developing and implementing PMT, for example, while the Webster-Stratton programme is being disseminated on a much more modest scale. PMT surely needs this level of support, but is there a case for devoting more resources to implementing *The Incredible Years*?

Within the programme this has not so far been seen as a fundamental issue. A platform for broad dissemination has not yet been created, though it will be, within the time scale indicated above. We have so far seen early onset conduct problems as a mental health issue. Children who are affected are at serious risk of developing long-term behavioural problems, and many of them are affected by other mental health problems. It is a matter of urgency to provide help for them, and for their families, and the main obstacles that have had to be overcome are that it is difficult to identify the children at an early stage, and difficult to develop accessible programmes that parents will want to use. Our programme has shown that there is a considerable potential for much better provision within child psychiatry, or – optimally - in a framework of cooperation between child psychiatry and community services.

Early intervention, however, is the key issue. BUP St. Olav, Trondheim, who have provided these treatments for nearly four years, and have a large population to serve, have nearly 40% of their referrals for children under six years of age. The proportion of young children referred might well increase considerably if early referral via pre-school

were more common. Our user evaluation provides some evidence that parents could well be induced to seek help earlier if referral procedures were changed and pre-school personnel were more confident. It would be a wise investment to develop the Classroom Management programme within pre-school. This would enable the personnel there to have a more proactive approach to behaviourally disturbed children, and establish a better platform for securing parent training for the children concerned, effectively lowering the threshold for referral.

Behavioural problems are a major problem in schools. Even with relatively low prevalence rates, they affect many children because of the disruption disturbed children cause, and because teachers are not trained to manage behaviourally difficult children in appropriate ways. They are perhaps often forced into inappropriate responses, such as imposing punishments that are entirely without any positive effect, or strategies that isolate the affected child and, in effect, make his or her situation even more difficult. In the USA preventive programmes designed to control behaviour and enhance learning potential for all children, are becoming increasingly widespread. They involve changes to the school curriculum and specialised training for teachers. Dinosaur School in its school version and the Classroom Management programme are well suited to use in preschool and the earliest years of primary school. Their effects have been empirically documented. The option of developing these methods and the preventive brief parent training versions developed at RBUP in Tromsø will soon be available.

Conclusion

The implementation of *The Incredible Years* raises a number of questions that cannot easily be answered *within* the project structure itself, since they require consideration of priorities for services and the kind of shape mental health provision for young children should have in the years to come. The project which we were able to initiate in 1998-99 has led to a threshold for implementation, and the contents of this report show that Webster-Stratton's programme works well in a Norwegian setting. It is of great value for families whose children develop severe behavioural disturbances, and produces solid results that parents recognise and appreciate. Only a few short years ago, these families had more or less no hope of obtaining effective help. Now all this seems likely to change, and the prospect of such change makes consideration of the implementation issues we have sketched out here, vitally important.