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National University of Ireland Maynooth

PhD Thesis

Implementing the Incredible Years Parenting Programme in disadvantaged settings in Ireland: A process evaluation

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ACRONYMS

ACS	The Agenda for Children's Services
ACT	Acceptance and Commitment Therapy
ANOVA	Analysis of variance
AP	The Atlantic Philanthropies
AP-OMCYA	The Atlantic Philanthropies-Office of the Minister for Children and Youth Affairs
ADHD	Attention Deficit Hyperactivity Disorder
CBA	Cost benefit analyses
CBT	Cognitive Behavioural Therapy
CCEMG-EPPI	Campbell and Cochrane Economics Methods Group-Evidence for Policy and Practice Information
CD	Conduct Disorder
CGT	Constructivist grounded theory
CSC	Children's Services Committees
DCYA	Department of Children and Youth Affairs
DFRC	Deansrath Family Resource Centre
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders IV
EBD	Emotional and behavioural difficulties
EBPP	Evidence-based parenting programme
ECBI	Eyberg Child Behaviour Inventory
FRC	Family resource centre
GT	Grounded Theory
HSD	Honestly significant difference
HSE	Health Services Executive
IF	Implementation fidelity
IFF	Implementation Fidelity Form
IMF	International Monetary Fund
IPA	Interpretative Phenomenological Analysis
IY	Incredible Years
IYIS	Incredible Years Ireland Study
IYPP	Incredible Years parenting programme
LWC	Leaders' Weekly Checklist

MRC	Medical Research Council
NICE	National Institute for Health and Clinical Excellence
ODD	Oppositional Defiant Disorder
OECD	Organization for Economic Cooperation and Development
PPP	Purchasing power parities
PSQ	Parent Programme Satisfaction Questionnaire
PWE	Parents' Weekly Evaluation Form
RCT	Randomised controlled trial
TFRC	Tallaght Family Resource Centre
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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ABSTRACT

Background: Conduct problems in children are common and have attracted considerable interest, not least because of their negative psychological, social and economic consequences. Controlled trials demonstrate that parenting programmes can be effective in reducing childhood behavioural problems, but much less is known about the processes of change or contextual factors that influence trial outcomes.

Objective: This study involved a process evaluation which was nested within a randomised controlled trial (RCT) of the Incredible Years Parenting Programme (IYPP) in Ireland. The study was designed to: (1) identify and examine the key facilitative and inhibitive factors associated with the implementation of the programme in disadvantaged settings; and (2) to assess the level of implementation fidelity (IF) achieved within the RCT evaluation.

Method: The process evaluation employed a longitudinal, mixed-methods approach, and consisted of two separate but related stages. In ***Stage One***, the experiences of stakeholders (parents, practitioners and organisational managers) were assessed and explored using semi-structured interviews and focus groups. A series of in-depth interviews (N=81) was conducted with parents at pre-intervention (n=20), and at three follow-up time points, including 6- (n=33), 12- (n=20), and 18-months later (n=8). A further 16 interviews were conducted with group facilitators (n=11) and service managers (n=5) following delivery of the IYPP. Interview data were analysed using constructivist grounded theory. ***Stage Two*** was based on a mix of parent reports (N=103) and facilitator reports (N=11) designed to investigate aspects of fidelity within the RCT. Data were examined using a series of ANOVAs and correlational analyses.

Results: Three overarching themes were identified from ***Stage One***, including: (1) 'Experiences of learned helplessness' (e.g. the association between child conduct problems and family conflict and social isolation); (2) 'Perceived benefits and mechanisms of change' (e.g. the links between positive outcomes and a number of factors, including key parenting skills, social support, longer-term resilience and commitment, and facilitative organisational practices); and (3) 'Challenges in programme implementation' (e.g. cultural discomfort with praise and positive attention,

conflict with partners; and organisational difficulties with fidelity, attrition and sustainability). The findings from ***Stage Two*** indicated that IF was high in relation to therapist adherence (M=90%, SD=4%) and parental satisfaction (M=6.69, SD=0.14), but lower with regard to the retention of parents (M=8.23 sessions, SD=4.79). There were no statistically significant relationships between IF and the primary child behaviour outcome.

Conclusion: This process evaluation is one of the first studies to investigate the key short- and long-term factors associated with implementing the IYPP within disadvantaged settings. The findings underline the many benefits gained from participating in the IYPP whilst also indicating that extra supports may be required to enhance outcomes for the most vulnerable families, particularly in the longer term. Overall, the study highlights the feasibility of implementing the IYPP within the existing infrastructure of mainstream health and social service settings in Ireland. These findings represent a valuable addition to current evidence on the effectiveness of the programme, whilst also informing its routine implementation both within Ireland and elsewhere.

CHAPTER ONE

INTRODUCTION

1.1 Background

Conduct problems in young children are a growing problem both in Ireland and elsewhere, and have attracted considerable interest, in recent years, from researchers, practitioners and policymakers alike. Early onset conduct problems, also known as emotional and behavioural difficulties (or 'EBD'), typically involve: aggressive and disruptive behaviour; few positive interactions with adults; poor social skills; emotional volatility; and non-compliance with instructions (Loeber, Burke, Lahey, Winters & Zera, 2000; Task Force, 2006). In more extreme cases, conduct problems can develop into conditions such as Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), both of which are formal childhood psychiatric disorders as classified by the Diagnostic and Statistical Manual of Mental Disorders IV (Diagnostic and Statistical Manual of Mental Disorders IV [DSM-IV], 2000).

International research indicates that approximately 5% to 10% of children aged 5 to 15 years present with clinically significant conduct problems (e.g. Farrington & Welsh, 2007; Offord, Boyle & Racine, 1989; Task Force, 2006) whilst the figures for Ireland range from 7% to 8% for this age group (Cleary, Nixon & Fitzgerald, 2004; Williams et al. 2009). However, research across several countries, including Ireland, has shown that the incidence of childhood conduct problems can be as high as 35% in socially deprived areas (Cleary et al. 2004; Farrington & Welsh, 2007; Martin & Carr, 2005). If left untreated, these kinds of problems can lead to a series of negative outcomes in adolescence and adulthood, including: an increased risk of future antisocial and criminal behaviour (Farrington & Welsh, 2007; Fergusson, Horwood & Ridder, 2005); early school leaving and low occupational status (Scott, 2005); mental health and social difficulties (Broidy et al. 2003); as well as greater utilisation of health, education, social and legal services (Farrington & Welsh, 2007; Sainsbury Centre for Mental Health, 2009; Scott, Knapp, Henderson & Maughan, 2001). Thus, the long-run sequelae of early onset conduct problems - especially in areas characterised by high levels of social exclusion - place considerable psychological and social burdens on affected families and

communities, as well as creating an additional financial burden on the public sector (McGroder & Hyra, 2009; Scott et al. 2001a).

Although a range of genetic, biological, social and environmental factors are associated with the aetiology of childhood behavioural difficulties (Wasserman et al. 2003), a large body of research has demonstrated that the development of early onset conduct problems is consistently linked to punitive and inconsistent parenting (e.g. Collins, Maccoby, Steinberg, Hetherington & Bornstein, 2000; Patterson, 1982; Patterson & Yoerger, 2002; Shaw & Winslow, 1997). Correspondingly, there is increasing evidence that group-based parenting interventions provide a cost-effective means of preventing and treating conduct problems, particularly when implemented early in childhood (e.g. Barlow & Stewart-Brown, 2000; Brestan & Eyberg, 1998; Furlong et al. 2012; Mihalic, Fagan, Irwin, Ballard & Elliot, 2002; National Institute for Health and Clinical Excellence [NICE], 2006). More specifically, the *Incredible Years BASIC Preschool/Early School Years Parent Training* programme (IYPP) has been identified in several systematic reviews as one of the few 'model' parenting interventions that has proven effectiveness in improving child behaviour outcomes, parent-child interactions and parental mental health (e.g. Brestan & Eyberg, 1998; Furlong et al. 2012; Mihalic et al. 2002; NICE, 2006).

The IYPP comprises an intervention within the *Incredible Years* suite of parent-, teacher- and child-training programmes, the collective aim of which is to prevent or alleviate emotional and behavioural difficulties in young children, to promote positive child social behaviour, and to enhance parental and teacher-management competencies and well-being (Webster-Stratton & Reid, 2003). The IYPP is a short, 9-24 session, group-based parenting intervention, guided by behavioural, cognitive-behavioural and social learning principles, and has demonstrated effectiveness within the USA and several countries in Europe, including Ireland (e.g. Gardner, Burton & Klimes, 2006; Hutchings et al. 2007a; Larsson et al. 2008; McGilloway et al. 2012a; Webster-Stratton & Hancock, 1998).

Despite the number of randomised controlled trials (RCTs) underpinning the effectiveness of the IYPP, one of the (few) limitations of RCTs is that, whilst they can provide robust evidence of effectiveness, they are less able to reveal the key processes

of change, contextual factors or intervention characteristics that may influence trial outcomes, particularly when delivered in 'real-world' service settings (Weersing & Weisz, 2002). For instance, core programme mechanisms of the IYPP are not yet wholly understood and little research has investigated the differential organisational structures and the cultural, socioeconomic and political factors that may influence the implementation of the IYPP within mainstream services (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). For this reason, the Medical Research Council (2000) recommends that process evaluations are conducted alongside RCT evaluations, in order to clarify causal mechanisms and to identify contextual factors associated with variation in outcomes. To date, few process evaluations have been conducted on the IYPP (and none within an Irish context) in order to provide insights into the factors affecting its implementation within 'real-world' service settings.

1.2 The current study: Aims and objectives

This study involved a process evaluation which was nested within a large RCT of the IYPP conducted in Ireland (McGilloway et al. 2009; McGilloway et al. 2012a) and funded by the Atlantic Philanthropies[1] as part of the *Incredible Years Ireland Study* (IYIS). This large four-year evaluation involved a series of three RCTs (with each RCT comprising a parallel process evaluation) that assessed the effectiveness and cost-effectiveness of the *Incredible Years* suite of parent-, teacher- and child-training interventions within an Irish context (Please see www.iyirelandstudy.ie).

The current study was conducted in two separate, but related stages and involved a longitudinal, multi-informant, process evaluation which was based on a mixed methods approach (i.e. using both qualitative and quantitative methodologies) in order to assess the 'on-the-ground' implementation of the IYPP in Ireland. The overarching aim of the study (i.e. ***Stage One)*** was to assess the experiences of key stakeholders (i.e. parents, group facilitators and organisational managers) involved in the intervention process,

[1] The Atlantic Philanthropies (AP) is a limited life foundation that provides funding to improve outcomes for disadvantaged people within many countries worldwide, including, for example, the Republic of Ireland (ROI), Northern Ireland, South Africa, the United States and Australia. Within the ROI, AP has collaborated with grantees to enhance the capacities of the Ageing, Children and Youth and Reconciliation and Human Rights sectors. AP has supported the Children and Youth sector in the ROI through funding the adoption and evaluation of focused prevention and early intervention approaches for children and families.

with a view to examining how and why the IYPP intervention worked, or did not work. A secondary, but related aim (i.e. ***Stage Two***), was to monitor and assess all aspects of implementation fidelity of the IYPP within the RCT evaluation. Implementation fidelity (IF) refers to the extent to which programmes delivered in more naturalistic service settings adhere to the original design of the intervention (Biglan & Taylor, 2000) and its assessment has been identified as crucial in investigating process mechanisms (e.g. Elliot & Mihalic, 2004).

The specific objectives of ***Stage One*** were to:

- Explore the pre-intervention 'lived experience' of parenting a child with severe conduct problems;
- Conduct a post-intervention analysis of the primary benefits obtained from the IYPP;
- Investigate aspects of the programme that were particularly valued by parents, as well as examining key challenges associated with programme participation;
- Assess the longer term experiences at parents 12- and 18-months after receiving the intervention; and to
- Examine the key organisational processes and socio-political factors which may have influenced programme implementation within an Irish health and social service context.

The specific objectives of ***Stage Two*** were to:

- Monitor various aspects of IF, including the level of therapist adherence to the programme protocol; quality of programme delivery; and parental attendance and responsiveness to the programme; and to
- Examine the relationship between the primary trial outcome of child behaviour and various aspects of IF, including programme adherence, participant attendance and responsiveness to the programme.

The above stages and associated objectives provided the framework for this study. The following section outlines the content of the remainder of the thesis.

1.3 Thesis outline

Chapter Two is the first of two literature review chapters which situate the present study within its empirical, theoretical and policy/practice contexts. This chapter begins by summarising the current national and international literature on childhood conduct problems with reference to their prevalence, risk factors and long-term social, psychological and economic consequences. The second section provides a descriptive and critical overview of the effectiveness of behavioural, group-based parenting programmes in the treatment and prevention of behavioural problems in young children. The third section of this chapter summarises the evidence for the effectiveness and cost-effectiveness of the IYPP. The fourth and final section compares policy initiatives and practice on parenting education and supports within Ireland and elsewhere.

Chapter Three describes the background to, and the results of, the RCT evaluation of the IYPP within various service settings within the greater Dublin area (McGilloway et al. 2012a). The second section within this chapter presents the rationale for the current study which focused on identifying the key facilitative and inhibitive factors in implementing the IYPP in mainstream services. Processes of change are considered on a number of levels, including: pre-intervention experiences; key intervention characteristics; cultural and socio-economic effects on trial outcomes; organisational and systems influences on implementation; and long-term processes of change.

Chapter Four provides an outline of the study design and a discussion of how important methodological issues were addressed within the study. This chapter is divided into three sections. The first section describes the epistemological foundations of the study and places it within a 'pragmatic', process-oriented, mixed-methods framework, which involves both qualitative and quantitative analytic strategies to address the research aims and objectives (e.g. Tashakkori & Teddlie, 2003). The second section of this chapter provides the methodological details (i.e. participant characteristics and settings, measures, procedure and data analysis) for each of the two stages of the study. The third section addresses other important methodological issues, including ethical considerations, reliability and validity concerns, and researcher reflexivity.

Chapter Five is the first of four Results chapters; the first three chapters pertain to Stage One (i.e. the qualitative analysis) whilst the fourth chapter relates to Stage Two (i.e. the

quantitative assessment of implementation fidelity). Three overarching or 'master' themes were identified from the qualitative analysis and, due to the extensive scope of each theme and the many sub-themes therein, a separate chapter was dedicated to presenting the findings within each. This chapter presents the themes and subthemes generated from the baseline (pre-intervention) interviews with parents (N=20). These focused on, amongst others, exploring the child's behaviour and its impact on familial, marital and community relationships, previous strategies employed by parents in dealing with their child's misbehaviour, and expectations of the IYPP.

Chapter Six presents the findings relating to the second overarching 'master' theme (and subthemes) generated from interviews with all stakeholders including parents interviewed at 6-, 12- and 18-month follow-up periods (N=61) as well as group facilitators and service managers (N=16) who were interviewed following delivery of the IYPP. Topics covered with parents across the three stages included: their short- and long-term experiences of the IYPP; a description of the child's behaviour in various settings; the identification of the most and least useful aspects of the programme; and any difficulties experienced in learning or implementing the taught parenting techniques. Parents who 'dropped out' early from the programme (N=8) were also asked about their reasons for non-attendance, their experience of the programme, and any other services that they were currently using. Issues related to delivering and implementing the IYPP within specific services were explored with group facilitators and organisational managers.

Chapter Seven presents the findings that relate to the third overarching theme of the qualitative analysis. As in *Chapter Six*, this analysis was based on interviews conducted with parents at six-month follow-up (N=33), 12-month follow-up (N=20) and 18-month follow-up (N=8). Some of the findings from the interviews with the group facilitators and organisational managers are also presented here. The main topics covered within the interviews are described above.

Chapter Eight presents the results of the second stage of the study which focused on various aspects of implementation fidelity, including: programme adherence; quality of programme delivery; parental exposure/attendance; and parental responsiveness to the IYPP. Statistical analyses investigated the extent to which fidelity varied across group

setting or intervention component. In addition, this section examined the statistical relationship between child behavior and all measured aspects of fidelity (i.e. therapist adherence, participant attendance and satisfaction with the programme). Additional findings pertaining to fidelity are also provided, including, amongst others, the degree of homework completion and difficulties experienced in promoting parents' problem-solving abilities.

Chapter Nine provides a synthesis and critique of the key findings from both stages of the study. The key factors influencing programme implementation and trial outcomes are discussed within a multi-dimensional framework and within a broad empirical and policy-based context. The chapter concludes with a discussion of the strengths and limitations of the study and considers future directions for research, as well as the implications of the findings for service providers and policymakers.

CHAPTER TWO

PARENTING PROGRAMMES FOR CHILDHOOD CONDUCT PROBLEMS: AN OVERVIEW

As described earlier, this chapter comprises four sections, beginning with an overview of conduct problems in young children both in Ireland and elsewhere and concluding with a discussion of national and international policy and practice in providing parenting support.

2.1 Conduct problems in young children

2.1.1 Defining conduct problems

Conduct problems in children are common and have attracted considerable interest in recent years due to their significant negative psychological, social and economic consequences. Conduct problems are the most common reason for referral to psychological and psychiatric services in childhood (NICE, 2006) and are characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant behaviour, including: frequent and severe temper tantrums; non-compliance with instructions; recurrent deceit; destruction of property; intimidation of people and animals; and an unwillingness or inability to perform school work (Loeber & Farrington, 2001; World Health Organisation [WHO], 2009). Children with the most severe conduct problems may be diagnosed with Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD) (DSM-IV, 2000), but less severe conduct problems, if left untreated, may also develop into Conduct Disorder (Burke, Loeber & Birmaher, 2002). ODD is classified as reflecting a less pervasive disturbance than CD (e.g. less physical aggressiveness) but may also function as a developmental precursor of CD (DSM-IV, 2000; ICD-10, 2010). Thus the term 'conduct problems' refers both to sub-clinical and diagnosed behavioural problems. Although several interchangeable terms have been used to describe aggressive and troublesome child behaviour (e.g. emotional and behavioural difficulties [EBD]', 'antisocial behaviour', and 'disruptive behaviour), the current study will utilise the term 'conduct problems' as this is most commonly used within the literature.

Conduct problems are three to four times more likely to be present in boys than girls (Burke et al. 2002). Co-morbidity for conduct problems and other disorders, such as Attention Deficit Hyperactivity Disorder (ADHD), emotional disorders and learning disabilities, is also quite common (Liabo & Richardson, 2007; Loeber & Farrington, 2001). For instance, 27% of those with CD also qualify for a diagnosis of ADHD (Ford, Goodman & Meltzer, 2003) and the co-morbidity rate with major depression and anxiety disorders is 17% and 15% respectively (Angold, 2002).

2.1.2 Long-term consequences of conduct problems

The prognosis for early-onset conduct problems (when compared with onset in adolescence) is poor and research indicates that there is a high degree of continuity in behavioural difficulties from infancy to early childhood (e.g. Keenan, Shaw, Delliquadri, Vannelli & Walsh, 1998), from early childhood to later childhood (e.g. NICE, 2006), from childhood to adolescence (e.g. Lahey, Loeber, Burke & Rathouz, 2002), and from adolescence to adulthood (e.g. Farrington et al. 2005). Indeed, 62 per cent of children who have conduct problems at age three will continue to be troublesome at age eight (NICE, 2006). Without treatment, childhood conduct problems are believed to become entrenched around the age of eight or nine years (Eames et al. 2009; Webster-Stratton & Reid, 2003). Negative outcomes in adolescence and adulthood may include: antisocial and criminal behaviour; psychiatric disorders; drug and alcohol abuse; higher rates of hospitalisation and mortality; higher rates of school drop-out and lower levels of educational attainment; greater unemployment; family breakdown; and intergenerational transmission of conduct problems to children (Broidy et al. 2003; Burke et al. 2002; Carey, 2000; Dretzke et al. 2009; Farrington & Welsh, 2007; Loeber & Farrington, 2000; Moffitt, 1993).

The costs of early-onset conduct problems to society are also considerable. Children with severe conduct problems, when compared to those without such problems: are more likely to require remedial help at primary and secondary school (Scott, 2005); are up to 10 times more likely to leave school with no educational or vocational qualifications (Farrington & Welsh, 2007); will make significantly more use of primary care services (e.g. doctor, hospital, speech therapist) (Edwards, O'Ceilleachair, Bywater, Hughes & Hutchings, 2007; McGroder & Hyra, 2009); and are significantly more likely to have contact with the police in adolescence (Gregg & Machin, 1999). By the age of

28 years, the cost of health, social, education and legal services may be 10 times higher for individuals with a clinical diagnosis of CD at age 10 years (EUR €115,450; GBP £93,815) than for those without such problems (EUR €12,240; GBP £9,940). The costs for those with non-clinical conduct problems at age 10 years (i.e. children who do not meet diagnostic criteria) have been found to be 3.5 times higher (EUR €42,940; GBP £34,900) (Scott et al. 2001a). Indeed, other research indicates that the lifetime cost per case of people who have CD from childhood is approximately €318,260 (GBP £258,610) and that the lifetime costs per case for those with sub-diagnosis conduct problems from childhood, is approximately $109,120 (GBP £87,760) (Sainsbury Centre for Mental Health, 2009).[2]

2.1.3 Risk factors for conduct problems

Multi-factorial theories are commonly used when investigating the causes of childhood conduct problems, as in the aetiology of other mental health difficulties. Thus, these kinds of problems have been linked to a number of complex, interacting dispositional and contextual risk factors, including: child developmental risk factors (e.g. childhood impulsivity, temperament, low verbal intelligence and neurochemical abnormalities); ineffective parenting (e.g. harsh discipline, low parental involvement); family factors (e.g. marital conflict, parental stress/depression, drug abuse, criminal behaviour in parents and low educational and occupational status); and peer and community risk factors (dangerous neighbourhood, small living quarters, deviant peer influences and socioeconomic deprivation) (Farrington, 2002; Frick & Morris, 2004; Kazdin, 2003; O' Connor, 2002; Patterson & Forgatch, 1995; Webster-Stratton & Reid, 2003). However, notwithstanding the effects of interacting and cumulative risk factors, there is now considerable evidence to show that poor quality parenting is one of the most important factors associated with early-onset conduct problems (Farrington & Welsh, 2007; Lipsey & Derzon, 1998; Odgers et al. 2008).

[2] The costs from Scott et al. (2001a) and from the Sainsbury Centre for Mental Health (2009) have been adjusted to the price year of 2011through using a web-based conversion tool - the 'CCEMG – EPPI Centre Cost Converter'. This tool uses conversion rates based on Purchasing Power Parities (PPP) for Gross Domestic Product and is available from the International Monetary Fund (IMF) World Economic Outlook Database (see http://eppi.ioe.ac.uk/costconversion/default.aspx). This data set contains 'PPP values' for 181 countries (currencies) from 1980 to 2011(most recent price year available).

Inadequate parenting is typically characterised by ineffective parenting skills, including low levels of parental supervision and involvement, and punitive and inconsistent discipline. These tend to positively reinforce childhood aggressive behaviour whilst reducing positive behaviours by not attending appropriately to them – this negative interaction style is often referred to as the 'coercive family process' (Farrington & Loeber, 1999; Patterson, 1982; Patterson & Yoerger, 2002; Reid, Patterson & Snyder, 2002). Moreover, other findings indicate that parental distress, mental illness, substance abuse and disrupted family life (all of which can affect the quality of parent-child interactions) are involved in the aetiology of early-onset conduct problems (Hogan, Halpenny & Greene, 2002; Mash & Johnston, 1983; Shaw, Vondra, Dowdell Hommerding, Keenan & Dunn, 1994). It should be noted, however, that the causal link between parental stress and depression and childhood problem behaviour may be bi-directional in that parents and children reciprocally affect and shape one another's behaviour (Long, Gurka & Blackman, 2008; Patterson & Yoerger, 2002). For example, the parent who lacks positive parenting skills may become increasingly restrictive and negative when trying to cope with their non-compliant child. This, in turn, makes the child more difficult to handle, which further increases parental distress and their sense of helplessness and hopelessness in managing the child's misbehaviour (Campbell, 1997).

Although there is a range of interventions which aim to treat antisocial behaviour (e.g. child cognitive therapy, social skills training, school-based interventions and pharmacology) (Sukhodolsky, Kassinove & Gorman, 2004; Wilson & Lipsey, 2006; Wolpert et al. 2006), there is growing evidence that improvements in parenting skills are particularly effective in reducing problematic behaviours in childhood, increasing children's positive social and compliant behaviours, as well as improving parental mental health (Hutchings et al. 2007a; Osofsky & Thompson, 2000; Patterson & Yoerger, 2002; Webster-Stratton, Reid & Hammond, 2004). More specifically, evidence-based parenting programmes (EBPPs) have been identified as an important early intervention strategy designed to improve child conduct problems, with the long-term goal of producing productive and well-adjusted adults (Barlow, Smailagic, Ferriter, Bennett & Jones, 2010; Hutchings et al. 2007a; NICE, 2006; Webster-Stratton & Hammond, 1997).

2.2 Parenting programmes

2.2.1 Parenting programmes: a brief history

Training parents as behaviour therapists for their own children began in the 1960s, when it was shown that parents could successfully produce a wide range of behavioural changes in children using behaviour modification techniques (Walter & Gilmore, 1973; Wiltz & Patterson, 1974). Previously, behaviour therapists had worked with children in clinical settings using applied behavioural analysis and while they succeeded in modifying children's behaviour within the laboratory, these newly acquired behaviours were not maintained within the home setting (Richardson & Joughin, 2002). Using parents as change agents overcame difficulties relating to the transfer of behaviour changes produced in the clinic to the home. It was also more cost effective and it seemed to eliminate some of the stigma associated with clinic attendance (Johnson & Katz, 1973).

Advances in several key areas influenced the development of parenting programmes. These include the development of social learning theory (Bandura, 1977) and its application to child antisocial behaviour; for instance, Patterson (1982) referred to a pattern of parenting behaviours that contributed to/maintained problematic child behaviours as a 'coercive family process', whereby parents who engage in negative coercive interactions with their children act as inappropriate models and reinforce similar behaviour in their children. Specific problematic parenting behaviours identified by Patterson included direct reinforcement of problem behaviour, inconsistent responding and harsh punishment. At the same time, Forehand and McMahon (1981) contributed to the development of parenting programmes through identifying key skills for effective parenting, which included relationship building, rewarding appropriate behaviour, giving clear commands, ignoring minor problems and using non-aversive strategies to manage problem behaviour (e.g. 'time out'). They also were one of the first to employ videotape footage of parent-child interactions as a format in which to teach parents.

Taken together, all of these varying influences dovetailed into a hypothesis that parents are the most powerful, and potentially malleable, influence on young children's social development, and as such, are in a better position than behaviour therapists to successfully modify the child's behaviour. Initially, interventions with parents were

conducted on an individual basis with the behaviour therapist (e.g. Wahler et al. 1965), but in the interests of efficiency, group-based parenting programmes became increasingly popular in the 1970s (Richardson & Joughin, 2002). The additional benefits of peer support and opportunities for modelling and peer learning were later recognised as an advantage of such programmes (Webster-Stratton, 1984).

2.2.2 Description of group-based parenting programmes

Current group-based parenting programmes are typically delivered by two trained facilitators to a group of approximately 8 to 12 parents, for weekly 2-hour sessions, over a period ranging from 4 to 24 weeks (e.g. Webster-Stratton, Kolpacoff & Hollinsworth, 1988; Sanders & McFarland, 2000). Such programmes typically involve an interactive and collaborative learning format and aim to decrease child antisocial behaviour and increase child pro-social behaviour by strengthening parent management skills and by promoting a positive relationship between parent and child. Key programme components include behavioural principles and parenting skills, such as teaching parents to build a positive relationship with their child through play, rewarding appropriate behaviour, ignoring and setting limits to undesirable behaviour and giving clear instructions (Forehand & McMahon, 1981; Hutchings, Bywater & Daley, 2007b; Patterson, 1982; Webster-Stratton, 1984). Social learning principles are evident within such programmes through the use of vignettes to model effective parenting behaviour, and also through role play, rehearsal, homework assignments, problem-solving and peer support (Bandura, 1986; Eames et al. 2009; Hutchings, Gardner & Lane, 2004). In addition, reframing unhelpful cognitive perceptions about their child or about child-management in general, and tackling barriers to attendance, appear to be key elements of effective programmes (Azar & Wolfe, 2006; Gardner, Lane & Hutchings, 2004; Hutchings et al. 2004; Mihalic et al. 2002).

However, it is important to note that behavioural and cognitive-behavioural parenting programmes vary in the extent to which they include these components; for example, it has been shown that differences in the duration of the programme, which may range from 4 (Martin & Sanders, 2003) to 24 weekly group sessions (Webster-Stratton & Hammond, 1997), affects the amount of time dedicated to practice and may impact upon the mechanism of group support. In addition, some programmes (e.g. the IYPP) place more emphasis on relationship building (though play) and on parental social support

(e.g. Hutchings et al. 2007a) when compared to others. Furthermore, some but not all programmes tackle barriers to attendance by providing transport and childcare facilities for participating parents (e.g. Gardner et al. 2006). Behavioural group-based parenting programmes may also vary in the extent to which they target clinical or 'normal' populations; for instance, the *Triple P Parenting Programme*[3] primarily adopts a preventive approach in working with non-clinical families whereas the IYPP, whilst also involving some preventative work, appears to be more effective with families who are most at risk and with children with the most severe problems (Hutchings et al. 2004; Hutchings, Bywater, Davies & Whitaker, 2006). However, irrespective of the differences among programmes, there is a general consensus in the literature that early intervention during the preschool and early school years (ages 3-8 years) is linked to better outcomes and to the maintenance of positive behaviour at longer-term follow-up (Essau, 2003; Webster-Stratton & Reid, 2003).

2.2.3 Group-based parenting programmes: an overview of effectiveness

Several systematic reviews attest to the effectiveness of group-based parenting programmes in reducing behavioural difficulties in young children, especially those that are informed by behavioural and social-learning theory principles (Barlow & Stewart-Brown, 2000; Brestan & Eyberg, 1998; Dretzke et al. 2005; Dretzke et al. 2009; Farmer & Compton, 2002; Furlong et al. 2012; Mihalic et al. 2002; NICE, 2006). Systematic reviews are based on only the highest quality studies and, therefore, include only randomised controlled trials (RCTs). Although there are different types of review, involving both statistical meta-analyses (e.g. Furlong et al. 2012) and those that evaluate studies against recognised criteria of well-established treatments (e.g. Brestan & Eyberg, 1998; Mihalic et al. 2002), every single review, to date, has mentioned the IYPP as an effective intervention in the treatment and prevention of childhood antisocial behaviour (e.g. Furlong et al. 2012; NICE, 2006; United Nations Office on Drugs and Crime, 2010).

[3] The *Triple P-Positive Parenting Programme* is a multi-level, parenting and family support strategy, whose aim is to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. The level of intervention with parents depends on the differing needs of families; some parents may receive an information leaflet or brief seminar whereas others may receive *Group Triple P* or a more individual, tailored approach. Group Triple P comprises 4 to 8 weekly sessions and is based on behavioural and social learning principles (Sanders, Turner & Markie-Dadds, 2002).

The Centre for Violence Prevention, funded by the US government, conducted a particularly rigorous review in which interventions were only identified as 'model' crime-prevention programmes if they fulfilled a number of stringent criteria; thus, programmes/interventions were only considered eligible if they had been evaluated as RCTs, had been independently replicated (ideally in service as well as research settings), had assessed outcomes at long-term follow-up, and provided tools and materials to enable accurate replication by others (Mihalic et al. 2002). From 600 programmes reviewed, only 11 met these stringent criteria, one of which was the IYPP. The IYPP was subsequently described as a 'blueprint' or 'model' intervention, with particular effectiveness in reducing conduct problems within high-risk, socially disadvantaged families (Mihalic et al. 2002).

The most recently conducted (Cochrane) review in this area (Furlong et al. 2012) has been described as providing the clearest, most robust evidence, to date, in support of behavioural, group-based parenting programmes (Gardner, 2012). The IYPP was identified within the review as the programme demonstrating most evidence of effectiveness and cost-effectiveness in treating early onset conduct problems (Furlong et al. 2012). Unlike previous reviews, studies were only included if the children evidenced clinically significant conduct problems at baseline. This was also the only review to conduct a series of sensitivity analyses in order to test for risk of bias (e.g. inadequate randomisation procedures, inadequate treatment of attrition and a lack of intention-to-treat analyses) within the included RCTs. Furthermore, this was one of the few reviews that conducted statistical meta-analyses, which indicated moderate to large effect sizes for the IYPP in improving child disruptive behaviour.

2.2.4 Limitations of group-based parenting programmes

Although there is substantial evidence for the effectiveness of group-based parenting programmes in reducing childhood behavioural problems (e.g. Barlow & Stewart-Brown, 2000; Furlong et al. 2012), some challenges remain. Firstly, there is a need to enhance the overall quality of RCTs in order to address areas of risk around randomisation procedures, high attrition, intention-to-treat analyses, sample size, implementation fidelity and an increased utilisation of independent, objective (versus self-report) measures (Furlong et al. 2012). Even comparatively well-designed RCTs

(e.g. Larsson et al. 2008; Martin & Sanders, 2003) often fail to address such risks of bias.

Secondly, there is an absence of long-term assessment of outcomes, with RCTs typically losing the control group at three months post-intervention (control groups generally receive the intervention following short-term follow-up as it is perceived as unethical to withhold a potentially efficacious programme from control group participants [e.g. McGilloway et al. 2012a].). However, a lack of long-term research undermines our confidence in relation to the maintenance of positive benefits over time. Although some long-term research has been conducted on group-based parenting programmes for the intervention group alone, which indicates the maintenance of treatment gains at 18-month follow-up (Bywater et al. 2009) and up to 12 years later (Webster-Stratton, Rinaldi & Reid, 2010), it is difficult to draw conclusions, at this stage, in the absence of control groups against which to compare the results. It is also important to note that a small number of RCTs have found that positive gains were not maintained at 12-month follow-up (e.g. Patterson et al. 2002; Spaccerelli, Cotler & Henman, 1992).

Thirdly, there is a need to address the issue of non-response, whereby one third of all children fail to derive clinical benefit from parenting programmes (Drugli, Fossum, Larsson & Morch, 2009; Greene, Ablon, Goring, Fazio & Morse, 2004). The failure to benefit from the intervention is primarily attributed to the often high rates of attrition/drop out from parenting programmes, which sometimes can be as high as 50% (Forehand & Kotchick, 1996; Liabo & Richardson, 2007; McMahon & Kotler, 2004). Socioeconomic disadvantage, disrupted family life, and parental psychopathology have all been associated with high attrition and poorer treatment outcomes in parent training (Reyno & McGrath, 2006). Some parenting programmes have improved retention rates with high-risk families by addressing access and childcare barriers (e.g. Webster-Stratton & Hancock, 1998). Others have evaluated adjunctive treatments to parent training, including marital skills training (Dadds, Schwartz & Sanders, 1987) and problem-solving skills training (e.g. Kazdin, 2001; 2003), and reported increased engagement of high-risk clients, as well as enhanced outcomes for families.

Other challenges include the transportation of EBPPs into ‘real world’ service settings, which are typically accompanied by fidelity and implementation difficulties and a

dilution of results obtained in controlled research settings (Fixsen et al. 2005; Mihalic & Irwin, 2003). In addition, the vast majority of RCTs in the parenting field fail to examine or report on any potential adverse outcomes, even though qualitative research indicates that conflict with one's partner can sometimes emerge when new parenting techniques are introduced into the home (Furlong & McGilloway, 2011; Mockford & Barlow, 2004).

Finally, high quality cost analyses of parenting interventions are relatively rare (Romeo, Byford & Knapp, 2005). Robust evidence of cost-effectiveness is vital if evidence-based parenting programmes are to be implemented more widely (Hutchings, in submission) and if policymakers are to make well-informed decisions about the relative cost-effectiveness of various parenting programmes (Furlong & McGilloway, in press). Recent cost-effectiveness analyses have demonstrated that, in comparison to standard service provision, parenting programmes may be cost effective in reducing clinically significant conduct problems to non-clinical levels (Edwards et al. 2007; O'Neill, McGilloway, Donnolly, Bywater & Kelly, 2011). However, there is still a need for future cost analyses to adopt a more 'complex intervention approach' so that the wider costs of delivering the intervention (e.g. adverse reactions to attendance, productivity costs for parents or employment agencies in attending the programme) are examined in more detail, as well as the wider benefits to society, including generalised benefits to other family members, the positive economic effects of improvements in parental mental health and other long-run educational and occupational outcomes (Aos, Lieb, Mayfield, Miller & Pennucci, 2004; Charles, Bywater & Edwards, 2011). Furthermore, reportage within economic evaluations could be enhanced across a number of key areas, including reporting measures of variance for all parameters; clearly delineating resource use from unit costs; and by carefully selecting outcome measures that can be compared with previous published studies (Furlong et al. 2012).

2.3 The Incredible Years BASIC Parenting Programme

2.3.1 Content of the Programme

The IYPP was developed over thirty years ago in the US by Carolyn Webster-Stratton. Similar to other group-based parenting programmes, it is based on behavioural and social learning principles and is influenced heavily by the work of Patterson (1982), Forehand and McMahon (1981), and Bandura's (1977) ideas of modelling and self-

efficacy. Early research by Webster-Stratton indicated that the combination of group discussion, a trained therapist, and videotape modelling produced the most lasting results in comparison to treatment that involved only one of these training components (Webster-Stratton, 1984; Webster-Stratton et al. 1988). This learning format is called the BASIC parenting programme.

As indicated in Chapter One, the IYPP is part of a suite of the *Incredible Years Parent, Teacher and Child Training Series* (see Figure 2.1), the collective aim of which is to systematically modify the home and school environments in which the child interacts (Reid, Patterson & Snyder, 2002). The Incredible Years (IY) has also recently added other programmes to its curriculae, including the *Baby Programme*, the *Toddler Programme* and the *Preadolescent Programme* (www.incredibleyears.com). In addition, the *ADVANCE Parenting Programme* is a separate, follow-on programme for high-risk parents who experience marital discord, depression, poor problem-solving ability and environmental stressors that may contribute to relapses subsequent to parent training. Components include a focus on marital communication and conflict management, depression, anger and stress management and developing strategies to obtain social support in parenting (Webster-Stratton & Reid, 2003).

Up until early 2008, the IYPP typically consisted of 12 weekly, 2-hour, parent-group training sessions. However, in 2008, the IYPP evolved into 18 to 22 weekly sessions and an abbreviated 14-week version of this newly developed programme was evaluated in the Irish RCT of the IYPP (McGilloway et al. 2012a). It was necessary for the programme to be condensed in order to fit with the original planned RCT schedule (More details on this process are provided in Appendix 1.). This longer version is viewed by the developer as being more suitable for high-risk families (Webster-Stratton, 2012). The addition of new components (e.g. social and emotional coaching; increased emphasis on academic persistence, and problem-solving strategies) is based on ongoing research developments within the parenting field (Webster-Stratton, 2012), as well as on research from prevention studies that indicates that the more sessions offered, the higher the effect sizes obtained from the intervention (Baydar, Reid, & Webster-Stratton, 2003). Briefly, it should be noted that other research did not find that longer versions of parenting programmes were associated with improved outcomes (Furlong et al. 2012). This issue will be discussed in more detail later.

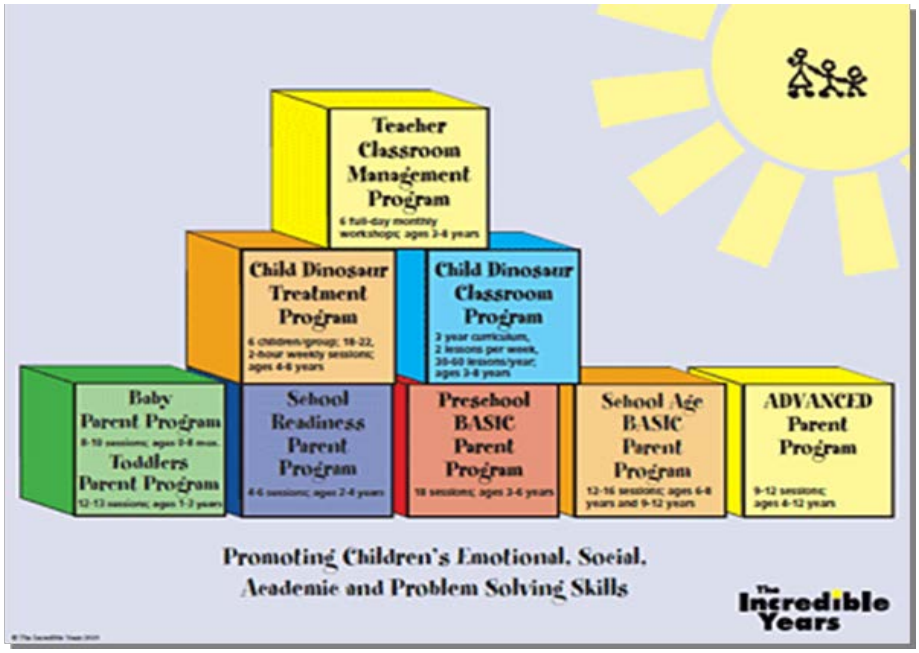

Figure 2.1 Components of the Incredible Years Parent, Teacher and Child Training Series

The IYPP is delivered by trained facilitators who receive regular supervision. It utilises a collaborative approach and supports parents as problem-solvers in achieving their own goals. The objective of the collaborative approach is to convey an attitude of hope without minimising the problem, with a focus on present and future possibilities rather than past problems (Hutchings et al. 2007b). A structured sequence of topics is presented within the programme, including: learning to play with the child; social and emotional coaching methods; increasing positive behaviour through praise and incentives; problem-solving; and managing non-compliance and aggression through limit setting, ignoring, time out and other strategies. Parents are taught to liberally apply skills such as play, praise, rewards and problem-solving and to selectively implement time out and consequences for defiant behaviour (see Figure 2.2). Sessions use videos, role play, modelling, group discussions, homework assignments and mid-week phone-call support to help parents rehearse and adopt positive parenting strategies (e.g. Webster-Stratton & Hancock, 1998). The IYPP also incorporates an ecological approach in ensuring that access issues are addressed for high-risk families, in terms of providing free transportation, childcare and meals to parents (Hutchings et al. 2004). Moreover, it also encourages parents to set up peer networks outside of the programme. Research indicates that programmes that promote connections to the community and the broader

ecological context increase the self-sufficiency of parents (Sanders, Cann & Markie-Dadds, 2003).

The IYPP also provides tools for ensuring fidelity of programme delivery. The concept of implementation fidelity (IF), sometimes also called adherence or integrity, encompasses the extent to which the intervention is implemented as originally designed. Quality IF is believed to be an important mechanism in ensuring that efficacious results achieved within experimental research settings are translated to mainstream service settings (Michalic & Irwin, 2003). In order to achieve optimal programme integrity, the IYPP includes a number of elements including: basic training for group facilitators; detailed manual and materials; session checklists; videotaped footage of sessions which are evaluated within supervision; and accreditation for facilitators who are required to achieve a high degree of proficiency in delivering the programme (Hutchings et al. 2007b).

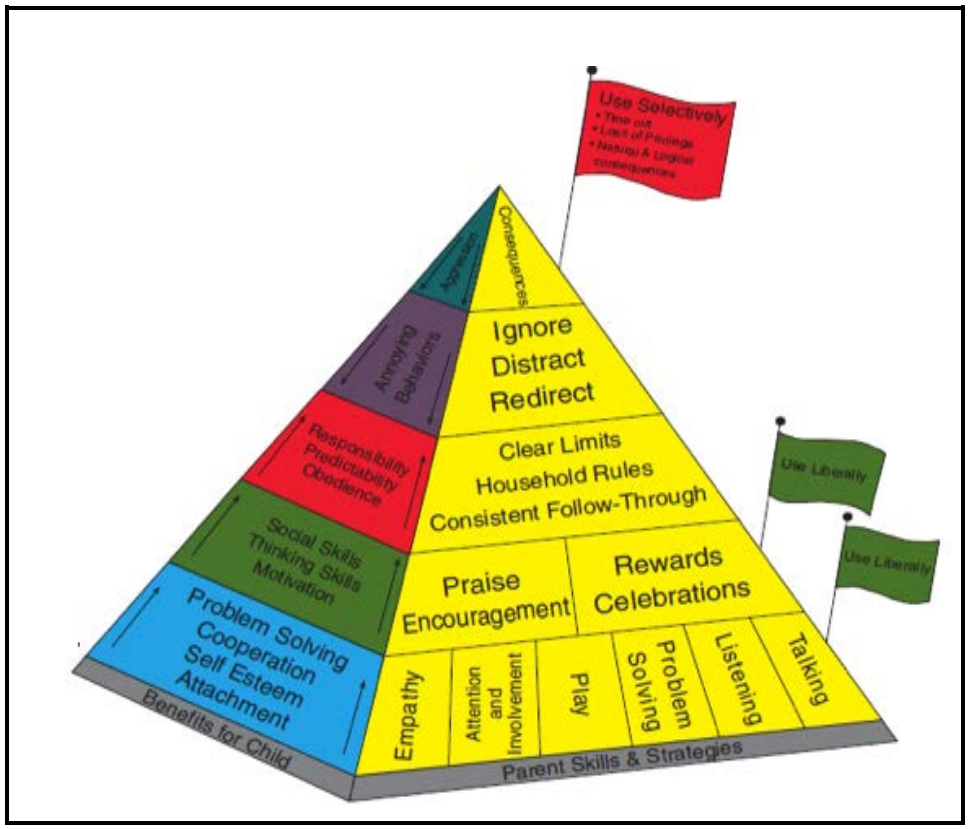

Figure 2.2 Key parenting skills taught within the IYPP

2.3.2 Psychological principles underpinning the IYPP

As indicated earlier in this chapter, behavioural, social learning and cognitive principles have informed the theoretical basis of group-based parenting interventions. This section will provide a more in-depth description of the psychological principles that underpin the IYPP.

The IYPP utilises operant learning theory in emphasising the environmental antecedents and consequences of behaviour (Skinner, 1938; 1953). Thus, parents are taught techniques of positive reinforcement, which help them to focus on the child's positive behaviour (by praising and rewarding the desired behaviour). Parents are also taught to ignore or introduce limit-setting and 'time out' consequences for the child's negative behaviour, which should dissipate through lack of positive reinforcement (Webster-Stratton, Reid & Hammond, 2004). Parents also learn how to pinpoint proximal and distal antecedents for identified positive and negative target behaviours for their child (Webster-Stratton, 2000).

Social learning theory posits that children learn how to behave by imitating the behaviour modelled by others in their environment and, therefore, if this behaviour is reinforced, it is likely to be repeated (Bandura, 1986). Thus, the IYPP uses videotape vignettes of parenting skills in order to help parents to model appropriate behaviour. In addition, group facilitators have the opportunity to model key parenting skills in each session, whilst parents imitate and practise the new skills through role plays and homework assignments (Webster-Stratton & Hancock, 1998). Parents may also be encouraged to act as empathic and supportive role-models for each other (Webster-Stratton & Hancock, 1998). The collaborative approach develops parents' problem-solving capacities, which, in turn, enhances their self-efficacy (Bandura, 1986).

The cognitive component of the IYPP focuses on problematic thinking patterns in parents that have been associated with conduct problems in their children (Azar & Wolfe, 2006). For instance, typical cognitive distortions include globalised 'all or nothing' thinking, such that one minor setback may trigger a negative automatic thought (e.g. 'I am a bad parent') thereby leading to feelings of stress, hopelessness and a perceived inability to cope with the situation (i.e. learned helplessness; Seligman, 1990). Thus, the IYPP teaches parents to reframe distorted cognitions or misattributions and to

coach them in the use of problem-solving and anger management techniques (Macdonald, Ramchandani, Higgins & Jones, 2004).

2.3.3 Evidence for the Incredible Years Parenting Programme

As indicated earlier, the IYPP is consistently mentioned throughout the literature as a first-choice intervention in the treatment or prevention of conduct problems in young children (e.g. Mihalic et al. 2002). A large number of RCTs have demonstrated the effectiveness of the IYPP in reducing childhood conduct problems, in improving parental mental health and parenting practices (e.g. Hutchings et al. 2007a; Gardner et al. 2006; Larsson et al. 2008; McGilloway et al. 2012a; Webster-Stratton & Hammond, 1997; Webster-Stratton et al. 2004). The evidence indicates that beneficial outcomes are achieved with both clinical (e.g. Larsson et al. 2008) and preventive target populations (e.g. Dionne, Davis, Sheeber & Madrigal, 2009); in both research (Webster-Stratton & Hammond, 1997) and service settings (Scott, Spencer, Doolan, Jacobs & Aspland, 2001); in different countries across the world (Gardner et al. 2006; Kim, Cain & Webster-Stratton, 2008; Larsson et al. 2008) and has been replicated by independent investigators (e.g. Hutchings et al. 2007a; McGilloway et al. 2012a). Generally, long-term assessment of outcomes (based on the intervention group alone) indicates the maintenance of positive gains at one year post-treatment (McGilloway et al. 2012b; Webster-Stratton et al. 2004), at 18-month follow-up (Bywater et al. 2009), at three year follow-up (Webster-Stratton, 1990) and up to 12 years later (Webster-Stratton et al. 2010). These results are encouraging, given that the long-term goal of the IYPP is to prevent a life course of dysfunctional and antisocial behaviour.

An increasing body of evidence indicates that early implementation of the IYPP is more cost-effective in the longer term than later intervention and represents extremely good value for money for the taxpayer (Charles et al. 2011; Furlong et al. 2012). Indeed, the potential longer-term economic benefits of reducing behavioural problems (e.g. reduced education, welfare and legal costs and increased tax returns) have been highlighted in recent research, both in Ireland as part of the *Incredible Years Ireland Study* (McGilloway et al. 2012a; O'Neill et al. 2011) and in the UK (Charles et al. 2011; Edwards et al. 2007).

2.4 Policy and practice on parenting

2.4.1 The international context

In recent years, the topic of parenting has assumed an increasingly prominent position on family policy agendas internationally. Across many countries, an increased focus on, and investment in, parenting education and support has led to a raft of government initiatives aimed at providing effective assistance to parents, in the hope that outcomes for children will substantially improve (Shulruf, O' Loughlin & Tolley, 2009). Such policy initiatives are underpinned by the principles of the UN Convention of the Rights of the Child (1989), which stipulates that it is the duty of the State to support and assist parents and families in the upbringing of their children (e.g. Towards 2016, 2006).

However, despite the increased emphasis on parenting in many countries, international policy appears to concentrate more on providing financial supports for families (e.g. maternity leave, parental leave, subsidies for early childcare and education) than on offering training and support in parenting skills (OECD, 2010; Shulruf et al. 2009). In a review of family policy within ten countries (including Ireland), none had a specific policy guiding the identification and implementation of EBPPs (Shulruf et al. 2009). This is despite evidence (e.g. within Finland and 'Sure Start' areas in Wales) that shows that comprehensive, integrated and flexible packages of parent training and support services perform better than financial transfers in improving children's educational and mental health outcomes (Hutchings et al. 2007b; Shulruf et al. 2009).

Some countries, such as the UK and the US, appear to be ahead of Ireland in terms of establishing national childhood initiatives (e.g. Sure Start and Head Start respectively; Every Child Matters, 2004; Flying Start, 2005; Reaching Out, 2006), but they have also experienced some challenges, which may provide important 'lessons' for the Irish government. The UK government, for instance, provides funding for a whole range of child-based interventions, but researchers and service-providers are frustrated by the lack of policy guidance on best-practice programmes (Hutchings et al. 2007b). Furthermore, despite NICE (2006) guidelines recommending the IYPP and the Triple P Parenting Programme as first-choice interventions in the prevention of Conduct Disorder in children, many agencies in the UK persist in using costly, ineffective and crisis-oriented programmes when dealing with distressed families (Sheppard, 2012). In addition, the growth in parenting programmes in the UK has not been accompanied by a

similar interest in their evaluation, which means that we do not know whether positive outcomes of evidence-based parenting programmes transfer across countries or across different settings (Hutchings et al. 2007b). There is now a growing recognition though, due in no small measure to current fiscal constraints, that policymakers should prioritise interventions that produce robust evidence of cost-effectiveness (Charles et al. 2011; Furlong et al. 2012; NICE, 2006). All of the above point toward an increasing realisation, internationally, of the need for explicit policy guidance for the implementation, regulation and evaluation of effective parenting programmes, with particular emphasis on assessing site readiness/capacity to implement the programme with fidelity, whilst addressing both accessibility for families and sustainability issues (Bell, 2007; Hutchings et al. 2007b; Nutley, Walter & Davies, 2007; Sheppard, 2012).

2.4.2 The Irish context

Irish family policy has made substantial progress in the last ten years in recognising the importance of supporting the family in order to improve a wide range of child outcomes, including education, employment, physical and mental health, and the prevention of antisocial behaviour (Department of Children and Youth Affairs, 2011; Government for National Recovery 2011-2016, 2011; National Children's Strategy, 2000; Statham, 2011; The Agenda for Children's Services [ACS], 2007; Towards 2016, 2006). Indeed, the creation of the new Department of Children and Youth Affairs (DCYA) in 2011 was a significant symbolic gesture in acknowledging the importance of child welfare within Irish government policy.

Similar to family policy agendas established in other OECD countries (e.g. the UK, the Netherlands, Finland, Canada, Australia and New Zealand), Irish policy recognises the need to support families and communities in helping to meet the physical, mental and behavioural needs of children (Shulruf et al. 2009). Irish policy also increasingly promotes the importance of accessible, evidence-based prevention and early intervention services in improving child outcomes (especially in socially disadvantaged areas) (DCYA, 2011). Moreover, policy documents advocate for integrated, community-based interventions, in order to enhance accessibility for families who need them (ACS, 2007). For instance, in order to improve inter-agency co-operation between services, Children's Services Committees (CSCs) were established in 2007 within four local authority areas to ensure that agencies co-ordinated their efforts to improve outcomes

for children and families in their area (Towards 2016, 2006). There are now ten CSCs throughout Ireland (Statham, 2011).

It should be noted, at this juncture, that the Atlantic Philanthropies' (AP) Children and Youth Programme in Ireland has been a major catalyst for change in encouraging government investment in several evidence-based prevention and early intervention programmes in recent years. AP has been instrumental in promoting evidence-based practice amongst some service providers, in supporting the integration of services in local areas and in engaging the academic sector in policy-oriented research (Paulsell, Del Grosso & Dynarski, 2009). Furthermore, AP contributed half of its €36 million funding toward the evaluation of three prevention and early intervention area-based initiatives in Ireland, involving: (1) the Tallaght West CDI initiative; (2) Preparing for Life and (3) youngballymun, of which the IYPP represents one of the component programmes (DCYA, 2011). These initiatives were implemented as part of the government's Prevention and Early Intervention strategy (DCYA, 2011), and the overarching aim of such research is to inform policy and service development of preventive and early intervention programmes throughout Ireland (ACS, 2007). Unfortunately, the withdrawal of AP funding in 2016 has potentially serious implications for the sustainability of AP-funded services within Ireland (Proscio, 2010).

Nevertheless, despite the progress achieved in recognising the importance of early support for families, Ireland still lags far behind international standards for the care and education of young children. For instance, UNICEF (2008) placed Ireland at the bottom of a league of 25 OECD countries in its performance in meeting only one of ten 'minimum standards' for early childhood education and care. In addition, international evidence suggests that Ireland is under-investing in services for younger children, especially considering that cost benefit analyses (CBAs) indicate substantial, positive returns on investment (Heckman, 2006; Melhuish, 2010). Currently, only 20 per cent of Ireland's public spending on children and families goes towards early childhood (ages 0-5) while 37 per cent goes to the middle years (6-11) and 44 per cent to the later years (12-17), even though the evidence demonstrates that the return on investment is far greater for monies spent in the earliest years (Heckman, 2006; OECD, 2010). Moreover, research evidence indicates that the provision of quality support in children's early years reduces the need for later expenditure in the Criminal Justice System, social welfare,

healthcare and remedial education (Aos et al. 2004; Marmot Review, 2010; Schweinhart, 2005).

Despite the large-scale investment in prevention and early intervention, and similar to other countries, there is currently no clear policy framework on parenting, or for the provision of EBPPs within Ireland (ACS, 2007; Start Strong, 2010[4]). Nevertheless, a large number of parenting programmes are currently available throughout Ireland; for instance, some statutory and voluntary agencies deliver a wide variety of parenting programmes and interventions (Scott & Hennessy, 2009). However, in the absence of an overarching policy framework to inform the implementation of parenting interventions, such programmes are typically not based on evidence of effectiveness, have not been rigorously evaluated and are heavily 'siloed', with provision occurring in an *ad hoc* manner, with little or no communication between services (Barnardos, 1995; Paulsell et al. 2009). For example, in an audit of parenting programmes delivered in the South East of Ireland (i.e. Carlow, Kilkenny, South Tipperary, Waterford and Wexford), statutory and voluntary services offered a plethora of non-evaluated 'home-grown' parenting programmes (Scott & Hennessy, 2009), none of which involved the IYPP, despite its demonstrated evidence of effectiveness in the prevention and treatment of child behavioural problems and in improving parental mental health (e.g. NICE, 2006; Furlong et al. 2012). Indeed, some argue that public funding should only be provided to services that implement and monitor clearly identifiable evidence-based programmes (Start Strong, 2010). However, it should be noted that the audit pre-dated the *Incredible Years Ireland Study*, the findings of which, as indicated later in this thesis, highlight the short- and longer-term effectiveness of the IYPP in an Irish context.

The lack of clear guidance from government with regard to effective interventions has meant that a considerable amount of time and resources may have already been wasted as a result of services delivering potentially ineffective parenting programmes (Hutchings et al. 2007b). A number of factors may explain the lack of policy in this area. Firstly, there is an ongoing debate as to whether the government should fund the provision of targeted or universal parenting programmes. Although the ACS (2007) and advocacy groups within the field (e.g. Start Strong, 2011) argue for universal access,

[4] Start Strong is a child advocacy group within Ireland that has regular contact with Irish government officials.

with extra parenting support for those who need it, most government investment in early interventions programmes, to date, has targeted areas of social disadvantage (DCYA, 2011). Secondly, government officials have indicated that they lack evidence to demonstrate that parenting programmes researched elsewhere can be implemented to scale within the existing infrastructure of health and social services in Ireland (Start Strong, personal communication, April 27, 2012). This highlights a need for evidence, not only on the overall effectiveness of interventions *per se* in an Irish context, but also on how best to implement EBPPs within Irish service settings. On a more positive note, however, the AP-OMCYA (Atlantic Philanthropies-Office of the Minister for Children and Youth Affairs)-funded Centre for Effective Services has set up a *Special Interest Group in Supporting Parents in their Parenting Role* (December 2010) in order to create a unique 'space' for developing thinking about issues relevant to parenting, to promote the sharing of good practice and learning and to avoid duplicating existing work and networks. The group currently includes a large number of Directors/CEOs of key agencies and organisations with an interest in parenting, as well as academics and other high level stakeholders. It is hoped that the work of this group will help to more actively inform policy and practice on parenting in Ireland.

2.5 Conclusion

This chapter outlined how behavioural, group-based parenting interventions, and particularly the IYPP, have demonstrated considerable effectiveness and cost-effectiveness in improving conduct problems in young children across a range of different settings. However, several challenges also exist, including, in particular, the transportation of EBPPs, such as the IYPP, to mainstream service settings where variable and diluted implementation is common. The lack of a clear and overarching policy framework for the provision and funding of EBPPs, especially within Ireland, and also, to some extent, internationally, further compromises the widespread and quality dissemination of such early intervention strategies. The next chapter will provide the context for, and results of the RCT evaluation of the IYPP in Ireland. It will also outline the rationale for the work presented in this thesis.

CHAPTER THREE

IMPLEMENTATION OF THE INCREDIBLE YEARS PARENTING PROGRAMME IN IRELAND

The *Incredible Years Ireland Study* (IYIS) was commissioned in late 2007 by Archways, with funding from the Atlantic Philanthropies. This national evaluation - conducted during 2008-2012 - involved three randomised controlled trials of the effectiveness of several components of the *Incredible Years (IY) Parent, Teacher and Child Training* series within an Irish context (McGilloway et al. 2009; 2012a). Although a large number of services in Ireland now deliver the IY series (e.g. at least 18 statutory and voluntary agencies are currently implementing the IYPP (Archways, personal communication, February 19, 2012), there had previously been no rigorous assessment of the programme within an Irish setting. This chapter will briefly outline the local context to, and the results of, the RCT evaluation of the IYPP within Irish service settings (McGilloway et al. 2012a). The rationale for the current study will also be outlined.

3.1 The local context

The evaluation of the IYPP took place within four urban areas in Dublin and Co. Kildare that are designated as disadvantaged according to information on demographic profile, academic performance, social class composition, and labour market situation (Fleming & Gallagher, 2002, Haase & Pratschke, 2008; McSorley, 1997). The intervention was delivered in five community-based organisations or Family Resource Centres (FRCs) that provide statutory-funded, individual or group services and support for vulnerable families who experience difficulties, such as socioeconomic disadvantage, social isolation, mental health issues, substance misuse, community conflict, and domestic violence. Facilities include talks, activities, workshops, children's groups, individual advice and support, assessments, and child care for preschool children (McGilloway et al. 2012a).

3.1.1 Summary of key findings from the RCT of the IYPP

The RCT of the IYPP included 149 families, who were randomly allocated, on a 2:1 ratio, to the IYPP intervention (N=103) or to a waiting list control group (N=46). All included children were aged approximately 3-7 years (32-88 months) and demonstrated persistent conduct problems. The results of this trial showed large, statistically significant improvements in childhood conduct problems (effect size = 0.75, $p < .001$), with moderate statistically significant improvements achieved with respect to parental mental health and parenting practices in the intervention group when compared to the control group at six-month follow-up (McGilloway et al. 2009; McGilloway et al. 2012a). Similar large and moderate effect sizes were reported at 12-month follow-up for the intervention group (McGilloway et al. 2012b). The IYPP also demonstrated evidence of cost-effectiveness within Irish settings; when compared to standard service utilisation, the IYPP cost €2,232 to return the average child in the intervention group to within the non-clinical range (O'Neill et al. 2011). These costs of programme delivery are modest in the context of the long-run health, educational and legal costs associated with early childhood conduct problems (Furlong et al. 2012; Sainsbury Centre for Mental Health, 2009). Furthermore, the results underline the short- and long-term effectiveness and cost-effectiveness of the IYPP when delivered in disadvantaged, Irish settings.

3.2 The Process evaluation: an overview of the study rationale

As mentioned in Chapter One, the process evaluation that formed the basis for this study was nested within the RCT evaluation of the IYPP described above (McGilloway et al. 2009; McGilloway et al. 2012a). RCTs are widely recognised to be a 'gold standard' methodology in evaluating healthcare interventions (Medical Research Council [MRC], 2000). However, in recent years, there has been a general shift in health services research from asking solely 'what works?' towards asking how, why and when an intervention works, or fails to work, in different settings or circumstances (MRC, 2000). Accordingly, the MRC guidelines encourage the use of process evaluations alongside outcome evaluations, primarily because they can help to clarify causal mechanisms and identify contextual factors associated with any variation in outcomes (Anderson, 2008; Craig et al. 2006; MRC, 2000).

Process evaluations are considered particularly apposite when conducted alongside complex interventions, such as parenting programmes, in which it can be difficult to specify the active ingredients of the intervention, especially when delivered in real-world service settings. For instance, evidence-based programmes may require facilitative institutional and socio-political structures if positive outcomes are to be achieved within mainstream services (Hawe, Shiell, Riley & Gold, 2004; Pawson & Tilley, 1997; Weersing & Weisz, 2002). In addition, process evaluations are necessary to study implementation issues within different service settings (e.g. adherence to the original programme protocol) and to differentiate possible implementation failure from genuine ineffectiveness (Hulscher, Laurant & Grol, 2003; Oakley, Strange, Bonell, Allen & Stephenson, 2006). Furthermore, process-oriented research can assist in: identifying new outcomes that should be measured within future RCTs (Craig et al. 2008); assessing the acceptability of the programme among participants (Hawe et al. 2004); exploring the experiences of various stakeholders (Campbell et al. 2000); and in informing the future development, refinement and scaling-up of the intervention (Perez et al. 2011). Data within process evaluations can be both quantitative and qualitative in nature (Oakley et al. 2006).

Although process evaluation methods are well established in the literature on education and social welfare programmes, the uptake of these methods in healthcare has been slow (Hawe et al. 2004). Indeed, process evaluations are typically undertaken alongside RCTs in only 13 per cent of trials within health services research, with only 8 per cent reaching publication (Glenton, Lewin & Scheel, 2011; Lewin, Glenton & Oxman, 2009). Similarly, few process evaluations have been conducted alongside RCTs of the IYPP (N=4)[5], or indeed within the parenting field in general (N=0). Stand-alone qualitative analyses of group-based parenting programmes are more common, with 9 conducted in relation to the IYPP and 15 in relation to other parenting programmes, including, for example, *Group Triple P*, the *Ninos Bien Educados Programme* and the *Family Links Nurturing Programme*[6].

[5] These four process evaluations are related to three separate RCTs of the IYPP (see Table 3.1 below).

[6] The *Ninos Bien Educados Programme* and *The Family Links Nurturing Programme* are both group-based parent-training interventions based on behavioural principles. The former intervention involves a culturally adapted parent-training programme designed specifically for Latino-American parents (Chang, 2008) whereas the latter is a component of a school-based programme for the treatment and prevention of child abuse and neglect (Barlow & Stewart-Brown, 2001).

The majority of these qualitative studies, to date (22/27), have investigated the experiences of parents, whereas only five (three of which involved the IYPP) considered implementation or organisational processes. In addition, only three studies (all IY) examined the experiences of stakeholders at longer-term follow-up, i.e. beyond one year post intervention (Morch et al. 2004; Patterson et al. 2005; Webster-Stratton & Spitzer, 1996). Furthermore, it should be noted that more than a third of the qualitative studies (10/27) are unpublished dissertations. Lastly, only 3 of the 13 IY qualitative studies involved a sample of parents with children who had clinically significant conduct problems (Morch et al. 2004; Spitzer et al. 1991; Webster-Stratton & Spitzer, 1996). The other ten studies involved a more preventive-based sample (see *Table 3.1* for an overview of qualitative studies of parenting programmes).

As indicated above, process evaluations are not restricted to qualitative analyses. With regard to the IYPP, two studies, to date, investigated core programme components using parent evaluation questionnaires (Birk-Olsen & Horsted, 2008; Webster-Stratton, 1989) whereas four studies utilised mediator and regressional analyses in order to elucidate putative mechanisms of change (Eames et al. 2009; 2010; Gardner et al. 2006; Gardner, Hutchings, Bywater & Whitaker, 2010). Further detail on all of the studies mentioned above will be provided later.

Table 3.1 Summary of qualitative studies of parenting programmes

Qualitative studies of parenting programmes

Qualitative studies of IYPP		Qualitative studies of other parent programmes		
Alongside RCT of IYPP	N	Stand-alone studies	N	Parent programme
Morch et al. 2004*	20	Grimshaw et al. 1998 [b]	80	Home-grown programmes [d]
Mockford et al. 2004 [a]	14	Barlow et al. 2001	11	Family Links Nurturing Programme
Patterson et al. 2005 [a]	26	Mondro, 2002*	6	The Family Guide
Kim, 2010	17	Burns et al. 2004	39	---[c]
		Ballew, 2006*	15	Parent-Child Interaction Therapy
Stand-alone studies		Woolfolk, 2006*	28	Parent as Teacher Programme
Spitzer et al. 1991	50	Day, 2007*	8	Family Adventure Group
Webster-Stratton et al. 1996	10	Friars et al. 2007	18	Behavioural Management Training
Kelleher et al. 2006	10	Owen, 2007*	---[c]	---[c]
Bell, 2007 [b]	26	Chang, 2008*	28	Ninos Bien Educados
Levac et al. 2008	37	Whittingham et al. 2009	29	Triple P
Rogers, 2008*	---[c]	Stewart, 2010*	---[c]	Teen Parent Programme
Marcynyszyna, 2011 [b]	5	Breitkrenz et al. 2011 [b]	72	Triple P
Aarons et al. 2012 [b]	---[c]	Holtrops, 2012*	20	Parent Management Training Oregon
Dunn, 2012	33			

***** Unpublished dissertations

[a] The qualitative studies of Mockford et al. (2004) and Patterson et al. (2005) relate to the RCT reported in Stewart-Brown et al. (2004).

[b] Only five studies investigated implementation issues from a service-provider perspective. The remaining studies investigated parental experiences of the parenting programme.

[c] It was not possible in some studies to ascertain the sample size of the qualitative analyses, or the specific name of the parenting programme, as these details were not reported in the Abstract and the full text was not available online.

[d] This study included three 'home-grown' parenting programmes, which comprised 5-8 weekly sessions, and incorporated elements from other well-known parenting programmes, such as the Incredible Years and Triple P.

3.3 Levels of analysis within the process evaluation

This longitudinal, multi-informant, process evaluation assessed the 'on-the-ground' implementation of the IYPP in Ireland by undertaking a multi-dimensional analysis of the processes or mechanisms relating to programme implementation. The identification of these levels or dimensions was informed by the MRC guidelines for process evaluations which advise the exploration of core implementation mechanisms and challenges from a longitudinal and multi-stakeholder perspective (MRC, 2008). The

levels of analysis within this study include: (1) pre-intervention experiences of parents; (2) key intervention components; (3) contextual factors influencing outcomes; (4) long-term processes of change; (5) monitoring of implementation fidelity and an examination of key organisational processes and socio-political influences; and (6) an analysis of whether the research process influenced trial outcomes (see Figure 3.3). Each of these aspects will be discussed in the sections that follow.

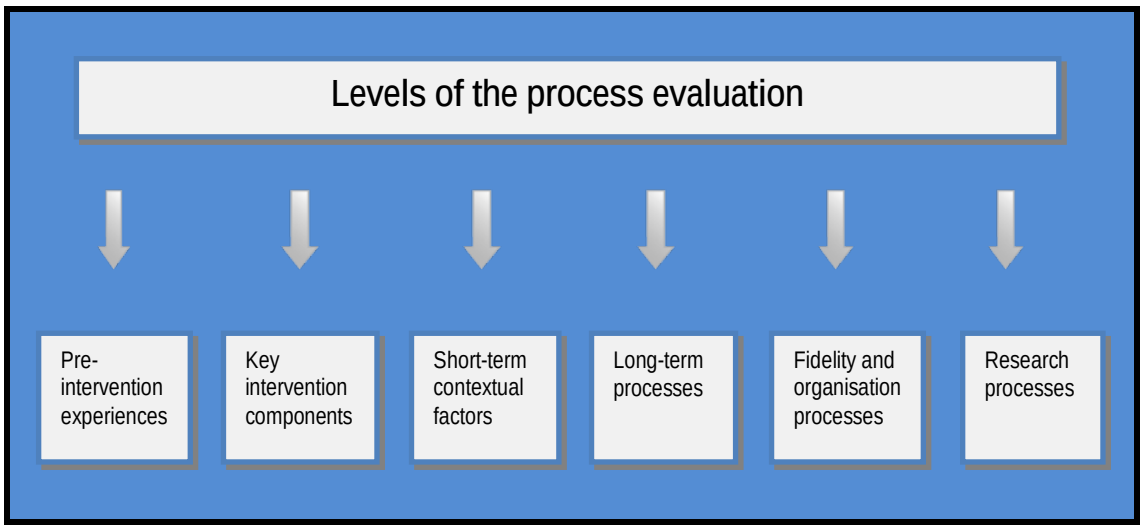

Figure 3.3 Levels of the process evaluation

3.3.1 Pre-intervention (baseline) experiences

Quantitative assessments of the IYPP typically indicate that parents of children with conduct problems were depressed, stressed and inclined to use aversive forms of discipline at the baseline assessment (e.g. Hutchings et al. 2007a; McGilloway et al. 2012a; Webster-Stratton et al. 1988). However, such quantitative data do not help us understand the 'lived reality' of parenting a child with conduct problems, as reported by parents in their own words. For instance, it is possible that parents may highlight issues and priorities different to those identified in typical standardised measurements employed within RCTs (e.g. the Eyberg Child Behaviour Inventory [Eyberg & Pincus, 1999]; Beck Depression Inventory [Beck, Ward, Mendelson, Mock & Erbaugh, 1961]; and the Parenting Stress Index [Abidin, 1995]). A qualitative study by Webster-Stratton and Spitzer (1996) revealed that parents at pre-intervention generally operated from within a learned helplessness framework, such that they perceived the child to be a tyrant and themselves as a victim. Similarly, another qualitative study briefly alluded to

the despair, lack of control and frustration evidenced by parents at pre-intervention as they struggled to deal with their child's problematic behaviour (Patterson et al. 2005). Although such data provide useful insights for therapists working with parents, these are the only studies that analysed the subjective experiences of parents prior to engagement with the intervention.

Baseline evaluations may also be useful in illuminating the impact of the child's problems on intra- and extra-familial relationships. Moreover, it is important to assess baseline experiences as these obviate the need for potentially less accurate retrospective accounts whilst also helping to sensitise researchers to the cognitive, emotional and behavioural processes that operate prior to the intervention. In addition, the exploration of expectations around the programme is valuable as research indicates that a mismatch between parental pre-intervention expectations and programme delivery leads to less successful outcomes (Woolgar & Scott, 2005). Likewise, Forehand and Kotchick (2002) found that parental attitudes, especially with regard to hopefulness and taking responsibility for change, were related to engagement with parent-training interventions. Furthermore, previous negative contact with social service agencies and fear of stigma may also present obstacles to attendance (Bell, 2007; Grimshaw & Maguire, 1998). Thus, a detailed assessment of pre-intervention experiences may enhance our understanding of key processes of change.

3.3.2 Key intervention components

Despite the number of RCTs demonstrating the effectiveness of the IYPP, less is known about the 'active ingredients' or key components of the intervention. Previous qualitative research of parents' experiences of the IYPP has suggested that several factors may act as the essential ingredients or mechanisms of change, including new-found parental confidence obtained through group support (Kane, Wood & Barlow, 2007; Kelleher & McGilloway, 2006; Morch et al. 2004), the acquisition of new parenting skills (Patterson et al. 2005; Rogers, 2008; Webster-Stratton & Spitzer, 1996) and the use of the group process to reflect on the experience of being parented in order to develop empathy for the child (Levac et al. 2008). Correspondingly, previous mediator/moderator analyses in the field have investigated similar variables as putative mechanisms of change (e.g. parenting skills and parental mood/confidence), with varying results. For example, some studies have found that more depressed mothers tend

to show greater improvement in conduct problems, suggesting that enhanced parental well-being may act as a mechanism of change (Bayder et al. 2003; Beauchaine, Webster-Stratton & Reid, 2005; Gardner et al. 2010), whereas other research indicates that this factor does not play a mediating role (Gardner et al. 2006).

Studies also vary in the extent to which a reduction in critical parenting (Bayder et al. 2003), or an increase in observed positive parenting strategies (Gardner et al. 2006), mediates outcomes. Only one study (Gardner et al. 2010) compared the relative mediating effects of critical and positive parenting skills and found that an increase in positive parenting skills was more important than a reduction in negative parenting practices in explaining trial outcomes. However, no specific skills were identified as being more instrumental than others. A recent study that aimed to identify specific mediating skills reported that changes in parental praise and reflection acted as core change components of the IYPP (Eames et al. 2010). Nevertheless, the essential ingredients of the IYPP programme are still far from being wholly understood. Further qualitative research may provide a more detailed and comprehensive analysis as to which aspects of the programme are considered by stakeholders (e.g. parents, practitioners and organisational managers) to be most influential in producing trial outcomes.

The utilisation of quantitative measures may also help to elucidate the 'active' ingredients of the IYPP. Staff at the Parenting Clinic at Washington University have developed the Parent Satisfaction Questionnaire (PSQ) and the Parent Weekly Evaluation form in order to assess parents' views on the acceptability and usefulness of the IYPP (e.g. Webster-Stratton & Hammond, 1997; Webster-Stratton et al. 2004). However, both of these measures may also be employed to examine which specific components of the IYPP were perceived by parents as being most beneficial in achieving outcomes; for example, the instruments allow parents to compare the perceived usefulness of parenting skills, group discussion and group leadership. To date, two studies have employed the PSQ in identifying key skills of the IYPP. Webster-Stratton (1989) reported that 'ignore' was the most difficult and least useful parent technique while 'reward' was the easiest; and 'reward' and 'time out' were the most

useful techniques.[7] Birk-Olsen and Horsted (2008) reported that parents valued 'reward', 'play', 'positive commands' and 'logical consequences', but that they did not like 'ignore' or 'time out'. Possible reasons underlying the differential perspectives on 'time out' were not discussed within this study.

In general, studies that focus on mechanisms of change within the IYPP tend to focus on the mediating impact of parenting techniques (e.g. Eames et al. 2010; Gardner et al. 2010; Webster-Stratton, 1989) when other non-specific variables, such as the group experience and teaching format, could also be important essential ingredients (Kane et al. 2007). The PSQ and PWE may be suitable in this context in illuminating the perceived usefulness of all aspects of the IYPP. Birk-Olsen and Horsted (2008), for instance, reported that parents viewed the group discussions and peer relationships within the group as being more beneficial than the acquired parenting skills. In addition, the authors reported that parents: (a) were not very enthusiastic about engaging in the role plays; (b) found the vignettes to be overly rehearsed and Americanised; and (c) found it difficult to complete their weekly 'homework' (Ogden, 2008). Thus, the PSQ and PWE may provide useful quantitative tools to complement any qualitative analysis that focuses on identifying key intervention components.

Identifying the key ingredients of the IYPP is important as it allows weak links in the causal chain to be detected and strengthened; conversely, components that appear to add no extra value to the effectiveness of the intervention can be removed (Craig et al. 2008). Furthermore, isolating key variables may help to further refine and improve the programme. For example, the development of briefer, low-cost versions of programmes, such as the IYPP, may become increasingly necessary in a recessionary era where there are limited economic resources available to services and organisations to implement the full programme with fidelity.

[7] 'Ignore' involves the removal of parental attention from the child's misbehaviour. 'Rewards', such as social encouragement or tangible treats, involve positive attention and may reinforce desired behaviours. 'Time out' is reserved for aggressive and destructive behaviour and involves an extended form of parental ignoring in which children are removed for a brief period from all sources of positive reinforcement, especially adult attention, and are given an opportunity to calm down (Webster-Stratton, 2000).

3.3.3 Contextual influences on the IYPP

An important challenge with regard to the implementation of the IYPP is the extent to which it can be successfully transported into 'real world' service settings, within socially disadvantaged communities and to different countries/cultures with differing child-rearing traditions (Gardner et al. 2010; Webster-Stratton, 2009). Two recent meta-analyses (Lundahl, Risser, & Lovejoy, 2006; Reyno & McGrath, 2006) concluded that children of disadvantaged parents, including those with depression, low income, and single parents, showed poorer intervention outcomes when compared to those facing lower levels of adversity. The IYPP has reported some success in engaging disadvantaged parents, largely due to its accessibility and strong focus on collaborative engagement with parents (Gardner et al. 2010; Hartman, Stage & Webster-Stratton, 2003). For example, a study in the UK (i.e. Gardner et al. 2010) found that the IYPP was at least as successful at helping the most disadvantaged families (teen or single parenthood, depressed mothers, very low income, high initial levels of problem behaviour) when compared to the more advantaged. However, other research indicates that parents of lower socioeconomic status tend to have an increased risk of non-engagement with parenting programmes as they are typically more difficult to recruit and retain and more likely to relapse following programme completion (Forehand & Kotchick, 2002; Weissberg, Kumpfer & Seligman, 2003). Furthermore, parents in the current study live in areas specifically designated as 'disadvantaged' where there are high levels of criminality, poor housing and unemployment (Fleming & Gallagher, 2002; McGilloway et al. 2012a). The parents also reported a high level of marital conflict, depression and substance abuse at baseline (McGilloway et al. 2012a), and research indicates that parents dealing with a large number of life stressors are less likely to engage with parenting programmes (Forehand & Kotchick, 2002). Thus, qualitative research may reveal the extent to which Irish parents from disadvantaged areas experience additional challenges when participating in the IYPP, whilst also enhancing our understanding of the reasons why parents may drop out of the programme.

In addition, it is important to understand to what extent a programme based on principles of child-directed play and praise will be accepted by Irish parents. Irish parenting culture has traditionally valued obedience, compliance and modesty, punishment of misdemeanours, coupled with a lack of positive reinforcement for

desirable behaviours (Greene, 1994; Littleton, 2009). For instance, the recent *Growing Up in Ireland s*tudy found that almost one quarter of Irish parents use harsh or coercive disciplinary strategies with their children (Halpenny, Nixon, & Watson, 2009). Furthermore, other research has found substantial resistance to using praise for child compliance to parental instructions in a variety of cultural groups, including African American families (Forehand & Kotchick, 2002) and South-Asian families (Paiva, 2008). However, it is important to note that no culture produces a homogenous set of values and there is also evidence to indicate that Irish parents are suspended between the uncertainties of conventional and newer parenting approaches, such that parents practise elements of both traditional, authoritarian parenting as well as more democratic or permissive parenting styles (Wieczorek-Deering, Greene, Nugent & Graham, 1991; Williams et al. 2009). It is important to investigate the potential influence of such cultural factors (e.g. distinctive child rearing traditions and values) on trial outcomes, as previous research indicates that they may affect initial recruitment, the ability to engage families in treatment - resulting in sporadic attendance, a reduced dose of the intervention and some level of attrition - as well as leading to less effective outcomes (Weissberg et al. 2003).

3.3.4 Long-term processes of change

Longitudinal evaluations of the IYPP are relatively limited. Nevertheless, there is some evidence for the longer-term effectiveness of the IYPP, based on the long-term follow-up of the treatment group alone, which indicates maintenance of positive outcomes for families at 12-month follow-up (McGilloway et al. 2012a, 2012b), at 18-month follow-up (Bywater et al. 2009) and up to 12 years later (Webster-Stratton et al. 2010). One long-term evaluation of the IYPP did not report positive outcomes at 12-month follow-up (Patterson et al. 2002). In addition, despite overall sustained improvements, quantitative data suggest that approximately one third of families report clinically significant behaviour problems at longer-term follow-up (Beauchaine et al. 2005; Drugli et al. 2010; McGilloway et al. 2012b).

It can be difficult to interpret such data without a process evaluation as we have only a limited understanding of the factors that influence the maintenance of gains at longer-term follow up; for instance, how relevant do parents find particular techniques? How important are internal resources or enhanced social support in the longer term? Nor do

we understand why some families appear to suffer from relapses in child positive behaviour. Moreover, little information exists on the nature of these relapses and how parents cope with them. Qualitative analyses of the IYPP reported periods of relapse for a substantial subset for parents when followed up one year (Patterson et al. 2005), eighteen months (Morch et al. 2004) and three years post-intervention (Webster-Stratton & Spitzer, 1996). For example, Patterson et al. (2005) found that these families did not recover from periods of sustained relapse by the 12-month follow-up period. Conversely, Morch et al. (2004) and Webster-Stratton and Spitzer (1996) found that the majority of parents recovered successfully from such relapses by using a range of coping strategies, such as cognitive reframing (e.g. focusing on overall positive improvements in child rather than on specific negative behaviours) and by obtaining external support through contacting the service providers. In addition, they reported that positive gains were sustained for the majority of parents, but that the process was typically characterised by continuing stigmatisation and stress in managing ongoing child behaviour problems at home and school. These findings suggest that parents expend considerable effort in maintaining positive outcomes in the longer term and may perhaps require additional supports beyond parent training.

None of the above long-term qualitative studies investigated the circumstances and duration of the relapses. However, it is important to be aware of those factors that may attenuate positive outcomes in the longer term. Qualitative results, based on short-term follow-up, suggest that many parents find it difficult to implement the programme at home without the support of the weekly group sessions (Kelleher & McGilloway, 2006; Mockford & Barlow, 2004). For instance, parents reported within these last two studies, that a key challenge involved changing their own and their partner's parenting habits and incorporating the new techniques into their busy lives. It is possible, therefore, that a lack of consolidation of taught parenting skills, combined with a partner's unfamiliarity with such techniques, contributes to short-term implementation difficulties, which may manifest in infrequent, inconsistent implementation in the longer term.

3.3.5 Implementation fidelity and organisational processes

Identification of effective parenting programmes is only the first step in the effort to prevent and treat childhood behavioural problems. Widespread dissemination of the IYPP is unlikely to affect the incidence of conduct problems in young children unless

careful attention is given to the quality of implementation. Many evidence-based programmes have been adopted in different settings with widely varying outcomes; in general, research indicates that better implementation produces more positive changes and poor fidelity is related to poor treatment outcomes (Eames et al. 2009; Fixsen et al. 2005). It should be noted that IF (i.e. the degree to which a programme is delivered according to the original programme design) is commonly characterised as involving four aspects: (1) therapist adherence to session protocols; (2) exposure of participants to the full programme; (3) participant responsiveness and engagement with the programme; and (4) quality of delivery, which may include the level of skill, enthusiasm, and preparedness demonstrated by the therapist (Biglan & Taylor, 2000; Dane & Schneider, 1998; Mihalic & Irwin, 2003; Webster-Stratton, Reinke & Herman, 2011).

The current 'science to implementation' divide may be explained, at least in part, by the fact that only about five per cent of crime-prevention research (of which parenting programmes represent a subset) is devoted to learning how to best implement evidence-based programmes within real-world service settings (Durlak, 1997; Fixsen et al. 2005). As a result, the importance of IF is not yet sufficiently appreciated and many tend to believe that implementation of at least some components of an efficacious programme is better than doing nothing at all (Webster-Stratton et al. 2011). However, this view is problematic since, currently, we do not know which components of a complex intervention lead to positive outcomes (Mihalic & Irwin, 2003). Therefore, programmes must be implemented with fidelity to the original model to preserve the behaviour change mechanisms that made the original model effective (Arthur & Blitz, 2000). Moreover, other research has demonstrated that the removal of programme components, or the addition of non-curricular elements, may undermine any beneficial effects of the programme, and, in some cases, may actually cause harm to participants (Aber, Jones, Brown, Chaudry, & Samples, 1998; Petrosino, Turpin-Petrosino, & Finckenauer, 2000).

The assessment of IF is also important as the failure to replicate positive outcomes within mainstream services may, in fact, be due to a failure in treatment adherence rather than to the ineffectiveness of the programme itself (Mihalic & Irwin, 2003). Furthermore, knowledge on best practice implementation strategies is key to the widespread replication and dissemination of evidence-based programmes (Breitenstein

et al. 2010; Hutchings et al. 2007b). Given the importance of programme integrity, the IY series has established training, certification, supervision, peer-coaching, manuals, session checklists, videotape recording of sessions and satisfaction questionnaires in order to attain high IF within the parenting programme (Webster-Stratton et al. 2004). However, notwithstanding the commitment of services to fully implementing the IYPP, it is still important that researchers assess programme fidelity, as studies demonstrate that even trained group facilitators can display differences in adherence levels (Eames et al. 2007; Eames et al. 2009). Moreover, very little research has been conducted to explore the organisational practices and system influences (e.g. political and economic factors) that may facilitate, and directly impact upon, the implementation of the IYPP (Fixsen et al. 2005). Thus, this study will investigate the primary drivers of successful implementation, as well as documenting key challenges encountered in delivering the IYPP within an Irish context. The next section will provide more detail on previous research in the assessment and monitoring of IF within parenting interventions.

3.3.5.1 Monitoring implementation fidelity of the IYPP

Even though more agencies are committed to a high quality delivery of parenting programmes (e.g. through using manuals, session checklists and supervision), only a very small number of studies within the parenting field have monitored the degree of IF within their evaluations or considered the impact of programme fidelity on outcomes (Eames et al. 2009; Fixsen et al. 2005). Within the crime-prevention literature - where evaluations tend to more commonly examine fidelity - the findings suggest that, on average, 71 per cent of the content is implemented, 54 per cent of the format is delivered whilst attendance is approximately 50 per cent (Gottfredson, Gottfredson, & Czeh, 2000). Thus, a degree of programme drift is common when mainstream services deliver evidence-based programmes (Bond, Evans, Salyers, Williams & Hea-Won, 2000). There is some evidence, however, which shows that the documentation of fidelity during the delivery of parenting programmes can improve treatment adherence (Eames et al. 2009; Forgatch & Degarmo, 2011; Mowbray, Holter, Teague & Bybee, 2003).

Recent evaluations of the IYPP have measured various aspects of fidelity: many studies report parental attendance rates and many others have assessed the responsiveness of parents to the programme by using the *Parent Satisfaction Questionnaire* (e.g. Birk-Olsen & Horsted, 2008; McGilloway et al. 2012a; Webster-Stratton et al. 2004). As well

as examining the degree of parental satisfaction with the IYPP, this instrument may also be useful in identifying potentially problematic areas of the programme with which parents may struggle. This information may help to refine the quality of the delivery of the programme within these areas. Furthermore, it is important within multi-centred research to examine whether aspects of fidelity (e.g. group differences in participant responsiveness and attendance) varied by service setting. If the IYPP is to be rolled out in a standardised manner, it is important to assess whether it is acceptable to the many different types of groups to whom it is delivered.

Although evaluations of the IYPP generally incorporate measures of parental attendance and satisfaction with the programme, few provide information on the degree of facilitator adherence to the programme protocol (McGilloway et al. 2012a). Most IYPP evaluations merely report that session checklists were completed by group facilitators (e.g. Webster-Stratton et al. 2004). However, as seen above, it should not be assumed that full adherence is normal practice in mainstream services (Gottfredson et al. 2000). As in the case of monitoring participant responsiveness and attendance, accurate measurement of programme adherence is particularly necessary in multi-centred research in order to ensure that the intervention provided across centres is the same (Mihalic et al. 2002). Only one IYPP study (Eames et al. 2009), and two others within the parenting field more generally (Breitenstein et al. 2010; Forgatch & Degarmo, 2011), have attempted to examine the relationship between programme adherence and intervention outcomes. Each of the three studies devised an observational tool to measure the skill level of group facilitators and related this score to the treatment outcome obtained within different parenting groups. Two of the studies indicated a statistically significant positive relationship between the therapists' skill level and the outcome of child behaviour (Eames et al. 2009; Forgatch & Degarmo, 2011), but the third study did not find any relationship between these two variables (Breitenstein et al. 2010). The current study will, likewise, investigate the relationship between therapist adherence and child behaviour and further information is provided in Chapter Eight. Furthermore, it might also be informative to examine the relationship between child behaviour and other aspects of fidelity, including parent responsiveness and attendance. No parenting study has, as yet, examined how other fidelity components, besides therapist adherence, may predict treatment outcome.

3.3.5.2 Organisational and system influences[8] on implementation

Arguably, the quantitative monitoring of fidelity within the IYPP is not sufficient to understand other factors that may influence the 'on-the-ground' implementation of the programme within mainstream service settings. IY researchers, in conjunction with research on implementation science more generally, agree that quality skills-based training and supervision are essential to the successful implementation of an evidence-based programme (Fixsen et al. 2005; Webster-Stratton & Reid, 2010). Indeed, research indicates that training and supervision produce significantly improved adherence to programme protocols (e.g. Forgatch & Degarmo, 2011). However, less is understood about how a complex ecology of organisational, policy and funding structures may impact upon the implementation of a programme (Fixsen et al. 2005). The IY developer has become increasingly aware, in recent years, that many agencies may wish to implement the IYPP with fidelity, but are constrained by organisational culture and political factors such as, lack of practitioner 'buy in' or funding difficulties (Webster-Stratton, 2011). Only three IY qualitative studies, to date, have considered implementation issues from an organisational perspective; for example, one study indicated that organisation-driven adaptations (due to resource limitations) partially compromised programme fidelity (Aarons, Miller, Green, Perrott & Bradway, 2012); another reported that the screening of parents' suitability for the IYPP was important for retention (Marcynyszyna, Mahera & Corwinb, 2011), and the latter study suggested that the sustainability of the IYPP within UK agencies may be undermined by inadequate policy and funding arrangements (Bell, 2007). Whilst these studies are useful, such preliminary research has not yet undertaken an in-depth analysis of the organisational processes involved in implementing the IYPP in mainstream healthcare settings. By contrast, a more thorough analysis of some of the key drivers of effective implementation of parenting interventions within different organisations, has been undertaken with the *Triple P programme* (e.g. Breitkrenz, McConnell, Savage & Hamilton, 2011; Sanders & Turner, 2005) as well as in the area of implementation science more generally (e.g. Dowling, 2004; Fixsen et al. 2005). This combined work may provide some useful insights for best-practice implementation of the IYPP. It is vital that findings on facilitators of, and barriers to, implementing parenting programmes

[8] 'Systems influences' refers to the wider political, economic and cultural macrostructures within a society (Bronfenbrenner, 2004).

are disseminated to other services so that they can know what to expect and may avoid common pitfalls (Sanders, Turner & Markie-Dadds, 2002).

3.3.5.3 Key indicators of successful implementation

A limited number of qualitative studies have investigated the key facilitative factors of best-practice implementation of parenting programmes within mainstream services. Nevertheless, this research indicates that several organisational factors may impact upon programme operation. Firstly, within the context of delivering the *Triple P parenting programme* in various social and health services in Canada and Australia, a key component involved implementing the parenting intervention within an established and stable organisation, in order to capitalise upon the trust acquired from previous positive contact with other services within the organisation, such as childcare, for example (Breitkrenz et al. 2011). Secondly, service providers also believed that it was important that there was a high degree of 'fit' between the value system of the new parenting programme and the existing agency. Thus, the provision of adequate organisational supports was important in allowing staff to integrate the running of the parenting programme with other work responsibilities, as was sufficient time and funding for training, preparation and supervision (Sanders & Turner, 2005).

Thirdly, service providers stressed that it was important to ensure that there was a high degree of practitioner 'buy-in', such that they were convinced of the relative advantages of the new programme over previous/current approaches (Breitkrenz et al. 2011; Sanders & Turner, 2005). The value of high quality and easy-to-use materials was also emphasised. Furthermore, service providers were more likely to continue delivering the programme if it provided evidence of cost-efficiency for their agency (Sanders & Turner, 2005). In addition, research has indicated that practitioner engagement could be enhanced by rewarding staff for implementing the programme (Sanders & Turner, 2005).

The sustainability of the parenting programme within agencies was also a key concern for service providers. Based on their experience, they suggested that an internal champion for the programme was necessary within services in order to ensure that quality standards were met and funding streams were secured (Sanders & Turner, 2005). In addition, Grimshaw and McGuire (1998) advised regular promotion and awareness-

raising of the programme amongst other community services in order to ensure regular referrals and early intervention for families. Other research advocates enhanced inter-agency co-operation as a key component in facilitating on-going funding and referral streams, training, supervision and childcare support (Fixsen et al. 2005; Perkins, 2010). However, we know from other literature, that there are many barriers to effective inter-agency work amongst children's services, both in Ireland and elsewhere. These barriers typically include: poor leadership; lack of consensus on goals; territorialism; poorly defined roles and responsibilities; lack of commitment from staff; and funding constraints (Dowling, 2004; Frost, 2005; Sloper, 2004; Statham, 2011). Thus, it would appear to take perseverance and vision to reach the stage where running a parenting programme becomes part of 'normal practice' within an organisation (Fixsen et al. 2005).

Lastly, both researchers and service providers advocate for the establishment of a national policy initiative which would create local and national funding avenues for the broad-scale implementation of evidence-based parenting programmes (Fixsen et al. 2005; Ogden, Amlund Hagen, Askeland & Christensen, 2009; Sanders & Turner, 2005). For example, Sanders et al. (2002) recommend that advocates for parenting programmes should not liaise with just one political party as there may be frequent changes in government. Rather, it is better if programme activities are communicated broadly across the political spectrum in an effort to gain bipartisan support. In addition, media awareness is one of the most important steps in raising awareness of the benefits of parenting programmes (and a consequent need for funding), which, in turn, creates pressure for policy change at governmental level (McGill, 2011).

3.3.5.4 Barriers to successful implementation

One of the primary barriers to the implementation of a parenting programme within mainstream services is a lack of organisational support. Many agencies have conflicting priorities which means that staff have heavy caseloads and cannot give enough time to the quality implementation of parenting programmes. In addition, a service may not provide adequate financial or administrative support for ongoing supervision and training, and sometimes the lack of funding means that only a reduced number of sessions can be offered (Aarons et al. 2012; Breitkrenz et al. 2011; Fixsen et al. 2005).

As indicated earlier, dilution of the intervention typically leads to little improvement in outcomes (Fixsen et al. 2005). This situation is likely to be replicated within an Irish context where the ongoing recession has led to significant reductions in funding for, and provision of, frontline children's services, with severe staffing shortages within many agencies (O' Halloran, 2012; Start Strong, 2010).

Another obstacle to the implementation of an EBPP is the difficulty in securing practitioner 'buy in'. This can be due to a number of reasons. For instance, tension developed between practitioners and the developer of *Triple P* with regard to the need for local adaptation of the programme. Staff believed that optimal outcomes were achieved by allowing flexibility to adapt the programme in order to increase its appeal and acceptability to different client groups (Breitkrenz et al. 2011; Sanders & Turner, 2005). This is a contentious issue within the implementation literature with some advocating for local adaptation, or a lessening of 'strict fidelity' (Castro, Barrera & Martinez, 2004) whilst others argue that the need for local adaptation is greatly overstated, and that deviations in the programme protocol usually result in reduced benefits (Elliot & Mihalic, 2004; Webster-Stratton et al. 2011). A lack of practitioner engagement with the programme was also evident in that some stated that they preferred their old relationship-based methods (e.g. Rogerian humanistic counselling/attachment counselling) compared to the new skills-based approach (Breitkrenz et al. 2011). In addition, practitioners within one study were concerned that their shortcomings would be exposed if they failed to replicate the positive results achieved in efficacy trials (Sanders & Turner, 2005). These findings suggest that it is necessary to pay attention to the views of practitioners as psychologically-induced resistance can obstruct implementation efforts (Sanders & Turner, 2005).

Other challenges identified in the literature may involve the discovery by a service that a parenting programme is not suitable for their client population; for example, the preventive-based *Triple P Parenting Programme* was found to be unsuited to a population who tended to present with more clinically significant conduct problems (Breitkrenz et al. 2011). Furthermore, sustainability issues may be a source of some concern and especially in view of the high cost of training and high staff turnover (Breitkrenz et al. 2011). As noted above, strategic planning is required to secure new funding streams when old grants end and to ensure the sustainability of the programmes

when champions move onto other causes. The lack of a clear policy framework within the Irish context, which supports the provision of funding for EBPPs, may exacerbate the difficulty of sustaining these interventions within Irish healthcare services in the longer term (Start Strong, 2010).

3.3.6 The impact of the RCT process on outcomes

While the primary aim of the research described here is to observe and evaluate the outcomes and mechanisms of the IYPP, previous research has shown that evaluation methods may occasionally produce their own effects - for example, the 'Hawthorne effect' (e.g. Hawe, Shiell & Riley, 2004; Rosenthal & Jacobson, 1992). For instance, the effect of monitoring and interviewing the participants within the IYPP trial may inhibit or improve usual performance and engagement levels (Hawe et al. 2004b). In addition, implementing the IYPP within a tight RCT schedule may affect the normal running of the programme within services as usual. More recent re-analysis of the Hawthorne data suggests, however, that the impact of this effect is substantially over-estimated (Lewitt & List, 2011). Nevertheless, it is important to examine whether any deviations from faithful programme delivery were due to organisational fidelity processes, or were perhaps a result of being involved in an RCT evaluation.

3.4 Conclusion

While the findings from previous process evaluations have been helpful, the majority of studies, to date, have investigated only the short-term experiences of parents involved in parenting programmes. Additionally, process evaluations of the IYPP have generally not considered potential intervention mechanisms and barriers to implementation from either a longitudinal or a multi-stakeholder perspective (MRC, 2008). In particular, a study of organisational processes, from a service provider standpoint, is long overdue. In addition, given the emphasis on implementation fidelity within the parenting field, it is perhaps surprising that very few analyses of parenting interventions have investigated the extent to which programme integrity may predict trial outcomes. Arguably, such knowledge is necessary for the future widespread implementation of the IYPP both within Ireland and elsewhere. Information on the study design and method is provided in the next chapter.

CHAPTER FOUR

METHOD

This chapter is divided into the following three sections: (1) a description of the epistemological and ontological foundations of the study and the overall study design; (2) detailed methodological information for Stages One and Two of the study; and (3) a discussion of more general methodological issues relevant to the study.

4.1 Epistemological and ontological approach

This mixed methods study subscribes to the epistemological and ontological tenets of *pragmatism*. Historically, pragmatism derives from the work of a number of authors and commentators (e.g. Dewey & Bentley, 1949; James, 1890; Mead, 1934; Peirce, 1905; Rorty, 1991) who rejected the 'either-or' choices stemming from the constructivism-positivism debate (e.g. subjectivism versus objectivism; narrative versus numerical/statistical data; inductive versus deductive logic). Pragmatists typically focus on the research question rather than any particular method and they use all approaches available (i.e. from both the qualitative and quantitative traditions) to understand and study any particular problem or phenomenon (Teddlie & Tashakkori, 2009). Thus, pragmatists view epistemological issues as on a continuum rather than being placed in direct opposition to each other. Consequently, and depending on the research topic, they endorse the use of both exploratory and confirmatory research questions, narrative and numerical data, and inductive and deductive logic. In addition, pragmatists view knowledge and 'social reality' as being both constructed and based on the reality of the world one experiences and lives in (Johnson & Onwuegbuzie, 2004). Table 4.1 provides more detail on the key characteristics of qualitative, quantitative and mixed-methods traditions. Currently, many applied and social behavioural researchers employ a mixed methods approach with little concern for the paradigm debate. For instance, the Medical Research Council (2008) recommends that process evaluations (using both qualitative and quantitative data) are conducted alongside RCTs. Thus, multiple research perspectives enable social science researchers to approach questions of interest within a wide variety of ways of knowing (Newman, Ridenour, Newman & DeMarco, 2003).

Table 4.1 Dimensions of contrast among the three main methodological paradigms in the social sciences

Dimension of contrast	Qualitative position	Mixed methods position	Quantitative position
Methods/designs	Idiographic and ethnographic research designs, e.g. grounded theory, case study	Mixed designs, such as parallel and sequential	Correlational, survey, experimental, quasi-experimental
Paradigm	Constructivism (and variants)	Pragmatism	Positivism Post-positivism
Epistemology (researcher/participant relationship)	Subjectivism; reality co-constructed with participants	Both subjective and objective points of view, depending on stage of research cycle	Objectivism Modified dualism
Ontology (the nature of reality)	Relativism – multiple, constructed realities	Diverse viewpoints regarding social realities	Realism (an objective, external reality that can be comprehended) Critical realism (external reality that is understood imperfectly and probabilistically)
Form of data	Typically narrative	Narrative plus numeric	Typically numeric
Logic	Inductive	Both inductive and hypothetico-deductive	Hypothetico-deductive
Sampling	Mostly purposive	Probability and purposive	Mostly probability
Data analysis	Thematic categories: categorical and contextualising	Integration of thematic and statistical; occasional data conversion	Statistical analyses: descriptive and inferential
Axiology (role of values)	Value-bound inquiry	Values important in interpreting results	Value-free inquiry Values in inquiry, but their influence may be controlled
Possibility of generalisation	Only idiographic statements possible; transferability issues important	Ideographic statements emphasised; both external and internal validity and transferability issues important	Nomothetic statements possible Modified nomothetic position; external validity important

Note: Numerous sources were used in the development of this table, including Creswell (2009), Denzin and Lincoln (2005), and Teddlie and Tashakkori (2009).

There are a number of advantages associated with mixed methods research. Firstly, a mixed methods approach can simultaneously address a range of confirmatory and

exploratory questions using both qualitative and quantitative approaches (Teddlie & Tashakkori, 2009). Secondly, they can often provide stronger inferences as they combine both breadth (e.g. statistical analysis of questionnaires) and depth (e.g. interviews) of analysis which may, in turn, offset the disadvantages of using single method approaches (Creswell, 2009). Thirdly, a mixed methods approach provides the opportunity for eliciting a wider range of divergent views, which may enhance the robustness of explanations for the phenomenon in question (Deacon, Bryman & Fenton, 1998). Disadvantages of the approach may include its time-consuming nature (Creswell, 2009). In addition, it is essential that the researcher is well versed in both qualitative and quantitative methodologies so as to ensure that data are interpreted in an appropriate manner (Teddlie & Tashakkori, 2009).

4.1.1 Study Design

The current study involved a process evaluation of the IYPP, which, as indicated earlier, was nested within the RCT evaluation of the IYPP in Ireland (e.g. McGilloway et al. 2012a). The process evaluation employed a parallel mixed methods design and involved the use of both qualitative and quantitative analytic strategies to explore and assess process variables relating to the RCT outcomes (MRC, 2000). The study comprised two parallel stages, each of which is described below.

Stage One was the core element of the study and involved a longitudinal qualitative assessment of the experiences of key stakeholders (i.e. parents, practitioners and service managers) involved in delivering and receiving the IYPP. Thus, a series of one-to-one semi-structured interviews, focus groups and participant observations were held with participants at various time points. A selected sample of parents was interviewed at baseline, 6-, 12- and 18-month follow-up; practitioners were interviewed once after the delivery of the IYPP to the first cohort of parents and once after study completion; and service managers were interviewed once following completion of data collection. The researcher also observed two of the fortnightly supervisory sessions that were attended by the practitioners. ***Stage Two*** involved a quantitative monitoring of IF within the study; this was a related, but secondary, more minor element of the study. Throughout the delivery of the programme, parents and practitioners completed weekly questionnaires relating, respectively, to issues of perceived usefulness and fidelity. Parents also completed an additional questionnaire following completion of the IYPP in

order to learn about their overall satisfaction with various components of the programme. Figure 4.1 provides a diagrammatic outline of the study design.

4.2 Method: Stage One

The following section describes the methodological details for Stage One of the study.

4.2.1 Participants and settings: overall RCT

As indicated earlier in Chapter Three, the RCT was delivered across five FRCs based in four urban disadvantaged areas in Dublin. FRCs aim to combat social disadvantage and improve family adjustment, and are typical of statutory-funded, community-based services in Ireland. Families were recruited to the study using existing service systems including public health service waiting lists, local schools, community-based agencies and self-referral. A total of 149 families took part in the RCT. All index children met the eligibility criteria for inclusion in the study in terms of scoring above the clinical cut-off point on either subscale of the main outcome measures – the parent-report Eyberg Child Behaviour Inventory (ECBI; Eyberg & Pincuss, 1999).

Two cohorts of parents were recruited over a six-month period, with 53 parents in the first wave and 96 parents in the second. Each cohort took part in the IYPP at a different time point (i.e. the first cohort commenced the IYPP in April 2008 and the second cohort commenced in September 2008). Participants were blindly and randomly allocated, on a 2:1 ratio, to the IYPP intervention (N=103) or to a waiting list control group (N=46). Across both cohorts, the intervention arm comprised nine parenting groups, with each group containing 8-13 parents. Assessments were carried out at baseline and at six and twelve month follow-up periods. At the six-month follow-up, 137 parents (from both the treatment and control groups) were retained in the trial (McGilloway et al. 2012a). At the 12-month follow-up, 87 (84%) of the original 103 families allocated to the parenting programme were successfully contacted and re-interviewed (McGilloway et al. 2012b).

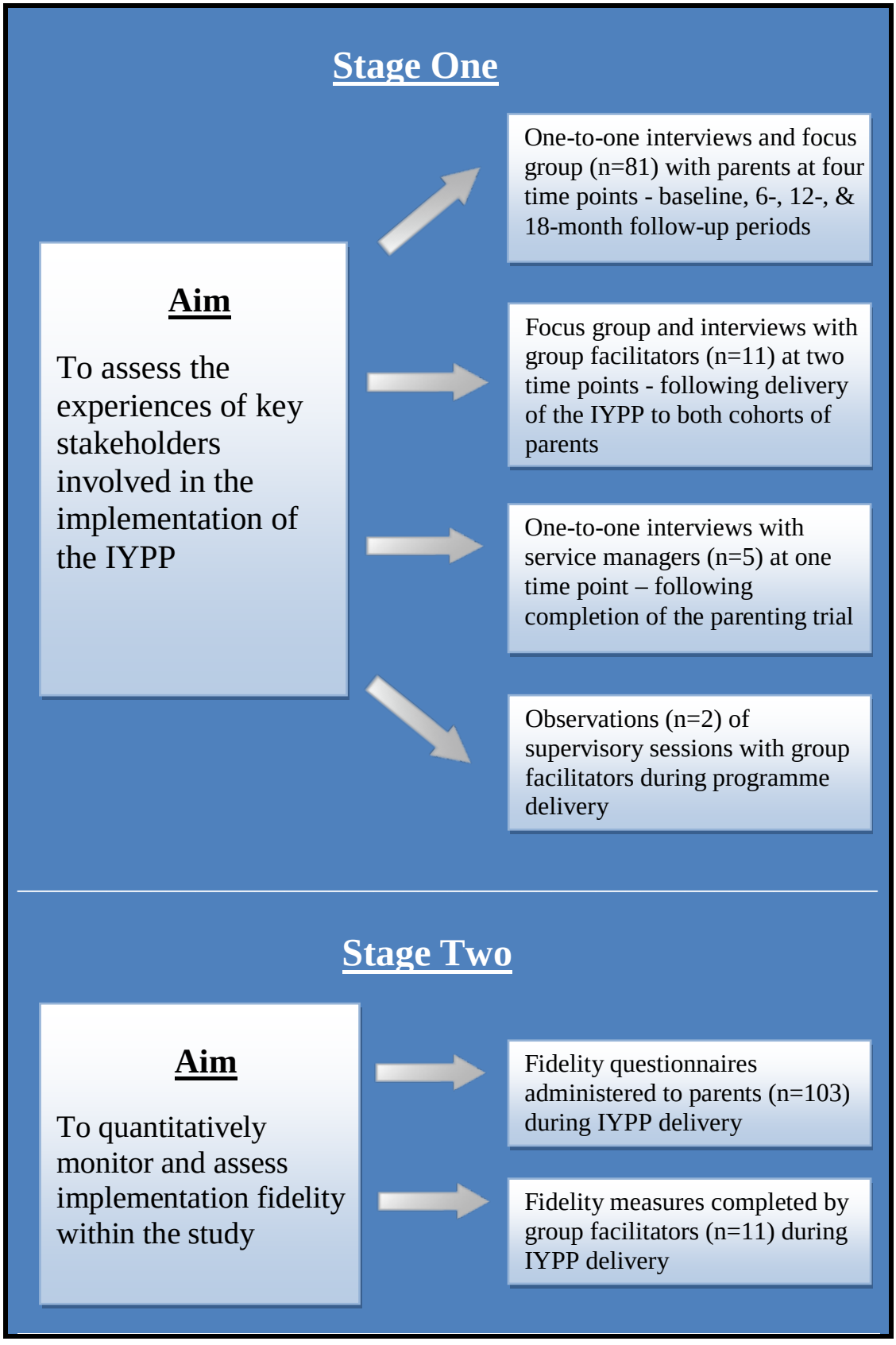

Figure 4.1 Outline of study design

4.2.2 Participants and settings: the qualitative study

As mentioned above, three sets of stakeholders (i.e. parents, practitioners and service managers) were interviewed at various time points throughout the study – yielding a total sample size of 59 participants (104 interviews). Further details on each of these stakeholder groups are provided below.

4.2.2.1 Parent participants

A total of 43 parents were interviewed at one or more time points during the course of the study, including baseline and/or 6-, 12- and 18-month follow-up periods. Overall, 81 interviews were conducted with the 43 parents, either on a one-to-one basis (N=77) or as part of a focus group discussion (N=4). Of the 43 parents, 18 were interviewed on just one occasion, 16 were interviewed twice, 5 were interviewed at three time points, and 4 were interviewed at all four data collection points. Further information is provided in Figure 4.2.

Parents at each data-collection phase were recruited using a maximum variation, purposive sampling method in which prospective participants were invited to take part in an interview on the basis of key demographic variables (e.g. their marital status and age, age and gender of their child, level of socio-economic disadvantage) and their membership across the nine parenting groups within the intervention arm of the trial. There were no differences between those parents who were, and were not, interviewed in terms of any demographic variables for the baseline, 6- and 12-month follow-up interviews. However, the participants interviewed at 18-month follow-up differed somewhat from the previous samples in that they tended to be slightly older (M=40 years), had a lower percentage of boys (50%) and experienced less social deprivation (50% socially disadvantaged). Parents came from different areas within Dublin (e.g. Clondalkin, Tallaght, inner city Dublin 8) and from within Co. Kildare. More details are provided below and in Table 4.2.

Baseline interviews: One-to-one semi-structured interviews were undertaken with 20 parents (19 mothers and 1 father) at the baseline period, i.e. at approximately one to two months before commencement of the IYPP (see Table 4.2). Thus, data collection occurred before parents were randomised to either the intervention or to the control group. Baseline interviews were conducted during February-March 2008 with the first

cohort of parents and conducted in August 2008 with the second cohort. All participating parents at the baseline period preferred to be interviewed on a one-to-one basis. All of the interviews took place in the parents' homes.

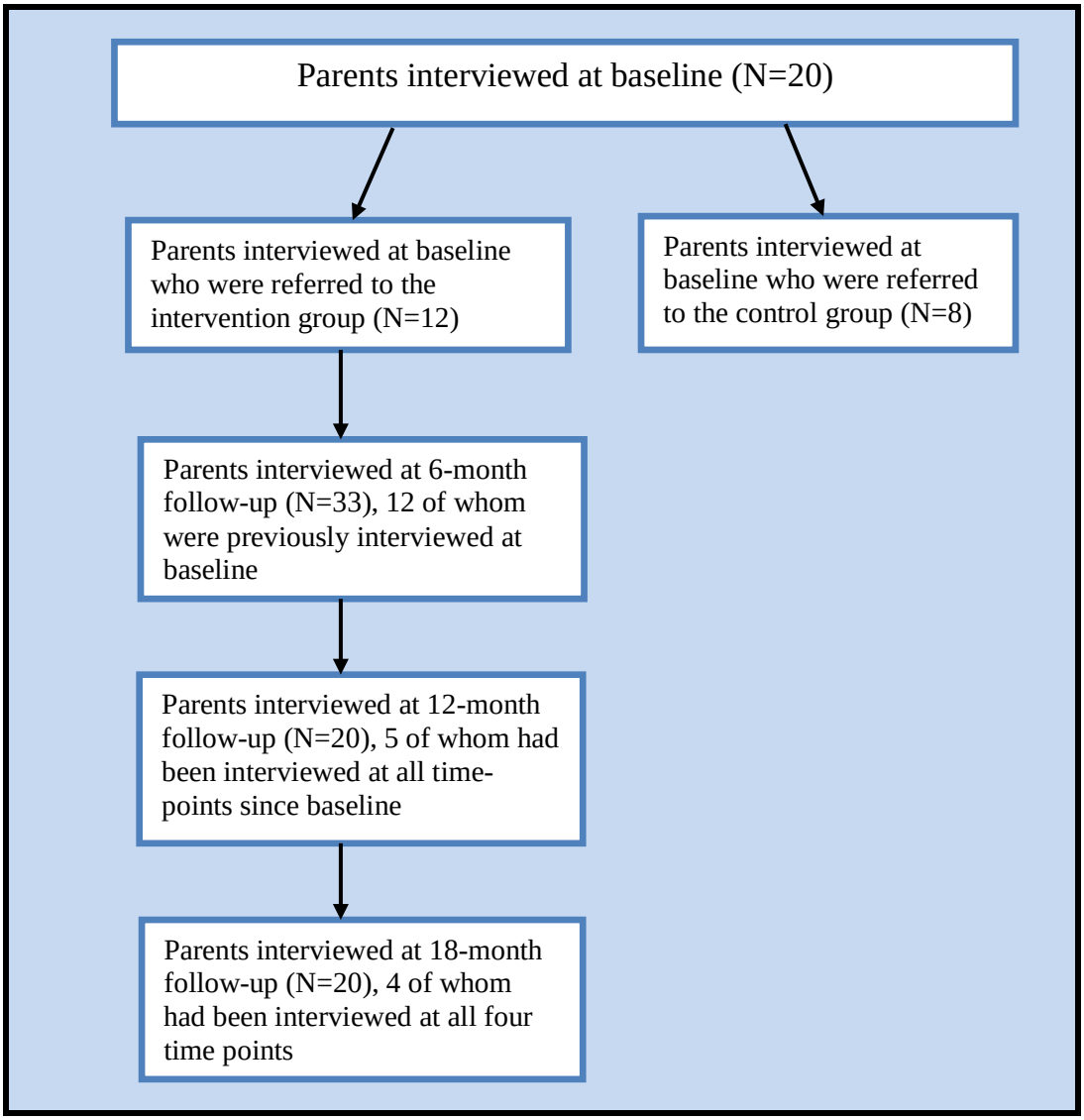

Figure 4.2 Study flow diagram of parents interviewed at each time point within the qualitative study

Six-month follow-up interviews: At six-month follow-up, semi-structured interviews were undertaken with 33 parents (31 mothers and 2 fathers) who had participated in the IYPP. A total of 29 parents chose the one-to-one interview whilst the remaining four (from within one parenting group) opted to take part in a focus group. The one-to-one interviews took place in the parents' homes and the focus group was conducted at

Archways, one of the services where the IYPP had been delivered and the national lead on implementing the IY programme in Ireland. The interviews were conducted during July-August 2008 with the first cohort of parents and during January-February 2009 with the second cohort.

Twenty-five of the 33 interviewed participants attended 10 or more of all 14 sessions. Eight of the 33 interviewed parents (24%) dropped out of the intervention after completing less than five sessions and were interviewed to provide a 'negative case' analysis. Of the eight parents who left the programme early, seven of them (88%) were at risk of poverty.

Table 4.2 Characteristics of parent participants within the RCT and qualitative studies (N, %)

	RCT group N = 149	Baseline group N = 20	6-month group N = 33	12-month group N = 20	18-month group N = 8
Parent mean age (yrs)	33	35	34	34	40
Lone family	60 (40)	7 (35)	12 (36)	7 (35)	3 (37)
Socially disadvantaged[1]	89 (60)	11 (55)	22 (67)	13 (65)	4 (50)
Caucasian Irish	137(92)	18 (90)	32 (97)	20 (100)	8 (100)
Mother	145(97)	19 (95)	31 (94)	16 (80)	7 (88)
Child gender (% boys)	92 (62)	14 (70)	21 (64)	13 (65)	4 (50)
Child mean age (mths)	58	56	57	66	75

1. When compared to average Irish norms in relation to employment status, parental status (lone vs. married or cohabiting), income divided by size of family, parental education, quality of housing, and levels of criminality in the participants' area of residence (Central Statistics Office, 2009). If the family experienced a risk factor score on more than two of the six variables, they were deemed 'disadvantaged'.

12-month follow-up interviews: One-to-one semi-structured interviews were undertaken at the 12-month follow-up period with 20 parents (16 mothers and 4 fathers) who had participated in the IYPP. Fifteen of these parents had been previously interviewed at the six-month follow-up period and five had also been interviewed at the baseline period. The 12-month follow-up interviews were conducted in March 2009 with the first cohort of parents and during August-September 2009 with the second cohort.

18-month follow-up interviews: Eight parents (seven mothers, one father) were interviewed at the 18-month follow-up. All of these parents had participated in the 12-month follow-up interviews and four had also participated in all interviews conducted since the baseline period (see Figure 4.2). The interviews were conducted in September 2009 with the first cohort of parents and in March 2010 with the second cohort.

4.2.2.2 Practitioners/Group facilitators

All 11 group facilitators who were involved in delivering the IYPP within the RCT were invited to take part in an interview in order to elicit their experiences in implementing the programme within their respective agencies. The nine parenting groups (four of which were delivered to the first cohort and five to the second) were implemented in various service settings including a HSE psychology clinic, a family resource centre, school completion service, HSE social work practice, and a community-based agency[9].

Eight group facilitators were involved in delivering the four parenting groups in the first cohort. All eight group facilitators (five female, three male) agreed to participate in a semi-structured interview following delivery of the IYPP to the first cohort of parents in July 2008. One practitioner subsequently left the study (to pursue other career opportunities), but three new therapists joined the study and were involved in delivering the intervention to the second cohort of parents. All ten facilitators (eight female, two male) were interviewed following the delivery of the IYPP to the second cohort of parents in January to February 2009. Hence, 11 different facilitators were involved in programme delivery across the two cohorts. Ten of the facilitators were Caucasian Irish and one was Caucasian German, with a mean age of 48 years. All group facilitators worked within the centre where the programme was delivered and all interviews took place within their respective service setting.

The group facilitators had a range of professional backgrounds, including psychology, counselling, education, social work or related fields. Each group facilitator had received a minimum of three days' training in the content and techniques of the IYPP intervention. All 11 had prior experience in delivering the IYPP in community-based settings (ranging from one to six years). Three had achieved full accreditation in

[9] The specific names of the organisations are not named in order to preserve participant confidentiality.

delivering the IYPP, and the remainder were working toward accreditation during the course of the study. The accreditation process involves rigorous independent assessments and regular reviews of delivery performance (Hutchings et al. 2007b). During course delivery, all group facilitators received fortnightly supervision and support from a certified IY trainer in order to assess progress and address issues that may have arisen during group sessions. Group sessions were videotaped and randomly reviewed by a certified trainer to evaluate programme delivery.

4.2.2.3 Organisational managers

Service managers (N=5) involved in the delivery of the IYPP were also invited to take part in an interview in order to investigate their experiences of integrating the IYPP within their agency. Five (four female and one male; mean age of 51 years) subsequently agreed to participate in January-February 2009. Four of these five managers were directors of the services mentioned above. One of the five managers involved in the RCT was not available for interview at this time due to personal reasons. Thus, one of the five managers interviewed in this study was not involved in the RCT, but was responsible for supervising the delivery of the IYPP within Galway city (located in the west of Ireland). This individual was approached in order to ascertain whether experiences of implementing the IYPP differed across various service settings in Ireland. In addition, this manager had extensive experience in delivering the IYPP within disadvantaged settings in Ireland. All five organisational managers were instrumental in introducing the IYPP within their respective agencies. Two of the five managers who were interviewed also acted as group facilitators in delivering the IYPP to parents during the RCT. All interviews took place within their respective services.

The services varied in terms of their experience in implementing the IYPP. Four of the services had delivered the programme since 2002, 2004, 2005, and 2006 respectively. By contrast, one of the services had only one year of experience in implementing the IYPP prior to the commencement of the RCT. The IYPP had been implemented within the school completion centre for 1.5 years prior to the RCT, although the resident group facilitators had extensive experience in delivering the IYPP within other services since 2003.

4.2.3 Measures

A number of measures were employed with the various stakeholders including: (1) one-to-one in-depth semi-structured interviews; (2) focus groups; and (3) participant observations. These are described in more detail below.

4.2.3.1 Stakeholder interviews

Four semi-structured interview schedules were devised in order to guide, and provide a framework for, the one-to-one interviews conducted with the parents at each of the four time points (i.e. baseline, 6-, 12- and 18-month follow-up interviews) (Please see Appendices 2-6). The baseline semi-structured interview explored, amongst other things, the experiences of parents in parenting a child with conduct problems, the impact of the child's behaviour on familial, marital and community relationships, and previous strategies employed by parents in dealing with their child's misbehaviour. Parental expectations and motivations for attending the IYPP were also assessed (see Appendix 2). Subsequent interviews conducted with parents at 6-, 12- and 18-month follow-up time points explored parents' experiences of the intervention and its impact on their lives both in the short and longer term. Parents were also asked to consider which aspects of the programme were most and least valuable and to identify any difficulties experienced in learning or implementing the parenting techniques (see Appendices 3 to 6). All interviews were semi-structured and commenced with open-ended questions (e.g. "Can you tell me about your child and his/her behaviour at home?"); probes were used, when necessary, to elicit further clarification or information. The duration of interviews ranged from 40 minutes to 1 hour and 45 minutes.

Six pairs of group facilitators also participated in a semi-structured interview; one pair had delivered the IYPP to the first cohort of parents and the other five pairs delivered the programme to the second cohort of parents (The remaining six therapists, involved in delivering the IYPP to the first cohort, chose to participate in a focus group; see section 4.2.3.2 below). The interviews involved both open-ended and focussed questions, including the assessment of views on the most effective components of the programme and experiences in implementing the programme with fidelity (see Appendix 7).

One-to-one interviews were conducted with organisational managers in order to assess their experiences in implementing the programme from a service provider perspective. Interviews were semi-structured and included a mix of open and focussed questions, including their reasons for implementing the IYPP within their service and their key successes and challenges in delivering the programme. Particular attention was paid to sustainability issues (Appendix 8).

4.2.3.2 Focus groups

Four parents at the six-month follow-up period opted to participate in a focus group rather than a one-to-one interview. Focus groups have gained popularity in health psychology as a method that can generate rich and divergent points of view. A key strength of the focus group as a method of data collection lies in its ability to mobilise participants to respond to, and comment on, one another's contributions. In addition, the focus group provides a setting that is arguably less artificial than the one-to-one interview and, thus, the generated data may have higher ecological validity (Lindlof & Taylor, 2002; Silverman, 2010; Willig, 2008). The focus group took place within a neutral location and involved questions similar to those asked within the six-month one-to-one interview (Appendix 9). Within the focus group, the researcher assumed the role of moderator; thus, the purpose of the focus group was outlined in the first instance, and while all of the parents were asked key questions, they were also prompted by the researcher to respond to issues raised by others. Expressivity and 'naturalness' of tone was enhanced as all four parents had attended the same parenting group and consequently were quite familiar with each other. On a more negative note, divergence of views may have been somewhat discouraged by the fact that participating parents all came from the same group.

Six facilitators were involved in a focus group following the delivery of the IYPP to the first cohort of parents. Similar to the interviewing style employed within the parental focus group, the researcher acted as moderator in steering the discussion. Interviews contained both open-ended and focussed questions, and included topics comparable to those the other interviews with group facilitators, such as perceived mechanisms and implementation challenges. Particular attention was paid to fidelity and retention issues (see Appendix 10).

4.2.3.3 Participant observations of group facilitators

The researcher also attended and observed two supervisory sessions, involving the group facilitators and an IY accredited supervisor (April 2008 and September 2008). The purpose of these observations was to allow the researcher to obtain a first-hand account of the various issues raised by facilitators within supervision. They also provided the researcher with access to video-taped footage of programme delivery. The researcher did not verbally interact with the participants during the supervision. Field notes were written during and after these supervisory sessions and the observations enhanced the researcher's understanding of the issues involved in delivering a parenting group to disadvantaged parents. For instance, the researcher learned how difficult it was for facilitators to cover all programme material within sessions whilst also addressing the many issues raised by vulnerable parents. These issues were occasionally not related to parenting practices *per se* but to personal issues that affected the implementation of parenting techniques (e.g. marital conflict; depression). The researcher also recognised the high level of skill and conscientiousness displayed by all group facilitators within the videotaped footage and throughout the supervisory sessions.

4.2.4 Procedure

4.2.4.1 Parents

Parents who partook in the qualitative study were recruited following their participation in the data collection relating to the RCT. In recruiting the parents for the qualitative study, the researcher, who was also involved in the RCT fieldwork, had to ensure that she was blind to the randomisation status of parents. The recruitment of parents at the baseline period for qualitative interview was relatively straightforward as they had not yet been randomised. Thus, following the RCT data collection at the baseline period, some parents were asked whether they would also like to participate in an in-depth interview. The researcher also analysed the central database of all families involved in the RCT in order to fill in gaps in terms of sample variation. Similarly, parents were approached for the six-month follow-up interview once the six-month, RCT data collection was completed. This procedure ensured that blinding was not compromised during the RCT data collection at six-month follow-up. The researcher was not blind to the trial status of some parents at 12-month follow-up (since she had interviewed some of them at six-month follow-up) and she was, therefore, less engaged in RCT data

collection during this period. Similar to the other phases, the in-depth interviews at the 12-month follow-up took place following the RCT data collection. There was no corresponding RCT data collection when parents were interviewed at 18-month follow-up for the qualitative study (i.e. the RCT included only a 12-month follow-up period).

At all stages of qualitative data collection, and prior to the interview, parents were informed that the interview would be digitally recorded and that there would be a small gratuity (i.e. a €15 shopping voucher) as a token of appreciation for their participation. All parents who agreed to partake in the qualitative study were offered a choice of participation in either a one-to-one semi-structured interview or a focus group. Parents at all stages of data collection (i.e. baseline, 6-, 12- and 18-month follow-ups) chose the one-to-one interview, with the exception of one set of four parents who preferred to meet within the context of a focus group at the six-month follow-up period.

An outline of the content of the interview was explained to all parents at the outset and all were asked to provide their written informed consent, both to participate in the interview/focus group and to have the discussion digitally recorded (see Appendix 11). Participants were told that: their data were anonymous and confidential; that they had the right not to answer any question; that they could stop the interview at any time; and that they could withdraw from the study and withdraw their data at a later date. Focus group participants were requested at the beginning to respect the confidentiality of information disclosed by other parents. Refreshments were also provided during the focus group.

A semi-structured interview schedule was used for each one-to-one interview and a topic guide was employed within the single focus group. Initial open-ended questions allowed participants to direct the interview and voice their experiences whilst pre-specified questions ensured that all relevant areas were covered. In order to obtain rich data, attention was paid to the behavioural and emotional cues presented by participants, as well as to their verbal responses. Follow-up questions, such as “How does that make you feel?” or reflection of implicit emotional responses (e.g. “You say that ‘things are going well’ but you sound tired and worn out when you say it…”) were employed at appropriate junctures to elicit further exploration of themes. With regard to the focus group, parents were encouraged to participate through asking, for example, whether their experiences were similar or different to those already vocalised. Each interview

was closed by asking parents whether they would like to add anything else and what it had been like for them to talk about these issues (see Appendices 2 to 6). The likelihood of obtaining rich data was enhanced through the involvement of the researcher in the collection of the quantitative data within the RCT; in other words, the researcher had already met and talked with many of the parents at least once prior to the first in-depth interview and thus a degree of background knowledge and rapport had already been established. This sense of rapport was particularly strong with parents who were interviewed twice or more. Detailed field notes were compiled after each interview.

The recruitment of parents at baseline, 6- and 12-month follow-ups ended when the researcher judged that themes and categories had achieved conceptual 'saturation', i.e. a point was reached where the collection and coding of additional data no longer contributed further insights to the analysis (Glaser, 2002; Strauss & Corbin, 1998). However, in the case of the small sample recruited for the 18-month follow-up, interviewing could not continue due to resource limitations. All but three interviews[10] were transcribed verbatim by the researcher, and each, on average, took approximately five hours. Transcription also noted non-verbal behaviour, such as sighing, laughing, crying and so forth.

4.2.4.2 Group facilitators and service managers

In April 2008, the researcher arranged a meeting with all of the group facilitators (N=8). At this meeting, it was explained to the facilitators that the researcher would like to interview them about their experiences in administering the IYPP following the delivery of the intervention to the first cohort of parents. All of the facilitators agreed to participate. All 14 sessions of the IYPP were delivered to the first cohort by early July, 2008. In late July 2008, the eight group facilitators were contacted and interviews were arranged. In accordance with their preferences, six facilitators agreed to participate in a focus-group interview at Archways' offices, and an interview was conducted with a pair of facilitators who had worked together in delivering the programme. Likewise, ten facilitators agreed to participate in another six-month follow-up interview in January to February 2009 following the delivery of the IYPP to the second cohort of parents.

[10] The other three interviews were transcribed by other people. Unfortunately, this process could not be continued as the interviews transcribed by others contained too many errors (and missing data) and it was too time-consuming to check the inaccuracies for the larger number.

Facilitators were interviewed twice in order to assess whether their experiences had changed over time or whether any new issues had emerged. At the six-month follow-up, five separate interviews were conducted separately with each pair of facilitators within their respective service, as was their preference. There was a sense from most of the group facilitators that they were uncomfortable with sharing their experiences and views within a larger focus group and that a more intimate interview with each pair would perhaps allow more divergent and honest views to emerge. Unfortunately, one of the disadvantages of focus groups is that disclosure may not be enhanced for sensitive topics (e.g. perceived organisational support) (Willig, 2008). As predicted, there was an enhanced diversity and expressivity of views communicated in the second round of interviews. In addition, the quality of data improved in the second interview, as by this stage, a considerable degree of familiarity and trust had been established between the researcher and the group facilitators. This relationship was facilitated by occasional meetings conducted within the context of the overall RCT, routine collection of their IF forms as well as attendance at two of their supervisory sessions.

Service managers were contacted in January 2009 and asked to participate in a one-to-one interview that would elicit their experiences of implementing the IYPP within their agency. One-to-one interviews lasted from 45 minutes to 1.5 hours. The manager involved in implementing the IYPP within Galway city participated in phone interview which lasted for 45 minutes.

Similar to the parents, both the managers and the facilitators were assured of the confidentiality of the data and that they could withdraw from the study and withdraw their data at any time. They also provided written informed consent to take part in the study and for their data to be published anonymously (Appendix 12). No gratuity was paid to the practitioners or managers for participation. As above, all interviews were again digitally recorded (including the phone interview) and transcribed verbatim by the researcher.

4.2.5 Analysis

The data from the semi-structured interviews, focus groups and two observation sessions were analysed using constructivist grounded theory [CGT] (Charmaz, 2006) in order to identify and organise key themes. This approach enables the study of individual processes, interpersonal relations, and the reciprocal effects between individuals and

larger social processes (Charmaz, 2008); therefore it was considered to be highly suitable for the investigation of stakeholder experiences of the IYPP. Grounded theory emerged from the field of sociology in the 1960s and subscribes to symbolic interactionism, an approach that has close intellectual roots with pragmatism (Glaser & Strauss, 1967; Ritzer, 2011). For instance, both approaches contain interpretative elements in that they see 'social reality' as dynamic and actively created (Ashworth, 2000; Mead, 1934). However, the two approaches also affirm the validity of both confirmatory and exploratory research, and believe that a degree of replication and generalisation is possible if the analysis is conducted in a systematic manner (Glaser & Strauss, 1967). Although grounded theory is often seen as an exclusively qualitative methodology (Creswell, 2009), many of its values fit squarely within the pragmatic tradition (Charmaz, 2008). For that reason, it was considered the most appropriate method of analysis for this study.

In the early stages of this study, Interpretative Phenomenological Analysis [IPA] (Smith, 2008) was also considered. However, when compared to CGT, IPA takes a more idiographic approach, places more emphasis on the in-depth analysis of the narrative arc of each participant's text, and consequently, involves a very small sample (Smith, 2008). While this study was also open to idiographic experiences, its main thrust was to examine themes relating to key processes of implementing the IYPP. Thus, it was believed that a larger sample would be more appropriate in order to shed light on those processes. Furthermore, according to the developers of grounded theory, the validity and 'conceptual saturation' of a study is enhanced if more, rather than less, participants are sampled (e.g. Strauss & Corbin, 1998), thereby providing a better 'fit' with the objectives of the process evaluation.

CGT is similar to other methods of grounded theory (e.g. Glaser & Strauss, 1967; Strauss & Corbin, 1998) in terms of the overall approach to data analysis; that is, data are analysed using line-by-line and focussed coding, constant comparison of data units within and across interviews to find similarities and variations within categories, the hierarchical linking of categories to generate super-ordinate (or overarching) themes and further constant comparison of study findings within the context of the extant literature. For instance, within the current study, initial codes on valuable aspects of learning and applying the programme (e.g. 'Non-judgemental support of group' and 'Tailoring skills

to busy lives') developed into more focussed codes on 'Importance of confidence' and 'Commitment and resilience'. Both of these focussed codes were subsequently linked to other focussed codes relating to facilitative organisational factors, which provided the basis for exploring an overarching theme of 'Perceived benefits and mechanisms of change' (See Appendix 13 for an example of line-by-line coding and Appendix 14 for an example of focussed coding).

Although it is quite similar to other grounded theory approaches, CGT was chosen as the preferred analytic strategy as both 'a priori' and 'emergent' concepts are considered acceptable as long as the theory is rooted or 'grounded' within the data (Charmaz, 2006). The originators of grounded theory, Glaser and Strauss, parted ways over their divergent stances on the relative importance of inductive and deductive analytic methods (Glaser, 2002; Strauss & Corbin, 1998). However, current theorists recognise that there are advantages and disadvantages associated with both methods and focus, instead, on ensuring that themes are embedded within the data (e.g. Cutcliffe, 2000). In addition, CGT was selected over either Glaser's or Strauss's versions of GT as it more explicitly acknowledges the interpretive or constructivist nature of generating themes (Charmaz, 2008). For example, within the context of this study, it may be important to note that the Irish cultural background of the researcher meant that she was sensitive to the possibility that traditional Irish parenting practices might conflict with the positive ethos of the IYPP. Other examples of how the researcher brought her own interpretations to the data are outlined later in section 4.4.3.

It should also be noted, at this juncture, that some of the narrative data within the results chapters were converted into numbers (e.g. Tables 5.1, 6.1 & 7.1 in the results chapters) due to the relatively large sample of participants. Furthermore, and in line with a mixed methods approach, a grounded theory analysis should be able to accommodate the presentation of descriptive numerical data to indicate, for example, the proportion of participants who speak on a particular theme (Miles & Huberman, 1994). Indeed, most qualitative analyses latently refer to frequencies when they use words such as 'many', 'most' or 'few participants', so the purpose of providing a table with numerical data is to add precision to the analysis. In addition, the inclusion of quantitative data complements the qualitative analysis. For instance, it is important in terms of the implementation of the IYPP, as to whether two or ten parents suffered from a period of

sustained relapse following the intervention. In the former, a targeted response by practitioners to the individual parents may be sufficient to reinstate positive outcomes. However, the latter suggests that the IYPP may need to consider a wider provision of follow-up support for parents.

Furthermore, it is important to note that the presentation of numerical data within this qualitative analysis does not constitute a content analysis *per se* because, firstly, the quantitative data merely indicate the proportion of participants who spoke on a theme as opposed to a thorough counting of how often the theme appeared within participants' reports. Secondly, no statistical analyses were performed based on frequency counts, as can often occur within content analyses (Krippendorff, 2004). Rather, the primary focus of Stage One was to explore stakeholders' varied and nuanced experiences of receiving or implementing the IYPP.

4.3 Method: Stage Two

As indicated earlier, the primary aim of this second stage of the research was to ascertain the degree of programme fidelity achieved within the RCT and to investigate whether aspects of fidelity differed across the nine parenting groups. A secondary aim was to explore whether aspects of fidelity (e.g. therapist adherence to session protocols; parental attendance or satisfaction with the programme) were related to the primary trial outcome of child behaviour.

4.3.1 Participants

Both parents and group facilitators participated in Stage Two. Parent participants involved those who were randomised to the intervention group within the RCT (N=103). Although all of these parents should have received and completed each fidelity instrument (see below), varying attendance rates at weekly sessions meant that the number who actually returned each measure, varied and, as such, there were slight variations in the demographic characteristics associated with the sample of parents who completed each instrument. However demographic characteristics (i.e. age, gender, social disadvantage) were comparable to those reported for the overall RCT (McGilloway et al. 2012a). Thus, 89 parents completed the Parent Weekly Evaluation, 57 completed the Parent Satisfaction Questionnaire and 103 completed the Eyberg Child Behaviour Inventory (see Table 4.3).

The characteristics of the group facilitators were described earlier in this Chapter.

4.3.2 Measures

Each of the five measures used in the assessment of IF is described below. These were completed by group facilitators or parents.

Facilitator-completed measures

(1) The Leaders' Weekly Checklist (LWC) is a self-report checklist completed by group facilitators on a weekly basis after each session. The checklists (comprising 10-15 items) require leaders to check ('Yes' or 'No') that they had covered all prescribed material for the session (e.g. showed required vignettes, covered relevant topics, checked homework) (see Appendix 15). This instrument was devised by the programme developer for the specific purpose of monitoring therapist adherence to programme protocols within each session and its use is reported widely in published studies of the IYPP (e.g. Webster-Stratton et al. 2004).

(2) The ***Implementation Fidelity Form*** (IFF) is a questionnaire, comprising 31 items, which was devised by the researcher in order to collect information from group facilitators on key aspects of IF, including adherence to the original design, quality of programme delivery, parental exposure to the intervention and participant responsiveness (Mihalic et al. 2002). The IFF was completed by facilitators on a weekly basis after each session. Due to the nature of the questions asked within the IFF, it was decided to report on the frequency of category response as this was considered to be more appropriate than converting each qualitative category into a number on a Likert scale (see Appendix 16).

Table 4.3 Demographic characteristics for participants who completed questionnaires (N, %)

Questionnaire	PWE [a] N = 89	PPSQ [b] N = 57	ECBI [c] N = 103
Parent mean age (yrs)	33	35	33
Lone family	37 (42)	22 (39)	40 (39)
Socially disadvantaged	53 (59)	33 (58)	70 (68)
Child gender (% boys)	56 (63)	36 (64)	59 (57)
Child mean age (mths)	57	59	59

[a] Parent Weekly Evaluation
[b] Parent Programme Satisfaction Questionnaire
[c] Eyberg Child Behaviour Inventory

Parent self-report measures

(3) The ***Parents' Weekly Evaluation Form*** (PWE) comprises four Likert scale items (ranging from 1 or 'not at all helpful' to 4 or 'very helpful') on which parents are asked to rate the helpfulness of each weekly session, with regard to the group discussion, content taught within the session, vignettes and quality of the facilitators' teaching (see Appendix 17). This form was devised by the programme developer in order to assess parents' satisfaction with the weekly sessions (e.g. Webster-Stratton, Kolpacoff & Hollinsworth, 1988). Within the context of this study, group facilitators administered the form to parents at the end of each weekly session.

(4) The ***Parent Programme Satisfaction Questionnaire*** (PSQ) consists 45 items, each of which is scored using a 7-point Likert scale response format ranging from 1 ('not useful') to 7 ('most useful') (Webster-Stratton et al. 1988). The questionnaire was administered (by group facilitators) on one occasion only, to parents who had received the intervention and attended the last session. Five subscales assess parent's satisfaction with: (i) child behaviour outcomes; (ii) competence of group facilitators; (iii) relationships with other group members; (iv) the perceived utility of the teaching format (e.g. group discussion, vignettes, and role play); and (v) specific parenting techniques (e.g. play, praise, rewards and time out). The internal consistency of the subscales in this study ranged from .81 to .90 (see Appendix 18).

(5) The ***Eyberg Child Behaviour Inventory*** (ECBI) (Eyberg & Pincus, 1999) was used as the primary outcome measure of child problem behaviour within the RCT and was used, therefore, in routine data collection. This tool, which is widely used in clinical practice and intervention studies, consists of two subscales that elicit parents' perceptions of 36 problem behaviours. The Intensity subscale comprises a 7-point Likert-type scale that measures how frequently each behavior occurs; the Problem subscale elicits information on the number of problem behaviours exhibited by the child, as well as a 'yes–no' response as to whether the parent considers the child's behaviour to be problematic (Internal reliability of .89 and .87 for the Intensity and Problem subscales, respectively). ECBI normative data, based on a sample of children in a south-eastern region of the United States (N = 798), indicate a mean score on the Intensity scale of 96.6 (SD = 35.2) and a mean score on the Problem scale of 7.1 (SD = 7.7; Eyberg & Pincus, 1999) (see Appendix 19).

Other

Information on ***parental attendance*** was also obtained from records kept by group facilitators during programme delivery. The researcher received this information from an IYIS team member, who calculated the mean score of attendance per parenting group (McGilloway et al. 2012a).

4.3.3 Procedure

A meeting was arranged between the researcher and all group facilitators before the commencement of programme delivery in April 2008. At this meeting, the researcher explained to the facilitators the nature of the research and the fidelity forms and all agreed subsequently to take part. Thus, group facilitators were asked to administer the PWE to parents at the end of each weekly session and to collect the forms. Likewise, they were asked to administer the PSQ to parents following the last session and to collect the forms. This did not add any extra burden on facilitators as the administration of these questionnaires was part and parcel of the usual delivery of the programme. Following each weekly session, every facilitator was also asked to complete the two leader fidelity forms (i.e. the LWC and the IFF). Again, it is common practice for IY facilitators to complete the LWC following weekly sessions.

Group facilitators were informed that their data were confidential and that they could withdraw from the study or withdraw their data at any time. Similarly, during the RCT baseline data collection, parents were given similar reassurances (Appendix 20). Nevertheless, the researcher instructed the group facilitators to remind the parents again about the confidentiality of their data when administering the questionnaires.

Each facilitator received a full pack of forms for the 14 sessions and was asked to return these to the researcher, on a weekly basis, using stamped addressed envelopes provided. Most group facilitators returned their forms on a regular basis although there were frequent and prolonged delays with three facilitators. Thus, fidelity data were gathered from 11 group facilitators and attendee parents during delivery of the IYPP, which ran from April to July 2008 for the first cohort of parents and from September to December 2008 for the second cohort.

4.3.4 Analysis

Both descriptive and inferential statistics were employed in the analysis of IF. A series of one-way, repeated and mixed between-within ANOVAs was used, followed by post-hoc tests, to investigate group and component effects on the instruments used to assess IF (i.e. the PWE and the PSQ). Correlational analyses (Spearman's Rho) were used to assess the relationship between the outcome of child behaviour (ECBI) and aspects of fidelity, including therapist adherence (LWE), parental satisfaction (PSQ and PWE) and parental attendance. Spearman's Rho was favoured due to the non-normal distribution of the data. In addition, the p-value was set at 0.10, rather than 0.05, because the small number of parenting groups (N=9) reduced the power of the analysis (Cohen, 1988). This was in line with a similar study which also involved nine parenting groups (Breitenstein et al. 2010). Moreover, it is recommended as a statistical technique in augmenting the power of the analysis when the N is low (Howell, 2009). It was necessary to use the parenting group, rather than the individual parent, as the unit of analysis, as data on the PWE and the PSQ were anonymous. However, it was possible to calculate a mean score on each measure for each of the parenting groups. Furthermore, the researcher did not have access to individual data on parental attendance, but mean attendance rates for each parenting group were available from the team statistician who was working on the larger trial. All inferential statistics were conducted using SPSS (version 19).

4.4 Other methodological issues

This section will address other general methodological issues relevant to both stages of the study including ethical considerations, reliability and validity issues and researcher reflexivity.

4.4.1 Ethical issues

This study was conducted in accordance with the ethical Code of Conduct of the Psychological Society of Ireland (2003) and the British Psychological Society (2000). It received ethical approval from the Research Ethics Committee of the National University of Ireland Maynooth in 2008**.** As outlined earlier in this chapter, all participants were informed, both verbally and in writing, of the purpose and nature of the study. They were also assured that their data would be treated in confidence and that they were free to withdraw from the study and/or withdraw their data at any time without explanation. Parents were also informed that their access to services would not be affected if they chose to withdraw from the study. All participants provided written informed consent (Appendices 11 & 20).

It is important to note that this study was conducted under the auspices of the larger *Incredible Years Ireland Study (*IYIS) which also received ethical approval from the Ethics Committee of NUI Maynooth in 2007. Accordingly, the parents recruited during the process evaluation represented a subsample of those parents (N=149) who were recruited to the RCT. As mentioned earlier, the families were either self- or professionally-referred to Archways. The latter were referred to Archways by a number of agencies including the HSE, schools, and a range of community and voluntary organisations. The securing of consent of referred families involved a three-stage process. Firstly, Archways contacted families in order to seek their consent for their names to be forwarded to the IYIS research project. Secondly, the RCT project manager contacted parents in order to inform them about the study and to obtain their verbal consent to participate in the study. Thirdly, all parents gave written informed consent when visited by a researcher in their homes as part of the initial consent and RCT data collection process (Appendix 20). Those parents who participated in the process evaluation also provided written informed consent (Appendix 11).

One of the most significant challenges in community-based research is the recruitment of participants. All of the available evidence indicates that financial and other incentives for participating parents in parenting programmes are critical to the retention of these, typically difficult-to-engage, families (e.g. Hutchings et al. 2007a; Webster-Stratton et al. 2004). Therefore, parents who participated in the qualitative phase of the study (i.e. in-depth interview or focus group) were each given a €15 shopping voucher at each visit as a small token of thanks for their time and their participation in the research. This approach has been used successfully in recruiting hard-to-reach families in other research (e.g. Hutchings et al. 2007b).

In order to safeguard participant welfare, the researcher was required to sign a declaration stating that she had no criminal convictions and that there was no reason why she should not work with young people (Department of Health and Children, 2002). A secondary potential concern in carrying out research with families is the risk of causing distress when, for example, raising sensitive topics around childrearing. Thus, parents were treated with appropriate compassion and warmth and allowed to talk at length about their experiences. In line with other IY research (e.g. Webster-Stratton & Spitzer, 1996), all parents appeared to find the interview sessions beneficial.

In addition, this study acknowledged the possibility that, in a project of this nature, some child protection and/or family welfare issues may emerge either directly or indirectly in the course of the interviews. Consequently, a protocol was developed whereby any issues of concern would be dealt with sensitively, promptly and in line with established guidelines for the protection of children (e.g. Children First, 1999; Our Duty of Care, 2002) with referral, where appropriate, to a relevant HSE agency. In the context of the interviews, the researcher was sufficiently concerned at six-month follow-up to refer two interviewed parents (who had left the programme early) back to the service from within which the IYPP had been delivered. The researcher was similarly concerned at 12-month follow-up to refer one parent back to the service where the IYPP had originally been delivered. The welfare issues related to school absenteeism, possible eviction and evidence of parental depression. At both follow-up points, at the end of the interview, the researcher encouraged the parents to contact the IYPP service in order to receive support for their issues. She also sought the consent of parents to speak with the group facilitators about the parents' issues. Furthermore, the researcher sought advice, at

this stage, from the RCT project manager and Principal Investigator, who supported the procedures undertaken to safeguard the welfare of the parents. The researcher then contacted the relevant group facilitators and expressed her concerns. Within a couple of days, the group facilitators reported to the researcher that they had contacted the parents in question, and referred them to the appropriate HSE agencies so that their welfare issues could be addressed.

Lastly, a number of measures were undertaken to protect the welfare of the researcher. Most of the interviews with parents took place in the parents' homes and, thus, the researcher followed the procedures and guidelines outlined in the Department of Psychology's '*Guidance for Safe Working Practice in Psychological Research*' (Appendix 21). More specifically, the researcher contacted the RCT project manager directly before and after each interview and also carried a panic-button. In addition, the researcher received regular supervision and support from her supervisor (and Principal Investigator). Fortunately, no potentially harmful situations occurred and the researcher did not experience any undue stress from the interviewing process.

4.4.2 Reliability and validity

It is also important to ensure the reliability and validity of the research. Arguably, reliability and validity criteria are as important within qualitative research as within quantitative studies (Murray, 2008; Smith, 2008). Thus, *trustworthiness* and *credibility* are seen as the qualitative analogues to internal reliability and validity whilst *transferability* is considered to be the qualitative analogue to external validity (e.g. Teddlie & Tashakkori, 2009; Yardley, 2000). A number of recommended procedures were employed in the current study in order to enhance the reliability and validity of the research.

For example, in **Stage One,** this included:

- Triangulating data from a number of sources;
- Using a maximum variation purposive sampling method to obtain a diverse sample of participants;
- Seeking disconfirming case analysis and 'theoretical saturation';
- Using audiotaped and verbatim transcription;

- Providing a detailed description of participants and settings;
- Conducting an audit trail of coding in order to enhance transparency (see Appendices 13 & 14);
- Examining themes and coding with colleagues and in peer-reviewed publications;
- Seeking respondent validation; and
- Promoting researcher reflexivity (Murray, 2008; Yardley, 2008). This aspect will be outlined in more detail in the next subsection.

More specifically, although all of the data were coded and analysed by the researcher, an independent reviewer assessed the reliability of coding on approximately 25 per cent of the interviews conducted at the six-month follow-up period. Due to time and resource limitations, it was not possible to conduct inter-rater comparison on themes generated during other stages of data collection. Research in the area indicates that inter-raters can realistically review only a segment of the total data since data in qualitative studies are usually rather substantial and inter-raters only have limited time (Armstrong, Gosling, Weinman & Martaeu, 1997; Creswell, 2009; Marques & McCall, 2005). Therefore, in relation to reviewing the remaining data, and as a second best option, the researcher discussed the themes, and any deviant cases, with colleagues and her supervisor. Indeed, this latter strategy is more commonly utilised within qualitative studies whereas inter-rater comparison has rarely been used as a verification tool in qualitative studies (Marques & McCall, 2005; Teddlie & Tashakkori, 2009).

The validity of the data was further enhanced by interviewing the group facilitators at two separate time points. As mentioned earlier, the quality of data obtained in the second round of interviews was superior to the data acquired in the first, larger focus group. Similarly, many parents were interviewed more than once. The reliability and validity of the analysis were also indicated through the presentation of verbatim extracts within the later Results chapters. Conferences, at which findings were presented, were also used as a means of seeking respondent validation on a larger scale. For example, the national Archways Conference in September 2009 was particularly useful in obtaining feedback from parents, group facilitators and service providers on the study findings. The feedback from stakeholders at this conference indicated that the thematic analysis accurately captured the substance of the interviews.

Establishing the transferability/generalisability of qualitative findings is more challenging due to the use of typically small, non-random samples. Thus, some researchers refer to a concept known as 'reader generalisability', i.e. where the reader determines the extent to which the findings from a study can be applied to their own particular context (Murray, 2008; Nutley, Walter & Davies, 2007). In this way, the researcher should be careful to provide a complete description of participants and settings (as in the current study). The generalisability of the findings within the current study is enriched to the extent that a very large sample of parents (in qualitative terms) was interviewed and their demographic characteristics did not differ from the larger sample randomised within the RCT. In addition, all of the facilitators involved in the RCT were interviewed whilst a service manager not involved in the RCT, was also interviewed in order to examine experiences across different services in various areas of Ireland. The utilisation of both qualitative and quantitative methods may augment the transferability of the findings, especially if the results from the various methods corroborate each other.

There was some variability in the reliability and validity of the questionnaires administered in ***Stage Two*** of the study. The ECBI is a well-validated scale that can differentiate children with clinical and non-clinical levels of conduct problems (e.g. Eyberg & Pincuss, 1999). Internal reliability was high for the Intensity and Problem subscales, respectively. In addition, within the context of this study, the measure was administered to all randomised parents. Similarly, the PSQ, which is used widely, had high internal consistency (subscales ranging from .81 to .90). However, the findings obtained from the PSQ were partially compromised as the questionnaire was only administered to those parents who remained with the IYPP until the last session. Other reasons for the low sample size may be that parents who were present at the last session did not return the questionnaire to the group facilitators and/or the form may have been mislaid by the group facilitators and not returned to the researcher.

The PWE is widely used (e.g. Ogden et al. 2009) and was completed by 89 parents. As both the PWE and the PSQ were administered by the group facilitators, it is possible that social demand characteristics may have played a role, in that participants may have felt some pressure to give a high rating to the quality of the teaching. At the same time, however, parents were not obliged to write their name on the form.

A limitation of both the LWC and the IFF is that both are self-report measures and may, therefore, be subject to positive bias. Unfortunately, an observational tool that is currently used for evaluating the IYPP (i.e. the Leader Observation Tool – Eames et al. 2010) was not fully developed at the time the programme was being delivered in Ireland in 2008. (In addition, the development of an observational tool would have been duplicative and beyond the scope of this study.) Reassuringly, however, other research indicates a relatively high inter-rater agreement (85%) between self-report and observational tools designed to measure fidelity within a parent-training programme. As expected, the positive bias was found within the self-report instrument (Breitenstein et al. 2010). The inter-rater relationship between the LWC and the Leader Observation Tool has not yet been examined.

Furthermore, there were frequent delays in receiving the LWC and IFF forms from three facilitators, and as such, it is not possible to be certain that these facilitators completed their questionnaires directly following the session, or whether they were completed retrospectively a few days or a few weeks later.

4.4.3 Researcher Reflexivity

Reflexivity refers to the process whereby the researcher's disciplinary and theoretical proclivities, relationships and interactions with participants, all shape the collection, content and analysis of data. Consequently, researchers who engage in qualitative analysis attempt to critically examine their own role in the research process in order to allow the reader to discern how they arrived at a particular interpretation of the data (Holloway, 2005). For instance, as indicated earlier, the Irish cultural background of the researcher may have increased her awareness of the possibility that traditional Irish parenting practices might conflict with certain principles taught within the IYPP. In addition, the researcher has a particular interest in family dynamics and has worked in various clinical settings with children and families as part of her training as a Counselling Psychologist. Furthermore, the researcher is aware of feminist literature with regard to 'parenting' and at several junctures, had to cross check (with herself and others) that data were not being forced to fit into feminist-oriented themes.

As indicated earlier, while the researcher was open to all reported experiences of participants, it was apparent from the content of the interview schedules and topic

guides, that the primary focus of the research was to investigate the key facilitative and inhibiting factors involved in implementing the IYPP within an Irish context. Thus it is quite possible that another researcher with another goal in mind may have analysed the data in a different manner.

It is also important to ensure, insofar as possible, the quality of the data. Thus the researcher placed considerable emphasis on placing participants at ease, such as, for example, being suitably attired and accepting offers of beverages (Holloway, 2005). Furthermore, the researcher is a trained Counselling Psychologist and has developed her interviewing skills through her prior experiences in working with individuals and groups within both research and therapeutic settings. Thus, the quality of the data was enhanced by paying attention to implicit and conflicting points of view.

Field notes were also important in clarifying the researcher's emotional responses to the interview process; for instance, the researcher might investigate whether her uneasiness following an interview may be attributed more to her own personal issues or were primarily related to implicit cues from the participant. In addition, field notes were useful in delineating the perspectives of both the researcher and participants, such that both did not converge into one (Teddlie & Tashakorri, 2009).

A limitation of the reflexivity process relates to the level of awareness and openness required from researchers with regard to their own thoughts and feelings (Taylor, 2005). It is possible that a whole range of other variables, of which the researcher may be unaware, may influence the interpretation of the data. In the context of the present study, these might include, for example, the socioeconomic status of the researcher and the fact that she does not have children.

4.5 Conclusion

In summary, this chapter outlined the main epistemological, methodological and ethical considerations relevant to the conduct of both Stages One and Two of this study. The next chapter will present the findings from the first theme within Stage One.

CHAPTER FIVE - RESULTS I

STAGE ONE

5.1 Introduction

This chapter is one of three that presents the results from Stage One of the study. Three master or overarching themes were generated during this qualitative stage of the study, each of which was sufficiently important and extensive to merit discussion within a separate chapter (See Figure 5.1). These include:

(1) 'Under siege': experiences of learned helplessness

(2) Perceived benefits and mechanisms of change

(3) Challenges in programme implementation**.**

A number of sub-themes were identified within each theme and these - together with the three master themes – are illustrated in Figure 5.1. It is important to note, though, that these are not mutually exclusive (as indicated by the arrows in Figure 5.1). For instance, the reasons for attrition reported in the third theme, overlap with some of the pre-intervention difficulties reported by parents in the first theme. In addition, there are several associations among various subthemes within Themes Two and Three. It is also important to note that there are links between the findings reported in Stages One and Two. These commonalities/relationships will be indicated, where appropriate, throughout the Results chapters and integrated within the Discussion. This current chapter presents the findings for Theme One.

STAGE ONE: THEME 1

5.2 'Under siege': experiences of learned helplessness

Three main subthemes emerged from an analysis of responses elicited at the baseline assessment period. These include: (1) the child's behavioural profile; (2) the psychological and social impact of parenting a child with conduct problems; and (3) expectations of, and motivations for attending, the IYPP. Each of these is discussed in more detail below.

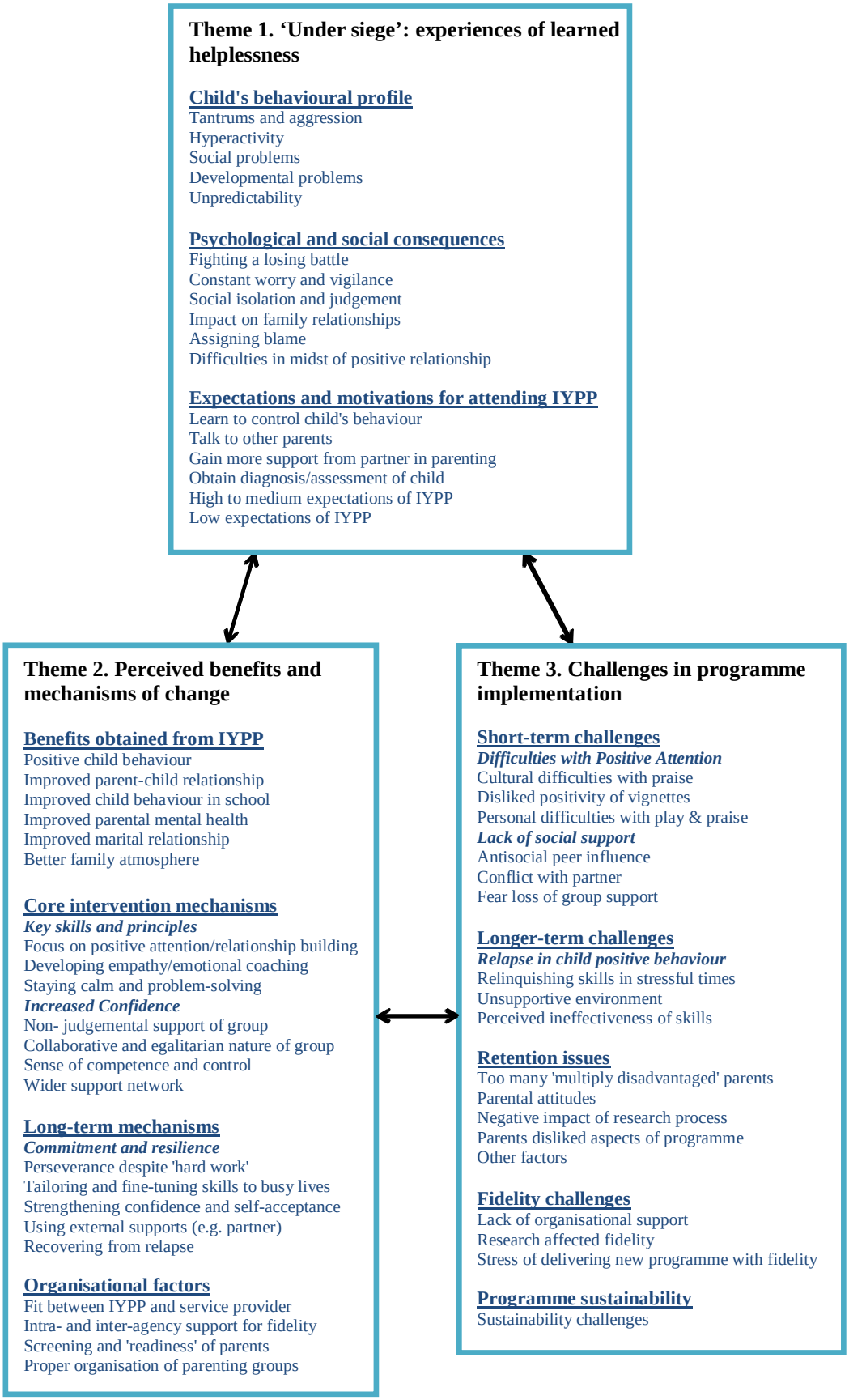

Figure 5.1 Key themes and subthemes generated from the qualitative analysis

5.2.1 Child's behavioural profile

At baseline, all parents (N=20) expressed considerable concern and upset in relation to the level of defiance and aggression exhibited by their children. A large proportion was also distressed about other behavioural patterns presented by their children, including hyperactivity, social and developmental problems, and a high degree of unpredictable behaviour. More than half of the parents reported that they had experienced difficulties with their child since birth, including dealing with the consequences of birth complications, feeding and health problems and problems in bonding with an irritable child.

5.2.1.1 Aggressive, hyperactive and unpredictable behaviour

All of the parents reported that their children were frequently non-compliant, defiant and prone to throwing temper tantrums when requested to follow instructions (e.g. requests to complete daily tasks, such as getting dressed). Common tantrums involved hitting, kicking and biting of self, parents, siblings and/or peers; destruction of furniture and property; and screaming and verbal abuse. Parents explained that the intense irritability and controlling nature of their child meant that the slightest trigger could trigger a tantrum, such as, not being allowed to take another child's toys or the parent speaking on the phone to another person. Some parents reported that tantrums occurred many times daily whereas others experienced tantrums only every couple of weeks. Tantrums reportedly lasted for hours or even days, in some cases. In addition, most parents viewed their child as cruel and capable of hurting others without guilt or remorse.

> "If he doesn't get his own way, he pulls the wallpaper off the wall, dashes things to the ground, breaks everything…He bites me and his sisters, pulls their hair out…There's at least three or more tantrums a day." *(Mother [3][11] of 4-year-old boy)*

> "He puts screws in his brother's mouth (10-month-old sibling) and things like that, that he knows are dangerous…He has no remorse. That child that he put into hospital the other day, I was petrified what would happen and he said, 'There's a million other kids. It doesn't matter if he dies'." *(Father [9] of 4-year-old boy)*

[11] Numbers in the squared parentheses refer to the identification number given to the participant.

Table 5.1 Theme 1: 'Under siege': experiences of learned helplessness' and subthemes (N, %)

Child's behavioural profile	Parents
Tantrums and aggression	20 (100)
Hyperactivity	10 (50)
Unpredictability	11 (55)
Social problems	10 (50)
Developmental problems	8 (40)
Psychological and social consequences	
Fighting a losing battle	17 (85)
Constant worry and vigilance	12 (60)
Social isolation and judgement	14 (70)
Impact on family relationships	17 (85)
Assigning blame	15 (75)
Difficulties in midst of positive relationship	3 (15)
Expectations and motivations for attending IYPP	
Learn to control child's behaviour	15 (75)
Talk to other parents	1 (5)
Gain more support from partner in parenting	2 (10)
Obtain diagnosis/assessment of child	2 (10)
Medium to high expectations of IYPP	7 (35)
Low expectations of IYPP	13 (65)

Half of the parents (N=10) believed that their child was unusually hyperactive for their age. For example, they reported that their child never sat still and always found themselves in dangerous situations, such as running out into traffic, climbing out of upstairs windows, or running away from the parent in shopping centres. These parents reported that their child was unable to learn from discipline or past experiences and always repeated the same dangerous behaviour. In addition, they described their children as being easily bored and distractible (e.g. always 'jumping' from one thing to another). Three of the parents also believed that their child had concurrent attention difficulties:

> "He's a lunatic, an absolute lunatic. The wildness he has, he has no road sense and he just doesn't have a fear of anything…I have all the windows upstairs locked with keys because

> he would jump out the windows. He never ever walks. He's never walked. He always runs." *(Mother [11] of 4-year-old boy)*

Eleven parents described their child as a 'Jekyll and Hyde', who alternately displayed both uncontrollable, defiant behaviour and a well-mannered, loving and considerate side. However, the latter was generally not viewed positively; rather, the child's unpredictability meant that parents found it even more difficult to manage their behaviour as they could switch from lovable to loathsome in an instant. In addition, the fact that their child could be well-behaved in other settings, such as in school or with other family relations, was a source of irritation to them and they interpreted this as evidence that their child was deliberately misbehaving when with them, but not with others. As a result, the parents tended to focus primarily on their child's problematic behaviour:

> "He can be very sweet and be can be so good. And I'd feel sorry for him but then he'd just go and be a little demon like he was before…It's like his brain just switches over and I'd be wondering, 'Where the hell did this come from? Why is he so angry?'" *(Mother [17] of 5-year-old boy)*

5.2.1.2 Social and developmental problems

Half of the parents described their child as experiencing significant social problems. Five explained that the social problems were due to their child's externalising behaviours (e.g. violence and verbal abuse) whereas the other five recounted that their child's emotional difficulties meant that they were occasionally bullied and/or isolated from others. In addition, the latter were concerned with the extent of the child's dependent or 'clingy' behaviour towards the parent.

> "He doesn't really mix or interact with anyone in school. He blanks everyone, even if someone says 'Hello" to him…He can't socialise in a group. He won't join in the game and now they won't play with him." *(Mother [18] of 7-year-old boy)*

> "She's always 'hanging out of me', hiding behind my leg and won't play with the other kids." *(Mother [8] of 6-year-old girl)*

> "The other kids have gotten sick of him kicking them and being a general bully." *(Mother [13] of 5-year-old boy)*

Eight parents were concerned that their child was not meeting their developmental milestones, with respect to talking, sleeping and toilet training. As indicated in Chapter Two, childhood conduct problems can often be comorbid with developmental and

emotional disorders (Loeber & Farrington, 2001). All experienced bedtime difficulties; their child would not go to or stay in bed, engaged in sleep-walking and/or experienced frequent night fears. In addition, five parents were confused about whether or not they should be concerned about their child's eating patterns although they tended to chastise their child for these in any case.

> "She doesn't sleep. It is very hard to get her down…She would be jumping all around and this would probably be half ten. And I've been trying to get her to bed since 8[pm]" *(Mother [1] of 4-year-old girl)*

> "I keep at him to eat his vegetables, which he hates, and that usually causes a row at mealtimes…I don't know whether it's a big deal that he eats them, I hated them when I was young too, but I keep onto him because he should eat them." *(Mother [3] of 4-year-old boy)*

5.2.2 The psychological and social impact of parenting a child with conduct problems

Most parents viewed their relationship with their child in a negative light, such that they experienced themselves as 'fighting a losing battle' against a formidable antagonist. They reported that their child's conduct problems had an adverse impact on all aspects of their lives. For instance they: were constantly worried; suffered social isolation and public censure; engaged in endless recriminations and assignations of blame; and endured conflict within their family relationships. Interestingly, however, three parents viewed their child's conduct difficulties in the overall context of a positive relationship with their child and this perspective appeared to reinforce their ability to cope. These sub-themes are presented in more detail below.

5.2.2.1 *"I'm fighting a losing battle"*

Most of the parents (17/20) experienced their relationship with their child as a battle for control which, on principle, they felt they had to win. However, despite their determination to win, it was clear that parents experienced themselves as fighting a losing battle. They could not compete with what they saw as the constant non-compliance, aggression and hyperactivity exhibited by their children. Typically, parents presented their child as a manipulative adversary, who knew how to provoke or upset the parent, or as an uncontrollable force, unable to listen to reason.

Parents interpreted many of their child's behaviours as evidence of deliberate 'meanness' and 'spite', including: being cruel and violent towards others; being

consistently non-compliant and uncooperative; being well-behaved in other settings but not with the parent; being able to rationalise their own misbehaviour and blame it on the parent; choosing not to eat food prepared for them; throwing a tantrum for no observable reason; saying 'sorry' to get out of punishment; pitting partners against each other for the child's gain; or misbehaving in public as the child knew that the parent would not admonish the child in front of others. Parents interpreted these behaviours as representing a personal attack upon them which, clearly, made them feel very angry and rejected:

> "He is a very clever and manipulative child. He comes by stealth. I actually think he plans his tantrums to get what he wants. I never get what I want from him. He knows how to wind me up and get in control of the situation." *(Mother [12] of 7-year-old boy)*
>
> "She actually knows to act up when we're out as she knows that I don't want to cause a scene…When out shopping, she roars if I say 'No' to something she wants and often I give in because of the people watching." *(Mother [6] of 5-year-old girl)*
>
> "You get to the stage where you think, 'My child does not like me' and it makes you feel awful especially when she will behave with other people. Sometimes I feel so angry I have to leave the room." *(Mother [10] of 4-year-old girl)*

Parents reported that they had employed a raft of different disciplinary methods in an effort to change their child's misbehaviour, including constant reminders and warnings, shouting, bribing, stickers, utilising the 'bold step', confiscating toys and treats, locking the child in a room, threatening abandonment and slapping the child. They felt extremely frustrated that none of their disciplinary strategies had any lasting effect on their child's misbehaviour despite spending so much time thinking about how to manage their child. A few parents recounted brief, short-term successes in changing the child's behaviour through the use of stickers/reward tokens, slapping or by establishing a routine. However, these strategies reportedly did not have any lasting impact. All of the parents stated that they did not believe in slapping although seven admitted that they did slap whilst a similar number feared that they were often on the brink of slapping their child:

> "She is very defiant and if she decides she's not wanting to do something then she's not doing it and I get that, 'Oh no, here we go again' panic feeling… Then it escalates and we're shouting and screaming at each other. It's such a madhouse…Sometimes it [smacking] does work, she'll do what she's told, but I don't like doing it. I end up crying my eyes out in the bathroom." *(Mother [2] of 6-year-old girl)*

It was clear that most parents believed that punishment of misdemeanours was the most effective parenting approach. However, some also reported, in a confessional tone, that they sometimes issued idle threats, or did not punish the child's misbehaviour. Reports of permissive parenting more commonly occurred in contexts where the parents felt empathy for their child's past difficulties, including being placed in foster care, nearly dying during childbirth, or where the parents had separated. In addition, some parents were confused as to whether they should employ a more or less stringent disciplinary approach with the child which, in turn, resulted in an inconsistent parenting style. Overall, despite the stress caused by shouting and slapping, parents reported that it was imperative that they should keep wrestling for, and gain, control.

> "I've tried everything but nothing works…I've tried being nice and I've tried discipline…I don't know what to do but I have to keep trying. It's important for him that I'm in control." *(Mother [17] of 5-year-old boy)*

> "I think you have to nip the bad behaviour in the bud or not they would run absolutely crazy. Although, can he get worse? He is crazy as it is." *(Mother [19] of 5-year-old boy)*

> "I know sometimes I let her away with things because of all she went through [child is in foster care]. I try to build a positive relationship but she throws it back in my face." *(Foster carer [14] of 6-year-old girl)*

Some parents (N=5) felt so helpless and out of control that they could not continue the 'battle' anymore and instead, in a reversal of the usual parent-child power dynamics, found it less stressful to acknowledge that the child was actually 'ruling the roost' at home. These parents were so worn out, exhausted and upset with their child's incessant misbehaviour that they admitted that they had given up trying to discipline them altogether. They had tried so many disciplinary strategies, but nothing had worked for them and they were at a loss as to how to proceed. Four of these parents had previously attended a child psychologist to seek help in managing their child, but reported that the advice they had received, usually around play, establishing a routine or setting limits to misbehaviour, had only a minimal impact on their child's misbehaviour.

These parents reported that they now coped by 'switching off' from their child in the sense that they chose not to notice their child's misbehaviour anymore and had become inured to it. They reported that living each day with their child's behaviour had become intolerable and that they felt they were standing on the 'edge of sanity', 'at their wit's end', 'running around like a crazy woman going nowhere', or 'at the end of their tether'. These parents felt hopeless and had thoughts of abandoning their children or placing

them into foster care. Indeed, approximately half of the parents (N=11) commonly used words such as 'demon', 'devil', 'tyrant', 'monster', or 'menace' to describe their child. The intensity of these descriptions suggests that many parents experienced themselves as at the mercy of a cruel, malevolent and frightening force; they felt helpless to change the situation and perceived that a 'child-tyrant' was in control.

> "He sets the rules telling me what to do. He's the boss, it's like he's the Ma and I'm the child. When he acts up and he keeps it up I end up giving into him for peace sake…I'm at my wit's end with him. I'm desperate. His problems are staring me square in the face and I can do nothing to fix it. I'm lost and he's going down the pan." *(Mother [20] of 4-year-old boy)*

> "I never want to get up in the mornings, it's like, 'God, another day with her'…I don't want to live. That's a terrible thing to say. I'm tearing my hair out with her. I hate being around her. Sometimes I feel like walking out and leaving her." *(Mother [10] of 4-year-old girl)*

5.2.2.2 Constant worry and vigilance: "I can't risk not watching him"

The level of the child's hyperactivity, destructiveness and violence towards others meant that many parents constantly worried and feared for the physical safety of both the child and others. Thus, they felt compelled to maintain a constant vigilance of their child in order to ensure everyone's safety, which often meant sacrificing their own leisure time or sleep. Indeed, three parents recounted how they had to keep a constant watch at night time for fear that their child would injure their siblings as they slept. Other parents expressed concerns that their child would destroy the house at night or would run away from home.

> "I have to watch him all the time for the safety of his brother…He's always trying to hurt him." *(Mother [16] of 4-year-old boy)*

> "He sneaks down in the middle of the night when we're asleep…and he breaks things and throws food around, scribbles on the walls…a neighbour found him out at 4am one morning." *(Mother [13] of 5-year-old boy)*

In addition, parents worried for the future emotional welfare of their children; they believed that their child would not have friends or relationships when they got older. Many highlighted their hopes that their child's behaviour would have improved by this stage, but now feared that it would never change and that they had left it too late to seek help. A couple of parents were also confused as to whether or not they should be worrying about their child's misbehaviour; they wondered whether the behaviour simply represented a developmental phase which their child would grow out of or, more

worryingly, whether it genuinely signified the beginning of a life-course of antisocial behaviour.

> "I'm worried about how it's going to work out in the future. If this carries on, he's going to be lost forever…Am I still going to have to watch his every movement him when he's twelve?" *(Mother [18] of 7-year-old boy)*

5.2.2.3 Social isolation and judgment: "*I'm a prisoner in my own home"*

Three quarters of interviewed parents explained how they had endured social isolation and judgment as a direct result of their child's behaviour. When outside the home, parents were stressed about, and alert to, the possibility that their child would throw a tantrum whilst feeling shamed when this occurred. They believed that other people judged them as being a 'bad parent' who lacked the ability to control their child; they also alluded to instances when members of the public often commented on their parenting, typically by criticising them for either slapping or not slapping their child. In order to avoid social censure, many parents had restricted their social outings with their child. However, as a result, they felt imprisoned within their own homes with their child and isolated from others. They were often ashamed to invite family members and neighbours to their house due to their child's destructive behaviour and a fear that their child might physically/verbally attack their visitors. They also indicated that they had no space or time away from their child and, thus, felt subsumed and overwhelmed by them.

> "It's very frustrating and em, he throws tantrums, screams and shouting in front of everybody, you know a public display. I get a lot of dirty looks off a lot of people. Strangers come over and say, 'Can you not control that child?' or 'That child needs a good slap', that kind of thing. It's mortifying…I can't cope bringing him out much now." *(Mother [5] of 5-year-old boy)*

> "I'm with him all the time and no-one wants to mind him, which I get because he's a little brat…And it's too much hassle bringing him out so I'm a prisoner in my own home." *(Mother [11] of 4-year-old boy)*

In addition, some parents reported how they experienced fraught relationships with their neighbours as a result of their child's violent behaviour and, consequently, had thought about leaving the area. They also believed that other parents shamed them with disapproval or aloofness when occasionally they tried to share their problems with them. The social restriction and judgement felt by these participants meant that they became increasingly isolated and felt condemned for admitting that they needed help:

"A lady at the end of the road gave out to me, said he was a 'little animal'. I was roaring crying and just walked away. But he keeps going back and keeps weeing in her garden, throwing stones at her dog, no matter what. He knows she gave out about him and he keeps doing it. He does it deliberately…It has become so bad between us that we are going to try and sell the house.' *(Mother [16] of 4-year-old boy)*

"I tried to talk to a neighbour about kids being little devils, you know, and she just kind of cut me short and said, 'Their behaviour doesn't come from nowhere'. We don't talk now after that." *(Mother [6] of 5-year-old girl)*

5.2.2.4 Impact of child's behaviour on family relationships: "*He ruins what should be happy family times*"

Most of the participants (17/20) reported that their relationships with their partners/ex-partners had suffered as a result of their child's conduct problems. One parent reported that her inability to cope with her child's constant misbehaviour, and her partner's lack of support in this respect, had contributed to the breakdown of her marriage. More typically, most parents recounted how they frequently argued with their partners about how to manage their child and admitted that they took their frustrations out on each other. Some also reported that each partner tended to criticise the other's parenting style. Two thirds of the mothers described their own parenting style as being more 'understanding' and indicated that their partners typically favoured a 'stricter' approach It should be noted, however, that even those mothers who espoused a more 'understanding' approach often utilised punishment-based disciplinary strategies similar to those parents who said that they favoured a stricter regime. In addition, participants reported that their child frequently avoided consequences for their misbehaviour because they were inconsistent and conflicted in their application of parenting strategies. A few parents reported that they had made efforts to discuss a common parenting strategy, although such discussions usually led to further conflict and a return to their original approach.

"He's [the partner] only in the door from work, he hasn't seen them [the children] all day and the first word out of his mouth is criticism. I hate when he does that and I'd say, 'No, don't do that. He doesn't understand why you're giving out to him'…He thinks I let them away with murder." *(Mother [3] of 4-year-old boy)*

"He [the partner] might slap him on the bum and he'd [the child] give me that look and my heart would break…so it puts him [the child] back in the good position even though he has been bold. We're arguing and he's got himself completely out of the bad books altogether." *(Mother [12] of 7-year-old boy)*

Parents also reported that their relationship suffered due to their child's continual disruption of any time they might spend together, especially at night time when the child refused to go to bed. Four parents spoke about the financial pressures caused by their child's hyperactivity (e.g. wearing out shoes) or destructiveness (e.g. constantly destroying doors, walls and furniture) and the additional stress or burden that this placed on their relationship. Many parents, mostly mothers, also reported a lack of support from their partner in dealing with their child. They believed that fathers increasingly removed themselves from the home, did not involve themselves with the children, and often sided with the wider family when they criticised the mother for her parenting approach. Indeed, some mothers often felt unsupported by the wider family in general, and especially by grandparents, whom they believed tended to undermine their parenting approach to such an extent that their child felt justified in not complying with their instructions.

> "It hasn't been easy for us since I lost my job. And with him needing new runners every second week, we're broke. We can't really afford it but the child has to have shoes." *(Father [9] of 4-year-old boy)*

> "It's hard to have time together when we can't get her to bed. We're exhausted." *(Mother [1] of 4-year-old girl)*

> "He [husband] gives out to his mother about me, often in front of me, and of course he [the child] thinks then that he doesn't have to do as I say. He says, 'Granny says it's ok'." *(Mother [12] of 7-year-old boy)*

Participants further reported that sibling and family relationships suffered as a result of the child's behavioural difficulties; some parents tended to ignore or spend less time with siblings as most of their attention was focused on their misbehaving child. There was further evidence to suggest that their child also encouraged their siblings to misbehave whilst some also stated that siblings were afraid of the child due to the level of aggression displayed by the child.

> "I can't do anything with him [sibling] but she's causing havoc because she doesn't like the fact that he's getting some attention." *(Mother [8] of 6-year-old girl)*

5.2.2.5 Assigning blame: *"I want to know why he is like this"*

Most parents (75%) reported that they spent a lot of time trying to understand the reasons for their child's misbehaviour. Typically, they assigned blame to the genetic/biological nature of their child, to their own parenting approach, to the

detrimental influence of ex-partners, or to earlier traumatic events, such as parental separation or birth complications. Most parents favoured either a genetic- or an environment-based explanation, although some were confused and vacillated between these different perspectives. Those who espoused a primarily genetic/biological explanation (N=7) believed that their child was 'born bold' and that it was in the child's nature to be spiteful or easily distracted. They tended to believe that the conduct problems/hyperactivity were inherited and explained how other relatives in the family displayed similar behaviour. A small number of parents (N=4) thought that their child had Attention Deficit Hyperactivity Disorder (ADHD) or a spectrum-type problem, such as Asperger's syndrome[12]. Overall, these parents appeared to believe that their child's personality was determined, was unlikely to change and therefore would probably be resistant to treatment. They wanted to learn how to cope with their child's problems rather than believing they could change their behaviour. Some of these parents were also keen to assert that the conduct problems were not due to their own parenting approach as they had other children who were well-behaved.

> "I wonder but I know there's nothing wrong with my home. My other children are fine. I think the problem is in her nature…I need to know that her problems stem from something that I can't help her with." *(Mother [7] of 5-year-old girl)*

> "I must be raising a demon child, just one of these kids that are born bold. I'm doomed to have a bold, spoilt, rotten child that will grow up to be a horrible spoilt adult." *(Mother [20] of 4-year-old boy)*

> "He's always been bored, no focus, jumping around…I had a difficult birth so maybe that has something to do with it…I don't think he'll change now." *(Mother [11] of 4-year old boy)*

A smaller proportion of parents (N=4) were racked by guilt and self-recriminations that they were responsible for creating '*this monster'*. Unlike those who attributed a genetic causality, these parents believed that children are shaped by their home environments and, thus, experienced an overbearing responsibility and attendant guilt that they had, in some way, failed their children. Such parents believed that some of their own behaviours could impact negatively upon their child; for example, they reported that they inconsistently applied discipline, and that they often criticised the child and/or

[12] Three of these four children had not yet been formally assessed for ADHD as, in line with best-practice guidelines, Child and Adolescent Mental Health clinics in Ireland do not diagnose for ADHD until the child is 7 years of age (DSM-IV-TR, 2000). The father of the other child reportedly would not give his consent for the child to be assessed for Asperger's syndrome within a psychology clinic as he did not believe that his son had behavioural or learning difficulties.

issued empty threats. In addition, three of the parents noticed that their child tended to misbehave when they were anxious and did not pay sufficient attention to them.

> "It must be my fault that he's like this. If I'm in a bad mood, he gets into a bad mood. *(Mother [12] of 7-year-old boy)*

> "I know sometimes I let him off with things he does and sure that only tells him that it's ok to be bold." *(Mother [3] of 4-year-old boy)*

It is interesting to note that these parents experienced guilt due to an admission that they often disliked their child. This disclosure was conveyed in lowered tones, thereby implying that such an admission broke the cultural expectation of unconditional love from parent for child. The perception of culpability appeared to operate under a number of implicit and typically unrealistic expectations. For instance, these parents believed: that parenting should be easy, natural and not require outside support; that other parents rarely experience difficulties; that children should always be perfectly behaved and that failing to reach that standard is evidence of poor parenting. Moreover, three parents believed that the standard was raised even higher for them, as stay-at-home-mothers and that, as a result, they felt they ought to have perfectly behaved children. Thus, parents (and specifically mothers) appeared to 'crumble' under the weight of assumed, internalised cultural expectations that they should find it easy to produce perfectly well-behaved children. Indeed, this also implies a belief or perception that society is less judgmental of conduct problems amongst children of mothers who work outside the home.

However, it is important to note that for these parents, the self-recriminations were qualified and accompanied by an acute sense of bewilderment that they could not identify *what* exactly they had done wrong. While they believed that the quality of parenting could impact upon the child, they did not consider that their own parenting behaviour could account for the child's *level* of conduct problems, especially in cases where they reported that they had other well-behaved children.

> "I feel like a complete failure. Nobody else's kids behave like this. What am I doing wrong? Have I made a complete mess of him? Is that why he's like that?... And then I see the telly and mothers saying, 'Oh my wonderful child, he brings me joy' and I'm thinking, 'Jaysus, what's wrong with me? I can't say that.' (Whispers) I don't like him; I don't even want to be around him." *(Mother [18] of 7-year-old boy)*

> "And you do feel like you're a crappy parent to be needing someone to tell you how to control your own children…You feel horrible when they're your own children, like, why can't I cope with my own children? What's wrong?" *(Mother [4] of 4-year-old boy)*

Four other parents attributed the source of their child's conduct problems to earlier traumatic events in the child's life, such as the fall-out from relationship breakdown or adoption. Ex-partners were generally portrayed as undermining and belittling the parent in front of the child. Thus, parents believed that their child could not handle the acrimony between the parents and, therefore, channelled their confusion, anger and insecurity into aggressive behaviour:

> "Every time he comes back from his Da's, he has tantrums, which could last for days…Like his Dad tells him, 'Your mother's a bitch. She's ugly'. How can a five-year-old handle being told things like that about his mother? And then I know that he does love his Da too. In his head he has to be messed up. He has to be." *(Mother [17] of 5-year-old boy)*

5.2.2.6 Difficulties in the midst of a positive relationship: "*I need some help but overall we're good*"

Three parents appeared to cope relatively well with their child's behavioural issues. While they acknowledged that they needed help with managing their child, they tended to perceive the child's conduct problems in the overall context of a positive relationship with their child. Thus, they tried to focus on their child's positive characteristics and believed, for example, that wilfulness represented the inversion of their child's independent-minded nature. They also tended to attribute benign explanations for their child's tantrums; for example, they tended to interpret a tantrum as frustration at an inability to articulate their annoyance rather than as evidence of deliberate spitefulness. These parents also reported that the use of parenting strategies, such as play, were helpful to some extent. In addition, they appeared to derive much fulfilment from their parenting role which, in turn, helped them to cope with their exhaustion. These three parents felt hopeful about the future and believed that they would learn useful parenting skills that would help them to move beyond this difficult period. While similar to other parents in experiencing some degree of worry as well as wrestling for control and social restriction and judgment, their ability to emphasise the positive aspects of their relationship helped them to cope relatively well with their child's conduct issues.

> "It's the most tiring and exhausting and unrewarding work. But the little things in between the tantrums, the little smiles, the little touches and cuddles, seeing them learning something, that sense will always overshadow the feelings of 'Oh God'." *(Mother [15] of 6-year-old boy)*

> "I'm glad she's able to speak up for herself and that will stand to her when she's an adult. But it makes it very difficult for me now (laughs)." *(Mother [8] of 6-year-old girl)*

Interestingly, all three parents had third level education, had previously worked in a professional capacity and had incomes comparable to population norms. Two of the three were married while one was separated from her husband. However, it is important not to overestimate the potential relationship between socioeconomic status and perceived parental stress, as six other non-disadvantaged parents in the qualitative sample (N=20) reported levels of stress comparable to their socially disadvantaged counterparts (N=11).

5.2.3 Expectations of, and motivations for attending, the IYPP

Most parents reported at baseline that their key objective was to feel in control, to gain compliance from their child without triggering a tantrum, and without resorting to extreme tactics, such as shouting, slapping and locking the child in their room. Most of the parents hoped to get specific advice around various behaviours, including calming the child's hyperactivity in social settings, improving the child's social skills, and establishing a routine whereby daily tasks (e.g. eating, sleeping, and getting dressed) could be performed without undue stress. One parent expressed a desire to know that she was not alone in suffering parenting difficulties and looked forward to talking with other parents. Two participants hoped that the programme would help them to gain more support from their partners whilst two others appeared to expect a diagnosis/assessment of their child's problems despite being told that this was not the purpose of the programme. Approximately one third of parents held medium to high hopes that the programme would help them achieve their goals and that they felt ready to change their parenting approach if necessary. However, two thirds admitted that they felt sceptical about the capacity of a short intervention to change their child's behavioural problems. Indeed, many believed that they had left it too late to seek treatment for their child. As mentioned earlier, four parents had already sought previous help from psychologists and reported that it had had a negligible impact on their child's misbehaviour. Two parents feared that it would be an American, 'hippy-style' programme and expected to feel uncomfortable with that approach. Another worried that the programme would

stigmatise her and her child as having '*mental problems*'. Overall, two-thirds of parents expressed minimal hopes about achieving positive outcomes from the programme.

> "I'm desperate for something to work and if I learn even one thing that'll be better than nothing…I don't expect much (laughs). I've been to psychology and while it's good to talk nothing has ever changed with him. He's just as bold as ever." *(Mother [5] of 5-year-old boy)*

> "I really hope this works. This is my chance to give it my all and if it doesn't work, then I know that it won't be my fault how she turns out." *(Mother [2] of 6-year-old girl)*

> "I hope it's not one of these American 'let's chill with the kids' type of nonsense, you know where the mother is so relaxed and grows string-beans and wears desperate, baggy clothes (laughs). I won't be staying around for that." *(Mother [12] of 7-year-old boy)*

5.3 Conclusion

At pre-intervention, parents typically exhibited helplessness and anger at their child's non-compliant, aggressive and hyperactive behavior. They also reported suffering from anxiety, guilt, family conflict, financial hardship, social isolation and censure as a result of their child's conduct problems. Two-thirds of parents, at baseline, expected the IYPP to offer little in terms of actually changing their child's behaviour although a readiness to change amongst most is notable. Thus, parents presented with numerous issues, and these do not include other challenges in their lives not related to their child's behaviour (e.g. indicators of social deprivation - inadequate housing, unattractive physical environment, unemployment and so forth). The next chapter will investigate the impact of participating in the IYPP, and will examine the key processes/mechanisms by which outcomes were achieved.

CHAPTER SIX - RESULTS II

STAGE ONE: THEME TWO

Perceived benefits and mechanisms of change

A second overarching theme identified within the data related, firstly, to parents' perceptions of benefits obtained from participation within the IYPP, and secondly, to the 'active ingredients' or perceived mechanisms of change of the IYPP. These were explored at the 6-, 12- and 18-month follow-up periods (N=33, N=20, and N=8 for each follow-up respectively). Group facilitators (N=11) and organisational managers (N=5) were also asked to identify what they considered to be the key drivers of successful implementation of the IYPP. A total of five subthemes were identified here (see Table 6.1), each of which is discussed below.

6.1 Benefits obtained from the IYPP

All of the attendee parents reported at the six-month follow-up that their participation in the IYPP produced positive changes in their child's behaviour and in the parent-child relationship. Some of the parents also reported mental health benefits for themselves and improved relationships within their wider family and community. Positive changes in child behaviour were reported for all parents who attended the programme (i.e. for parents who attended more than seven sessions), regardless of pre-intervention expectations or the extent of the difficulties reported at the baseline interview. These findings support the results reported within the RCT (McGilloway et al. 2012a), whilst also illustrating the magnitude of the achievement, especially when compared with the helplessness and despair experienced at pre-intervention. For instance, in terms of child behaviour, all parents reported: improved child obedience; a dramatic decline in tantrums and defiance; developmental progress in conducting age-appropriate tasks (e.g. eating, sitting at table, going to bed); enhanced relationships with siblings; greater capacity to cope with frustration; greater creativity in play; and in five cases (20%), improvements in schoolwork and peer-interactions. Parents also reported a warmer, more trusting and communicative relationship with their child.

Table 6.1 'Perceived benefits and mechanisms of change' and subthemes (N, %)

Benefits obtained from IYPP	Parents	GF [a]	OM [b]
Positive child behaviour	25 (100)	11 (100)	5 (100)
Improved parent-child relationship	25 (100)	11 (100)	5 (100)
Improved child behaviour in school	5 (20)	4 (36)	---
Improved parental mental health	17 (68)	7 (64)	2 (40)
Improved marital relationship	8 (32)	---	---
Better family atmosphere	9 (36)	---	---
Core intervention mechanisms			
Key skills and principles			
Focus on positive attention/relationship building	22 (88)	11 (100)	5(100)
Developing empathy/emotional coaching	13 (52)	5 (45)	3 (60)
Staying calm and problem-solving	16 (64)	5 (45)	2 (40)
Limit setting skills	10 (40)	4 (36)	1 (20)
Increased Confidence			
Non- judgemental support of group	22 (88)	11 (100)	2 (40)
Collaborative and egalitarian nature of group	12 (48)	2 (18)	---
Sense of competence and control	25 (100)	11 (100)	2 (40)
Wider support network	7 (28)	4 (36)	1 (20)
Long-term mechanisms			
Commitment and resilience			
Perseverance despite 'hard work'	12 (60)	---	---
Tailoring and fine-tuning skills to busy lives	13 (65)	---	---
Building confidence	12 (60)	---	---
Using external supports (e.g. partner)	7 (35)	---	---
Recovering from relapse	8 (40)	---	---
Organisational factors			
Fit between IYPP and service provider	---	2 (18)	5 (100)
Intra- and inter-agency support for fidelity	5 (20)	11 (100)	5 (100)
Screening and 'readiness' of parents	---	9 (80)	4 (80)
Proper organisation of parenting groups	1 (4)	11 (100)	4 (80)
Positive impact of research			
Research as refresher course	3 (15)	---	---
Research enhanced fidelity to programme	---	3 (27)	---

[a] GF - group facilitator
[b] OM - organisational manager

> "He's just a different child…no-one can get over it. They wonder where I found him. He does what he's told, there's no whinging, no tantrums anymore. He just plays happily, even on his own, he doesn't always need me…I can't believe how clean my house is now!" *(Mother [21] of 4-year-old boy)*

> "I'm closer to him and I feel like he's actually communicating with me now whereas before he was just lost in his own little world, you know (tremor in voice)…even if the tantrums hadn't improved, that alone was worth to me a million quid because I had a child who wasn't even like my own child." *(Mother [18] of 7-year-old boy)*

Furthermore, over two-thirds of attendee parents recounted many mental health benefits for themselves including a replacement of guilt, worry and depression with a sense of confidence and competence, whilst improvements in physical and psychological health were also noted. In some cases, parents had started to develop interests outside their parenting role. Moreover, a substantial proportion explained that the transferred skills had also benefitted their marital relationships (32%) and wider family dynamics (36%). The programme also appeared to encourage parents (48%) to become more connected to the wider community by establishing closer relationships with other parents in the locality and, in some cases, with the child's school.

Such positive gains appeared to be generally maintained, and in some cases, had even improved at the 12- and 18-month follow-up interviews; for example, further improvements were reported in child social skills and school behaviour. Group facilitators and organisational managers reiterated similar positive outcomes for parents who participated in the IYPP.

> "I feel so much better in myself…I came off my antidepressant medication a couple of months ago as I didn't feel I needed it anymore…I feel in control, much happier, and I don't worry about him anymore. I can't thank that course enough for changing my life." *(Mother [20] of 4-year-old boy)*

> "We're all much better at home – the other kids get on better, my husband and I are less stressed. There is more calm overall. It's great." *(Mother [23] of 5-year-old girl at 12-month follow-up)*

> "I'd have to say that she gets on better with kids her own age now even compared to six months back." *(Mother [6] of 6-year-old girl at 18-month follow-up)*

> "I've made some friends from the course, which has meant that I get out more and am just more involved in the school and have expanded my interests, you know." *(Mother [2] of 7-year-girl at 18-month follow-up)*

> "Most parents who stayed with the programme found that their lives were substantially different: their child's behaviour was improved; they could cope with behavioural difficulties; they were less stressed and felt more confident in themselves…Some parents got on better with the child's school; probably their whole family benefitted." *(Group facilitator 3)*

Interestingly, 4 of the 25 attendee parents who described substantial positive changes in their lives as a result of participation in the IYPP, still reported clinically significant levels of childhood conduct problems on the ECBI (i.e. above 127) at the six-month follow-up period. However, it should be noted that, despite the lack of clinical improvement, these four parents still achieved a considerable reduction in childhood conduct problems, as reported on the ECBI. These results, combined with the interview data, suggest that it was possible for these parents to experience considerable changes in their lives (e.g. acquiring a more positive perspective on their child; achieving some reduction in childhood misbehavior) despite managing a child who, in their view, continued to present with a large number of behavioural problems. The remaining 21 attendee parents all reported non-clinical levels of conduct problems in their children on the ECBI at the six-month follow-up.

6.2 Core intervention mechanisms

Key parenting skills and increased parental confidence were identified by parents, group facilitators and organisational managers as important in producing positive outcomes. These subthemes are outlined in more detail below.

6.2.1 Key skills and principles: *"When I praised the good…the rest fell into place"*

At the six-month follow-up, parents reported that, whilst they found most of the programme content to be relevant, certain positive parenting skills (positive attention through play and praise, reacting calmly and problem-solving and developing empathy through labelling emotions) were more useful than others in helping them to manage their child's behaviour. However, a large proportion of participant attendees (22/25) indicated that the most fundamental insight for them was to learn to focus on their child's positive behaviour (achieved through play and praise), rather than constantly seeking to eliminate their child's negative behaviour.

Approximately half of the parents reported that learning to become emotionally articulate helped them to attune to their child's emotional state in order to understand the feelings of anxiety or frustration that may underlie misbehaviour. Almost two-thirds identified one of the essential skills as learning to react more calmly when their child misbehaved. Although parents valued the effectiveness of play, more than half felt that they would have learned the skill in fewer sessions and that more time could perhaps be

dedicated to teaching problem-solving skills. This was also echoed in the comments of three group facilitators (and one organisational manager).

> "I found that when I praised the good she was doing the rest just fell into place." *(Mother [2] of 6-year-old girl)*

> "I understand his temperament more now. I recognise when he's nervous…He can get all hyper and destructive if he's nervous because he's acting out the feeling he has. I say, "Do you have stress-belly?"...And he'll cuddle into me and say, "Yeah", and he'll calm down and he's happier." *(Mother [12] of 7-year-old boy)*

> "I grasped what they were saying around child-led play very quickly so they could have cut some of those sessions. But then again they kind of rushed through the problem-solving part and I would have liked more time around that." *(Mother [10] of 4-year-old girl)*

> "I certainly think play is a hugely important element of the programme…but I find, and I've delivered the programme myself, that some of the parents want to move onto other elements of it. So maybe there needs to be more emphasis on elements at the end, like problem solving." *(Organisational manager 5)*

Ten parents also indicated that limit-setting skills (e.g. consequences and follow-though, clear commands and 'ignore') were occasionally useful and they were pleased to learn that they could be authoritative with their children without being authoritarian. 'Time out' was generally disliked by parents (18/25) and perceived as difficult to implement; this was also corroborated by several group facilitators. Interestingly, although 80 per cent of parents reported that they were keen to enrol in the programme to seek advice around 'time out' or other disciplinary strategies to deal with their child's conduct problems, all but two related, at the six month follow-up, that the use of skills such as positive attention were so effective that they obviated the need to regularly employ limit-setting skills. Identifying both the critical and less active ingredients of the IYPP is important so that programme effectiveness may be enhanced and refined.

> "I'm glad that my children are confident and happier and it's not about me just controlling them and keeping them in line… I used to think that the odd smack never harmed anyone, would keep them in line…I remember as a child and you were always told, 'Be quiet, sit there' and we were the 'good girls', meant to be from a 'respectable family' and you were afraid to pass your opinion on anything… We were well behaved but we were afraid of our parents." *(Mother [33] of 6-year-old boy)*

> "I don't use the time out. I'm not sure whether I'm doing it wrong but it doesn't work for me…I prefer to use other techniques really." *(Mother [20] of 4-year-old boy)*

> "It's great to have the back-up of warnings and consequences but I find that I rarely need to use them as he's just great now with the play and praise." *(Mother [22] of 5-year-old boy)*

> "Many of the parents in my group didn't particularly take to the time out. Maybe they were getting tired coming to the end of the programme but they seemed to prefer using other strategies." *(Group facilitator 7)*

The value of particular parenting skills was largely corroborated by group facilitators and organisational managers. They similarly believed that consistent implementation of the bottom half of the parenting pyramid (i.e. relationship building between parent and child through play and praise; see Figure 2.2 in Chapter Two) led to the most positive changes in child behaviour and precluded the frequent use of harsher strategies, such as time out and consequences. Relationship building was identified by service providers as the single most effective component and this reportedly differentiated the IYPP from other parenting programmes, such as, the *Triple P Parenting Programme*. These other parenting programmes were described as focusing solely on teaching specific behavioural techniques whereas the emphasis on play in the IYPP, meant that subsequent disciplinary strategies were implemented within the context of a positive parent-child relationship. Interestingly, although both parents and facilitators rated play and praise skills highly, facilitators were more inclined to speak of them in a context of 'relationship building' whereas parents spoke about them in terms of 'looking for the good in the child' (i.e. positive attention). Both perspectives are clearly linked, however, in that positive attention is arguably an important element/subset of relationship building.

Overall, group facilitators commended the manualised and practical nature of the programme for its capacity to teach parents how to implement key skills (e.g. labelled praise) rather than merely encouraging them to praise their children more.

> "The play, the notion of the parent sitting down with the child for as little as ten minutes, the children just love that, that undivided and unconditional time. It's massive and the praise bit. I mean the bottom part of that pyramid is gold-dust. It's massively successful in treating emotional and behavioural problems." *(Group facilitator 4)*

> "I've had other parents who'd done previous programmes and with the consequences bit, the whole thing was, they never worked. With the IY it has worked wonderfully for them because you go in on the relationship level. You're starting where you should be starting from, building the relationship, building a solid foundation." *(Group facilitator 3)*

6.2.2 Increased confidence: *"I know now that I'm a good enough parent"*

At the six-month follow-up**,** all attendee parents reported that participation in the programme had increased their confidence and well-being and helped them to believe that they could cope with any current or future behavioural difficulties. Typically, parents explained that their new-found confidence was based on various aspects of the

group experience; they valued the non-judgemental support received from the group facilitators and other parents, which helped to dispel/normalise parental feelings of guilt and isolation and also affirmed them as being 'good enough' parents. The fact that all of the parents felt relieved at being accepted by others, suggests that, initially, they felt fearful of being judged by taking part in the parenting programme, even though many did not articulate such apprehension during the baseline interview. In such a context, their decision to participate in the parenting programme was shown to be a particularly courageous one.

Another positive aspect of the group experience was the experiential and collaborative learning format of the programme. This helped to establish an egalitarian relationship between the parent and the group facilitator and allowed parents to set their own goals. Other important sources of confidence included the sense of competence and control which all parents experienced in being able to effect positive behavioural changes in their children. Even in cases where some behavioural problems had not improved, a small number of parents indicated that they felt more confident because they perceived the problems in a more positive light. Seven parents also reported that their wellbeing and social life had improved due to the receipt of more support from their wider family network, who were now more willing to babysit as a result of the child's improved behaviour. Thus social support from the parenting group enhanced participant confidence, and also activated a range of unexpected, 'spin-off' personal benefits for parents. Moreover, it appeared that such social support was perceived as being as useful as the taught parenting techniques in achieving positive outcomes.

> "Because you do tend to feel isolated that you're the only one, that your child is the only one acting up like that. …We all really supported each other…I know now that I'm a good parent, even if I make mistakes." *(Mother [25] of 5-year-old boy)*

> "I just feel more confident and competent as a parent. I have a system in place and I know I can help him with any obstacles that may happen in the future." *(Mother [29] of 7-year-old boy)*

> "It was holistic…it wasn't just about your child's difficulties but about you as a whole person and I found that very welcome, being affirmed as a person. It's about taking time for yourself and not always being focussed on the kids." *(Mother [10] of 4-year-old girl)*

> "I've made two really good friends from the course and we talk to each other very often. We really help each other out because we understand what's going on." *(Mother [2] of 6-year-old girl)*

All group facilitators (and two organisational managers) also affirmed the importance of enhanced parental confidence in achieving positive outcomes. They believed that, as a first step, creating an accepting, non-judgmental atmosphere allowed parents to share experiences in parenting a child with conduct problems. Secondly, the support from the group facilitators and other parents appeared to reduce social isolation and depression (also seen in the findings of the larger RCT), thereby enhancing parents' confidence that they would be able to implement the new skills and effect positive change in their child's behaviour. In addition, facilitators believed that more confident parents were better able to cope with obstacles and behave in a more relaxed manner which, in turn, impacted positively on their child's behaviour. Thus, increased parental confidence was viewed both as an important precursor to, and accompaniment to, the effective implementation of skills.

> "I think the group and the power of the people sharing their experiences, it's really powerful stuff. It's our job to create that atmosphere." *(Group facilitator 9)*

> "We were getting individuals who had not spoken about their child to anyone for a long time…So they sit here and hear about other parents' difficulties. It seems manageable and almost normal…Parents get out of this process a feeling of confidence and a belief that they can better handle a situation as it develops." *(Group facilitator 4)*

> "It's an old question: is the change in the child's behaviour or in the parents' attitude towards the child? At the very least, it [the programme] certainly helped parents gain confidence and feel better able to cope. And because they were calmer and more relaxed, it changed the nature of their interactions with their children, and as a consequence, the child's behaviour changes." *(Group facilitator 7)*

6.3 Longer term mechanisms: commitment and resilience

Parents at both the 12- and 18-month follow-up periods emphasised the commitment and resilience required to maintain positive outcomes in the longer term. They reported that these had not been required at the six-month follow-up as their motivation in applying the skills at that stage had been buoyed by the weekly group support and their initial enthusiasm at the scale of the achieved results. Parents showed a commitment to the ongoing implementation of the programme by: (1) persevering in the application, and modification of skills despite the challenges in so doing; (2) utilising internal and external resources; and (3) recovering from a sustained relapse in child positive behavior. Each of these is discussed in more detail below.

6.3.1 The 'hard work' of implementing, modifying and tailoring skills

Five parents (5/20) reported that they had naturally incorporated the skills into their daily lives whereas seven others still found it 'hard work' and had to make an ongoing conscious commitment to implementing the skills lest they would become diluted or disappear over time. The 'hard work' was mentioned, in particular, with regard to the duration of daily playtime with their child, and the time and planning required to devise appropriate rewards and consequences. Four parent participants appeared to apply the skills more in a treatment than preventive sense; in other words, they applied the skills more rigorously when their child misbehaved, but not on a consistent daily basis. Two parents also reported that they were somewhat disillusioned that they still had to work hard to achieve results, and that everyday still represented a challenge, albeit one which they believed they could manage. Indeed, both of these parents still reported a clinical level of conduct problems within their children on the ECBI at 12-month follow-up, thereby corroborating the subjective reports of persistent behavioural difficulties in their child.

> "Sometimes you're so busy, you just forget…you don't realise until you see the kids acting up and you think, 'Oh God, I haven't played with them in ages' or even really praised them in the last week…They usually come around again once I play with them." *(Mother [3] of 5-year-old boy at 12-month follow-up)*

> "It doesn't take effort. It becomes second nature. You just get into the habit of doing it and when you know that that works you stay doing it. Now and again, you might have to stop and think what to do but otherwise no big deal." *(Father [38] of 5-year-old boy at 12-month follow-up)*

> "I think the temptation when you finish the course is to say, 'Right, I've finished the hard work. The kids are fine. That's it now'…You have to be willing to keep learning because no two days stay the same. It's a new challenge every day you get up with the kids…You have to be willing to put the work into it all the time and it will work." *(Mother [28] of 6-year-old girl at 12-month follow-up)*

As a result of the 'hard work' associated with the daily implementation of skills, parents reported that it was necessary for them to tailor specific skills so that they could be assimilated into their busy lives. For example, play time was re-defined by many parents as 'spending time' with their children on daily tasks and activities rather than sitting down with their child on a daily basis for twenty minutes to play a game (as advised in the programme). In addition, parents with heavy workloads reduced the time dedicated to one-to-one playtime. As an alternative, they said that they had learned to appreciate how small moments of time could be spent with their children; for instance, they could play a game with their child in the car on the way to school rather than just listen to the

radio. Furthermore, a few parents alluded to the difficulty in finding individual playtime for all of their children and so they had discovered that it was better to play with them altogether and then give each of them a minute or two on their own every day.

The importance of fine-tuning and tailoring skills was underlined at the 18-month follow-up when three parents who had previously reported the implementation of the skills as 'hard work', had subsequently learned how to make this process easier. For example, two of these parents had become more flexible with regard to when, and for how long, they played with their child, such that they were more adaptable in balancing the needs of the child with their own needs depending on the situation. Thus, at the 18-month follow-up, most parents (6/8) were more likely to have integrated the skills more naturally into their lives. They had also become increasingly fluent in knowing which skills to use in which situation. It should be noted, at both the 12-and 18-month follow-ups, that parents emphasised the effectiveness of key skills that they had highlighted at the six-month follow-up, such as empathy, positive attention through play and praise and maintaining calm in response to child misbehavior. Overall, when compared to the six-month interview, parents at the later follow-up periods appeared to have gained a broader perspective of their child and tended to understand instances of misbehaviour within the context of the whole child, whom they viewed as being generally well-behaved. Furthermore, due to their increased expertise in identifying antecedents for child misbehavior, they also placed a greater emphasis on problem-solving and problem-prevention skills than reported at the six-month follow-up period.

> "I spend some time with her every day. It doesn't always have to be play. It could be cooking or gardening. We do that all the time. She helps me looking after the vegetables." *(Father [39] of 5-year-old girl at 12-month follow-up)*

> "In your mind it takes up a lot of time but in actual reality it doesn't. And I would be fobbing them off all the time, 'I will in a minute', 'Just let me do this', 'Just let me do that', thinking, 'I don't have the time'. But it's just saying, 'Right. Do it'… I had thought that she wouldn't be happy with less than 20 minutes but now if I say, 'I have ten minutes', she is actually quite happy with that." *(Mother [6] of 6-year-old girl at 18-month follow-up)*

> "She has definitely changed a lot, so much in the last year. So much more loving and confident. And it's all down to the way I've changed in relation to her. Instead of condemning her and complaining about her, I see all the good things that she has done and that has just put everything into perspective. She doesn't have to be perfect all the time…And when some little bad behaviour creeps in, I think, 'What is going on here? What do I need to do?' and when I understand what is going on, like I figure out what is causing her rattiness. And I think is it because she needs reassurance or approval, and I know then whether to praise her, use a star chart, just spend some time with her, or whether to use consequences." *(Mother [2] of 7-year-old girl at 18-month follow-up)*

As well as tailoring the skills to suit their lifestyles, parents reported a need for ongoing modification and improvement of the skills that they had learned. For example, three participants reported that, as their children got older, they had learned to replace sticker charts with more age-appropriate rewards. Furthermore, some parents also recognised that, while they may have improved in many respects, they still needed to practise certain skills.

> "Just because you might be a million times better than before, you might still have a bit of work to do around a certain theme. And sometimes I question, 'Am I being a harsh parent?'…It's tough…but it's worth it because your child is only going to turn out how you helped it." *(Mother [37] of 6-year-old boy at 12-month follow-up)*

> "You do have to change the rewards and follow through consequences as they get older…like star charts don't work with my eight year old anymore but a reward of an hour of football will. It's not a big deal for me…I've heard some others in the group say, 'You need a different programme for older children' but I'm confident that I can use the same principles even when they're teenagers. They work with my husband and others in my family." *(Mother [12] of 8-year-old boy at 18-month follow-up)*

6.3.2 Utilising internal and external resources

In order to maintain positive outcomes in the longer term, particularly in the absence of the weekly group support, it appeared necessary for parents to further develop their own internal resources. For example, parents (12/20) recounted that the sense of confidence and self-acceptance that they had developed in being a 'good enough parent', had allowed them to move on from mistakes and had acted as a buffer against what they perceived to be a judgmental and neglectful society that encourages parents to feel guilty and isolated when they encounter parenting difficulties. For some parents, important external resources for maintaining (and sometimes improving upon) positive outcomes included having a supportive partner, family or friend(s); benefiting from an improved social support network (through staying in contact with parents from the group); and developing interests and an identity aside from being a parent. In relation to the last of these, two parents reported an improvement in their child's social skills at the 18-month follow-up, which compared favourably with the child's reported social skills at the 6- and 12-month follow-up interviews. Such progress was attributed to the parents' increased engagement with the local community, which meant that their children had more opportunities to meet other parents and their children.

> "It's so easy to feel on your own as a mother and that everyone has it sorted but you. Other people can often be full of lecturing or pretending their kid has no problem so it's hard not to feel judged…I learned to appreciate myself in the group whereas before I thought I was a

terrible parent… You learn to move on from mistakes and don't dwell and stress about them." *(Mother [24] of 7-year-old boy at 12-month follow-up)*

"He's [her partner] very good now. If there's a difficulty we try to sort it out some way or another. We sit down and plan it and use our brains…If one of us is stressed out, the other can step in so the two of us share the responsibility in handling the kids… I am very fortunate, I know." *(Mother [34] of 6-year-old boy at 12-month follow-up)*

"We keep in touch, four of us, to see, 'How are you getting on?'…It's just even if somebody has had a bad day that you can call each other and have someone listen to you. Instead of going off to their sister or mother and sounding off on them and getting really angry with them because they don't get it whereas we've all been on the course and can say, 'Well, did you try this?' and you might just have lost sight of that during a bad couple of days." *(Mother [32] of 6-year-old girl at 12-month follow-up)*

"They have been fantastic all summer, even better than last time [previous 12-month interview]…And so much more social…it's because I have being out and about more and doing things for myself [courses] and it has snowballed…You do a course and then you get chatting and that leads to another and another. I've gotten to know so many people around the village that she's gotten familiar with their kids and is not afraid to hang around with them anymore.." *(Mother [23] of 5-year-old girl at 18-month follow-up)*

6.3.3 Recovering from relapse

The resilience and commitment to the programme of some parents (8/20) was severely tested when they experienced a sustained period of relapse (ranging from one to four months) in child positive behavior between the 6- and 12-month follow-up phases (More details on reasons for this relapse can be found in Section 7.2). However, it is reassuring that all but two of this group (6/8) had managed to reinstate positive outcomes for their children at the 12- and 18-month follow-up periods. Key indicators of the successful recovery of parenting skills included: overcoming feelings of guilt and worthlessness through willpower and self-empathy (i.e. through allowing oneself to make mistakes and move on from them); self-efficacy beliefs derived from previous successes in implementing the programme; and being proactive in seeking support from kin and group facilitators. The first two factors appeared to be most instrumental in restoring positive outcomes, which suggests that parents experiencing difficulties generally did not seek external support.

"And I mean at the end of the day it's taught me that if something happens you just say, 'Ok, forget it. Let's move on'. Rather than always concentrating and dwelling on their bad behaviour and your bad behaviour and beating yourself up inside, to just move on…not doing the programme for a couple of months can't be an option again." *(Mother [30] of 5-year-old boy at 12-month follow-up)*

"I was so guilty that I had gone back to the bad old ways… Things were crazy here [parent had started work and husband was ill] and I let it all go… It seemed easier in the short term but I knew I was damaging their confidence…Deep down, I knew I had it inside me to get it back because I'd done it before. I say nearly four months passed before I got myself

> together…I've been doing it right for six weeks now and the kids are better, although I don't think they trust me fully yet." *(Mother [3] of 5-year-old boy at 12-month follow-up)*
>
> "I was very lucky my family were around and could fill in as 'parents' when I was emotionally AWOL since the baby...[died]…It was still hard for him [her child] but not as bad as if I'd had no support." *(Mother [12] of 8-year-old boy at 12-month follow-up)*

Some parents also demonstrated a tough, proactive attitude in dealing with difficult situations; for example, those who believed that their child's behaviour was negatively influenced by an unsupportive environment (despite the parents' continued application of parenting skills), reported that they succeeded in recovering the situation by: minimising the contact that their children had with their ex-partners; investing greater effort in conscientiously implementing skills on a daily basis; and trying to educate their partners or schools (with some success) about positive management techniques:

> "He's brilliant now because he's here with me and he hasn't been going to his Dad that much." *(Mother [19] of 6-year-old boy at 12-month follow-up)*
>
> "He went backward with the new teacher…I talked to the teacher about being positive, you know praise and rewards and to ignore, and I think it's beginning to work now. He has less report cards coming home." *(Mother [31] of 6-year-old boy at 12-month follow-up)*

Thus, the long-term experiences of parents may be divided into four categories, i.e. (1) those who easily assimilated the skills into their daily lives; (2) those who maintained the skills with hard work and minor relapses; (3) those who recovered from a sustained period of relapse in child behaviour; and (4) a small number who did not recover from such setbacks (see Table 6.2). Overall, the majority of parents demonstrated considerable resilience and commitment to the longer-term implementation of the programme, despite interim difficulties and relapses (See section 7.2 for more details on reasons for relapses).

Table 6.2 Experiences of parents at long-term follow-up

Group	Description	N (%)
Group One	Easily assimilated skills	5 (25)
Group Two	Maintained skills with hard work and minor setbacks	7 (35)
Group Three	Suffered major relapse but reported recovery	6 (30)
Group Four	Did not recover from major relapse	2 (10)

Lastly, as shown in Table 6.1, neither the group facilitators nor the service managers spoke about the long-term experiences of parents who had participated in the IYPP. However, they did display an awareness of the issue. For example, one group facilitator did briefly wonder whether or not parents were coping well without group support. In addition, one manager spoke about the feasibility of establishing a post-course support service for parents. Moreover, two parents at the 12-month follow-up indicated that they had recovered from relapse by obtaining support from their group facilitator.

> "People get a lot of intensive contact and support and then all of a sudden it's gone…Parents are always nervous about it and obviously we should be preparing them for that at the end. I'm not so sure whether you should make a few contact calls after. You don't want to be, 'Oh, you can't survive without the programme' but I'm just conscious about it…We do leave them our number to contact us if needed but is that enough, I don't know." *(Group facilitator 11)*

6.4 Organisational factors necessary for effective implementation

Group facilitators and managers identified several organisational components which they perceived to be necessary for successful implementation of the IYPP. These included: (1) 'goodness of fit' between the IYPP and the ethos of the service provider; (2) intra- and inter-agency support required for achieving programme fidelity; and (3) lessons learned in delivering the programme, such as screening for suitability of clients and careful attention paid to group composition.

It is important to note here that, while this chapter focuses on identifying the 'active ingredients' of successful implementation of the IYPP, useful linkages may also be made between this current section and the implementation challenges presented as part of Theme Three (e.g. Sections 7.3 (Retention issues); 7.4 (Fidelity challenges) and 7.5 (Sustainability issues)). Furthermore, the findings from Stage Two, which presents the quantitative assessment of various aspects of IF, are also relevant. These relationships will be further discussed and integrated in the next Results chapters and in the Discussion.

6.4.1 'Goodness of fit' between the IYPP and the ethos of the service provider

All of the five managers, and two of the group facilitators, reported that the effective implementation of the IYPP relied on its ability to match seamlessly with the objectives of the service provider. Managers chose the IYPP predominantly because they could use it as a preventive and/or targeted strategy within the context of their agency. For example, the Social Work agency utilises the IYPP to prevent children from being placed in state care. Similarly, the HSE Parenting Clinic, the community group and the family resource centre each employ the IYPP as both a preventive and targeted approach for families in trouble. Other agencies that target school completion in disadvantaged areas deliver the IYPP to parents of children who are experiencing school attendance difficulties. Thus, according to interviewees, the IYPP is a flexible programme that can function well in different settings. Indeed some managers reported that their agency now ran more smoothly and effectively as they had mainstreamed the principles of the IYPP across different services within their organisation.

Furthermore, the IY series was selected by service managers because its suite of interventions, aimed at parents, teachers and children, was compatible with the goals of the different agencies to provide a comprehensive, multi-setting support for vulnerable children. Moreover, the IYPP was selected due to its substantial evidence base, the easy-to-use manualised nature of the programme, the provision of essential information on implementation and costs data, and its approach to tackling barriers to retention. Lastly, and importantly, each service manager reported that they currently had sufficient resources to implement the programme with fidelity.

> "The service we provide here is quite unusual in terms of social work because we're geared very much towards working preventively with children and families to help parents improve their parenting skills, to prevent children coming into care and that's where the Incredible Years fits in…it has really benefited the service." *(Organisational manager 3)*

> "Everyone can see the value of it [IYPP)…it has increased job satisfaction for everybody, the seamlessness that's operating…not all of the staff have done the training yet but with the communication amongst ourselves, everybody on the team understands the principles and we've been utilising those principles in all aspects of our work because they're totally transferable. And that's really useful that we're all operating from a similar base." *(Organisational manager 1)*

> "We felt a lot of the previous work we'd been doing in the partnership wasn't impacting enough and we investigated other programmes and got in contact with Archways…I think the primary benefit of this programme for us is that we can strengthen the relationship between the parent and the child and I think that has the effect of strengthening the relationship between the parent and the school…It helps the young person stay in school." *(Organisational manager 5)*

6.4.2 Intra- and inter-agency support for achieving programme fidelity

Organisational managers stressed that internal and inter-agency supports were vital for achieving implementation fidelity, in terms of the provision of childcare, meals, supervision, training of facilitators, and referral and funding streams. In particular, both group facilitators and managers reported that on-site crèche facilities were essential to reduce programme attrition, a point that was reiterated by some parents. Three of the agencies provided on-site crèche facilities whereas two reimbursed parents for their childcare costs. Both parents and group facilitators reported that the latter strategy was often unsatisfactory as babysitters could occasionally fail to appear. The managers in both the social work and family resource centres indicated that they committed a lot of internal wrap-around services in order to ensure that parents could actually attend the IYPP; for example, family support workers within their centres would call to parents who had missed a session, or they would occasionally help parents get their children up for school in the morning and bring the parent to the programme. In addition, other services within these agencies, such as family mornings, assisted the referral process as they provided easy access to parents who might be suitable for the IYPP. Thus, it is important to note that agencies within the RCT differed in their capacity to offer internal wrap-around support services[13], which may potentially have affected the recruitment and retention of parents within these organisations.

[13] 'Wrap-around support services', in this context, refer to the services available to some agencies which support the implementation of the IYPP. These services included, for example, family support workers, home visitors, and family support mornings. In other contexts, a 'wrap-around intervention' can refer to a multi-component service (Burchard, Bruns & Burchard, 2002); for instance, the suite of the IY parent, teacher and child programmes may be defined as a 'wrap-around intervention'.

Overall, managers reported that a considerable level of organisational commitment was required to co-ordinate services and staff in order to ensure the optimal delivery of the IYPP within their agency. The general consensus was that such allocation of resources was worth the effort as they believed that it was a highly effective intervention for families. However, a couple of group facilitators were concerned that the implementation of the IYPP impinged upon the optimal delivery of other services within their agency (See Section 7.5 for more details on the future sustainability of the programme).

> "The IY has looked at the bigger picture. You need to have childcare and to offer food if you want it to work. If you take on the IY, you have to take it on wholly; you can't take on bits of it. Fidelity is hugely important and I think once you get that into your head and into your brain, the organisation, that is how it's meant to be done." *(Organisational manager 4)*

> "The time and commitment to developing it, making it part of how the agency works, that this is another service we're going to do. We're not going to do it one term and then it's gone again. This is what we're going to do from now on and we need to find ways of doing it. A lot of planning and work in the early stages to get all our services working together. Not so much an issue now." *(Organisational manager 2)*

> "We'd love to have it that when the programme was running, that there automatically is childcare there…We give out babysitting money but it's not enough…I know parents have dropped out because there's too much stress about who is going to mind the child." *(Group facilitator 7)*

> "I don't have a car so I couldn't have come to the course without the taxi. And who could have minded her [her child] if there had been no crèche? I couldn't have done it without those supports." *(Mother [1] of 4-year-old girl at six-month follow-up)*

Both group facilitators and managers indicated that fidelity could not be achieved without regular supervision (group facilitators received fortnightly supervision during programme delivery from a certified IY trainer, in which videotapes of group sessions were analysed). In general, facilitators focussed more on the benefits of supervision whereas the managers spoke about the external inter-agency supports required to attain regular supervision. Facilitators reported that supervision helped them to review and plan for the next session, facilitated learning from mistakes and working with resistant parents, kept them focussed and energised, and provided support and encouragement. Supervision also helped to ensure that facilitators maintained/acquired all the requisite skills and attributes for quality delivery, including: a commitment to programme principles, compatibility with the co-facilitator, being caring and supportive, possessing adept problem-solving skills and having a sense of humour. Facilitators also recounted how the delivery of an intensive programme to many troubled parents can be

emotionally draining and that supervision provided a reflective and open 'space' or forum for resolving issues. One key issue that emerged for all facilitators concerned the need to balance delivery of the content within a session (i.e. with fidelity) with the capacities of the parents to receive all of the information. However, from observing videotaped recordings within supervision sessions, it was clear that all group facilitators were skilled in addressing parents' individual issues while also staying 'on topic'. Typical strategies appeared to involve using a more goal-oriented approach with parents rather than one overly focussed on exploring past and present feelings; and also through selecting key vignettes (rather than show all prescribed vignettes) to illustrate a principle so that parents were not overwhelmed with content.

> "Supervision helped us work through resentment with resistant parents, to stay empathic with them, so much help all round." *(Group facilitator 5)*

> "It was really great because we learned how others dealt with fitting in all of the recommended content and yet stay attuned to parents' needs. Like you can't decide not to listen to a parent crying because our schedule says we should now be showing them this and that DVD. It's a constant challenge – balancing fidelity with sensitivity to the real time needs of parents." *(Group facilitator 9)*

> "Our supervisor gave us the confidence to be flexible in picking out the best video to show…We had been tearing our hair out with trying to show all of the vignettes and it was just not possible in the time." *(Group facilitator 2)*

Managers were very appreciative that the involvement of their staff in the RCT process had provided them with externally funded supervision by experts in skills-based parenting (e.g. certified trainers in the IYPP). However, despite their involvement in the research process, it was also necessary for organisations to develop relationships with other services engaged in IYPP delivery, so that they could provide peer supervision and training to each other. Such peer supervision was perceived by group facilitators as being very helpful and indeed, it continued beyond the completion of the RCT. Interestingly, three of the managers indicated that they were aware of staff in other services who had delivered the IYPP without supervision and that such an approach had resulted in high attrition, unmotivated staff, and eventually, a discontinuation in programme delivery.

> "We've got all our supervision courtesy of the research…but we're going to have to look at this…We have staff practising out there, we need our own peer-support systems set up. We need to ensure, and this is something I push [for] with meetings with managers and so on, they've got to go through the consultation days, they've got to hand in their tapes, they've got to have supervision to ensure programme fidelity." *(Organisational manager 1)*

All of the managers also maintained that inter-agency support was important in improving referral and funding streams across agencies. Indeed, overall, it appeared that quality implementation of the IYPP necessitated the development of inter-agency relationships among children's services within the Dublin/Kildare region. Such inter-agency co-operation is significant as it is often associated with earlier referral and more positive outcomes for families (Statham, 2011). A number of parents reported that they believed that the future implementation of the IYPP could be further enhanced by improving early referral among agencies, such that more public health nurses, pre-schools and national (primary) schools were informed about the programme.

> "We informed many groups about our service and said, 'Look, we're doing this now'…More agencies know we're delivering the programme and word gets around…Agencies are referring people to us and they have some knowledge of the programme itself so parents are more confident about what they are being referred to." *(Organisational manager 3)*

> "All public health nurses should know about this programme. They can see if the parent is struggling and tell the parent about it…People shouldn't have to suffer for years just because professionals don't know about it. They should know about it." *(Mother [43] of 6-year-old girl at 12-month follow-up)*

> "We always have to be on the lookout for funding…It involves establishing relationships with several different organisations that will fund us." *(Organisational manager 4)*

6.4.3 Other lessons learned: Appropriate screening and organisation of parenting groups

Four managers reported that they had learned the 'hard way' that it was necessary to screen parents for readiness before they started the IYPP. They were at pains to point out that, in order for the programme to be effective, parents needed to demonstrate motivation and commitment at the outset and throughout the programme, to take responsibility for any change, and preferably to be self-referred. Two of the services operate a case-management approach in assessing the suitability of parents for the programme. All four managers maintained that the socio-economic background of the parent did not necessarily impact upon the outcomes achieved, but it was important that parents were able to complete the programme and were not overwhelmed with other issues, such as drug and alcohol problems. These managers believed that some services had incorrectly perceived (and promoted) the IYPP as a panacea for all social ills, which inevitably led to high attrition rates. These interviewees also believed that establishing a pre-programme relationship with the parent led to better attendance, and that merely

sending out letters to parents, without establishing a prior relationship, typically resulted in only 50 per cent attendance at the first session.

> "We work with parents beforehand to ensure that we have selected a group of parents that will be able to complete the programme. Sometimes the programme has been misinterpreted as solving all crisis situations, not just behavioural ones." *(Organisational manager 2)*

> "The approach that we use here in the Incredible Years is trying to build relationships, working off a community-based initiative, in the sense of going into the community and calling out to parents…It's significantly different from how other parenting programmes are implemented around here…They're delivered with a practice of 'we write to people, we invite them to a parent programme'. Now you invite ten people to a programme and maybe five turn up. You hope that they might return to the next session. Whereas we're dropping out to people's houses before the programme starts. We pop out if there is a problem. That doesn't happen in other programmes here and their attendance is less than 50%." *(Organisational manager 5)*

All managers (and some of the group facilitators) indicated that they had learned from experience that it was also important to organise the groups properly. Thus, they advised: (1) that the parents within the group should all have children of a similar chronological or developmental age; (2) that groups were more dynamic if parents were of varying socio-economic backgrounds and if the group was composed of between 8 to 12 parents; (3) that preferably parents should not know each other before the programme; (4) that delivering the programme in the school-term ensured higher attendance; (5) that evening courses encouraged fathers to attend; and (6) that better outcomes were achieved if the partner was also present. In addition, two managers asserted that providing too many individual 'catch-up' sessions to absent parents did not encourage group attendance and, moreover, was a drain on the resources of the organisation. Currently, one service manager was exploring whether it would be feasible for the organisation to provide post-course support for parents.

> "We're very conscious that within a group that parents have kids roughly in the same age range…There's got to be a commonality to the experience so that they're getting the same kind of concepts…We also look at the developmental age as well as the chronological age…a number of our parents come from areas where they're dealing with a number of very difficult social issues so we're always thinking that the child could be developmentally delayed by their environment." *(Organisational manager 3)*

> "A group of over 12 parents is probably too large…means parents can drop out because they're not getting enough individual attention and very stressful for facilitators…A group of six or less can easily turn into a counselling session and there's less learning." *(Group facilitator 9)*

> "We had thought that 'catch up' sessions were important, that if a parent is not able to attend for whatever reason, the facilitator will either go to the parent's home or they come here [the centre], for fidelity, you know, the parent won't miss out…But we're finding that these parents are thinking that they don't need to come to the group, as long as they get the

information, and the group experience is very important also…It places a lot of extra work on us here…we're not so sure about the 'catch up' sessions anymore." *(Organisational manager 1)*

6.5 Impact of the research process on outcomes and programme delivery

Findings from previous studies suggest that participation in research may potentially enhance the therapeutic effects of an intervention (Eames et al. 2009; Hawe et al. 2004b). Within the context of this study, three parents spontaneously reported that they believed the research process (i.e. both the completion of quantitative assessments and participation in the qualitative interviews) had helped them to reflect on their parenting practices and had helped them to gain more understanding and benefit from what they had learned on the programme. In addition, several of the group facilitators reported that the research had improved their delivery of the programme through its emphasis on fidelity and the provision of expert supervision. Certainly, a commitment to fidelity and supervision represents part of the 'normal' implementation of the IYPP; nevertheless, group facilitators emphasized that the monitoring involved in the research process enriched their learning from supervision and improved their delivery of the IYPP. Moreover, they stated that the research interviews gave them an opportunity to reflect on their practice, which they found helpful.

It is possible, of course, that some level of social desirability was present in the responses, but it appeared that this point was stated in a deliberate, rather than off-hand manner, as if they had reflected meaningfully on the issue. It should not be concluded, however, that the IYPP is normally delivered less competently when not subjected to a research evaluation as other findings indicate that the research process may also have inadvertently impinged upon programme outcomes. Further information on this is provided within 'Fidelity challenges' in Chapter 7, Section 7.4.2:

"The research actually has been very good because it's made me reflect on the course and that makes you understand it more. It focuses you a bit more and has helped keep me on track…It's almost like a refresher course because you're kind of recapping on what's been happening in the last six months in each case so that's been quite good actually." *(Mother [33] of 7-year-old boy at 18-month follow up)*

"I think we were all more honest about our paperwork, we got great supervision and made more appropriate use of it. I'm not so sure that we would have learned so much if the research hadn't been part of the process." *(Group facilitator 5)*

The interviews that were conducted as part of the process evaluation were also perceived as useful in improving the delivery of the IYPP to the second cohort of parents in the RCT. For instance, two parents from the first cohort informed the researcher that they had not been reimbursed for childcare expenses and as a result, were unable to afford to attend the last few sessions of the programme. The researcher relayed this message to the research team and to the service provider so that such oversights would not recur with the second cohort of parents. Furthermore, the group facilitators informed the researcher in their first interview that they were unhappy that the RCT had impinged upon the time they usually devoted to establishing a pre-programme relationship with parents. As a result, the research team made every effort to randomise the participants within the second cohort at an earlier date in order to give the group facilitators more time to make contact with the intervention parents.

> "I couldn't attend the last few weeks as they hadn't paid me for the babysitter for at least three or four weeks. I hadn't the money upfront. I said it to them in their office and the money was meant to be there every week but it wasn't…I'm glad that it was sorted out for other parents as it actually stopped me from going to the last three weeks." *(Mother [40] of 5-year-old girl)*

> "We had a small bit of extra time to make contact with the parents before the programme started, which was some help. So the research team obviously learned lessons along the way as well." *(Group facilitator 2)*

6.6 Conclusion

In line with MRC guidance (MRC, 2008), this chapter identified the key mechanisms that were perceived as contributing to positive outcomes. Understanding the 'active ingredients' of the IYPP is critical for mainstream replication, and particularly from both organisational and long-term perspectives on which little research, to date, has been conducted. Furthermore, the reported benefits support and extend those reported in the larger RCT (McGilloway et al. 2012a). For instance, this analysis produced evidence of positive changes not examined in the RCT, including the child's school behaviour and performance; enhanced family/marital relationships; and parental community engagement. These findings will be critiqued and discussed in more detail in the concluding chapter. All of the participants also experienced a range of challenges in implementing the IYPP and these findings are presented in the next chapter as part of the final overarching theme to emerge from these results.

CHAPTER SEVEN - RESULTS III

STAGE ONE: THEME THREE

Challenges in programme implementation

Whilst all attending parents reported that they derived considerable benefits from the programme, a number of potential barriers to programme participation and success were also identified. These included short-term challenges (e.g. discomfort with the principle of positive attention and praise) as well as longer term challenges at the 12-month follow-up, related to sustained relapses in child positive behaviour. Retention issues, fidelity challenges and the future sustainability of the IYPP were also key subthemes identified here (see Table 7.1). Each of these is discussed below.

7.1 Short-term challenges for parents: Difficulties in learning and implementing skills

It would be expected that programmes, such as the IYPP, would present participants with challenges (to a greater or lesser extent) at various junctures throughout and following the intervention period. This section considers the short-term challenges for parents including: discomfort with the principle of positive attention and praise; living in a community with high levels of antisocial behaviour; increased conflict at home with partners in implementing the new skills; and fears that without the group support, parents would return to their old parenting style.

7.1.1 Difficulties with positive attention and 'positivity': "It's a very 'Irish' thing…"

Approximately half of the parents (13/25) reported that, during the initial sessions, they were puzzled as to why the programme focussed on paying positive attention to their child and did not provide them with guidance on how to deal with negative behaviour. The emphasis on positive attention appeared to be inconsistent with their 'informal' theories of successful parenting (e.g. negative behaviour should be punished immediately and not ignored) and, as a result, they found the programme to be overly positive and unrealistic and believed it would not be helpful in eliminating behavioural problems.

Table 7.1 Respondents who alluded to 'Challenges in programme implementation' and associated subthemes (N, %)

1. Short-term challenges	Parents	GF [a]	OM [b]
Difficulties with Positive Attention			
Cultural difficulties with praise	13 (52)	4 (36)	---
Disliked positivity of vignettes	20 (80)	7 (64)	---
Personal difficulties with play & praise	2 (8)	---	---
Lack of social support			
Antisocial peer influence	11 (44)	---	---
Conflict with partner	11 (44)	3 (27)	---
Fear loss of group support	11 (44)	1 (9)	---
2. Longer-term challenges			
Relapse in child positive behaviour			
Relinquishing skills in stressful times	4 (20)	---	---
Unsupportive environment	3 (15)	---	---
Perceived ineffectiveness of skills	1 (5)	---	---
Unknown reason for relapse	1 (5)	---	---
3. Retention issues			
Multiply disadvantaged parents	---	4 (36)	---
Parental attitudes	3 (38)	9 (82)	---
Negative impact of research process	---	10 (91)	---
Dislike of aspects of the programme	3 (38)	9 (82)	1 (20)
Other factors [c]	8 (100)	10 (91)	---
4. Fidelity challenges			
Lack of organisational support	---	11 (100)	---
Research affected fidelity	---	10 (91)	---
Stress of delivering new programme with fidelity	---	11 (100)	---
5. Programme sustainability			
Sustainability challenges	---	11 (100)	5 (100)

[a] GF - group facilitator (n=11)
[b] OM - organisational manager (n=5)
[c] Other factors include circumstantial reasons, lack of on-site child care, intrusion of privacy and seeking alternative treatment to the IYPP

Four fifths of the parents also found the vignettes to be too 'American' in tone and overly positive. Almost two-thirds of the group facilitators (64%) also reported that parental scepticism about the utility of the principle of positive attention, as well as

some discomfort with the American tone of the vignettes, may have led to some early attrition from the programme.

> "I think, at the start, that it comes across as a bit fluffy…I wasn't sure at the beginning that they would be dealing with more of the nitty-gritty…the time-out and the discipline. The positive thing doesn't make much sense at first…it seems too 'happy clappy'." *(Mother [10] of 4-year-old girl)*

> "They [the vignettes] were somewhat contrived…A woman on my estate dropped out because she thought, 'This is just silly nonsense, all happy smiling'... It was like watching the *Cosby Show* and I think it's distracting and you have to get past it. I think Irish people would find it hard to relate to them." *(Mother [30] of 5-year-old-boy)*

> "I remember two parents in particular who did not react well to the 'American' style of the DVDs. Although we explained the principles to them, they didn't come back the following week." *(Group facilitator 2)*

Thirteen parents further recounted their discomfort that praise and rewards might cause their children to become overbearing and arrogant and this was seen, in some ways, as culturally inappropriate. This cultural specificity is an interesting finding and highlights the need for service providers to be sensitive as to how the principles of the IYPP may be received by parents from differing child-rearing traditions.

> "It's a very 'Irish' thing not to give or accept praise…You know there is this thing: are you making them big-headed, are you making them cocky, are you giving them too much confidence?...I know it works now…but at first when you praise them, it was really odd, awkward." *(Mother [6] of 5-year-old girl)*

Furthermore, two parents experienced resistance towards praise, play and the generally positive relationship they were now building with their children because they felt envious, upset and angry that they had been treated harshly and had not received similar positive attention from their own parents. Both of these parents chose to attend counselling as they felt that they could not participate fully in the programme if they did not deal with their unresolved childhood issues. Eight other parents spontaneously reported that the course had caused them to reflect on their own experience of being parented, although this was often expressed in a manner that suggested they were fearful of appearing disloyal to their parents. However, at the same time, their own personal history did not appear to impede their ability to implement the skills with their own children; rather they were grateful that the intergenerational cycle had been broken.

> "I think I would have given up the course if I hadn't had the counsellor because it was too much at one point…I was jealous of the kids…And I think a lot of parents there haven't had

> the perfect upbringing and I think there's certain things that could come up out of the course that could upset a lot of people." *(Mother [29] of 6-year-old girl)*
>
> "My parents are wonderful people and I'm not saying that I didn't have a good childhood but the course does things differently…My parents didn't know any different…I didn't want to smack my kids like we were so it's great now that we don't have to do that anymore to keep control…I know they'll have a closer relationship to me because of it." *(Mother [3] of 4-year-old boy)*

7.1.2 Skill maintenance and lack of social support

Three fifths of the parents in this study were living in disadvantaged communities and, as a result, many of them felt unsupported in implementing the skills that they had learned. For instance, approximately half reported that, while they could create a positive environment within their own home, their children were routinely exposed to high levels of antisocial behaviour in their wider neighbourhood which, in turn, impacted negatively on their child's behaviour:

> "This place is overrun with drugs and gangs…It is a horrible place to raise your children. I don't personally allow my children out to play unless I'm there to supervise because there's children and they're as young as four and five and they are bullies. It is hard." *(Mother [32] of 6-year-old girl)*

A similar proportion of parents reported a lack of support and increased conflict with partners or ex-partners due to the introduction of new behavioural management techniques in the home. All but five of the parents indicated a preference for their partner to attend the programme, but most were unable to do so due to work or childcare obligations, although some partners were also resistant to the idea of a parenting programme in the first place. The majority of parents reported, at the six-month follow-up, that most conflicts were resolved once partners had witnessed the benefits of the programme for themselves. However, a small number (N=4) reported that, although their partner was less antagonistic than before, they still unwittingly caused confusion for the children as they did not implement the new techniques. Similarly, some of the group facilitators reported that, even when partners were supportive, there were difficulties in implementing the techniques in a consistent manner:

> "We had several rows about it…It's hard to teach your partner the techniques you've learned in the class without sounding like you're the know-it-all…But now he sees the difference hugely with the kids and I find now that he's copying everything I'm doing and it's all happier all round. I got him onside…eventually (laughs)." *(Mother [23] of 5-year-old girl)*
>
> "He often bulldozes through my system of rewards and consequences. He doesn't mean to but it's annoying." *(Mother [26] of 6-year-old girl)*

Approximately half of the parents reported that, without the group support, the daily implementation of the skills was 'hard work' and required much conscious effort, time and organisation on their part (This aspect was also outlined with regard to longer-term experiences in Chapter 6.3.1.). As a result, they feared returning to some of their previous parenting approaches; these parents indicated further that they would benefit from a refresher course in order to re-motivate themselves.

> "I have to make a big effort to keep it in my head, to keep the awareness of the techniques, or not I would let it go…I definitely miss the group…it kept me focussed…It's quite a short, sharp burst as well. It's 14 weeks after a lifetime of the other way of parenting." *(Mother [14] of 6-year-old girl)*

> "I'd love to meet once every so often just to remember how to do the skills right and just to get that support, you know." *(Mother [15} of 6-year-old boy)*

7.2 Longer term challenges: relapse in child positive behaviour

Little is known about the challenges in maintaining programme benefits in the longer term. Unfortunately, some of the fears reported by parents at the six-month follow-up were realised in the longer term. Six months later, 8 of the 20 interviewed parents (40%) reported that their child's behaviour had relapsed considerably, albeit varying in intensity and duration (ranging from one to four months). These relapses appeared to occur in three main contexts, the primary one of which concerned the relinquishment of parenting skills in stressful times (e.g. resorting to previous, familiar parenting strategies in times of family bereavement and sickness; undergoing separation from partner; work demands or financial pressures).

> "You are so busy and because everything else in life is pulling you in all different directions and sometimes you are actually neglecting them without realising,…And sometimes you have a bad day in work and you just break all the house rules, like shout and roar at them…And of course it affects them, you would see a slip in their behaviour...I felt so far gone that I couldn't bring it back. It took me at least a few months to bring back the basics again." *(Mother [41] of 5-year-old boy)*

> "I haven't even wanted to do the skills. It's a terrible thing to say but since the baby died I haven't really wanted to be a parent. And he [her child] can sense the difference in me, that I have not been a proper Mammy. He pushes the boat to try and get the right reaction from me but I haven't been bothered about setting boundaries to his behaviour." *(Mother [12] of 8-year-old boy)*

Relapse in child positive behaviour was also attributed to the negative influence of an unsupportive partner or ex-partner, school or antisocial neighbourhood, despite the parent's reported persistence in implementing the programme principles. Furthermore, one parent attributed her child's relapse to the perceived long-term ineffectiveness of the

parenting skills. Another parent was at a loss to understand the reasons behind her child's recent relapse. However, while both of these last two parents believed that they consistently implemented the skills throughout the interview, they tended to over-emphasise consequences, time outs and an ethos of negative attention rather than talking about the more positive aspects of the programme, such as play, praise or rewards. Thus, it is possible that the principle of positive attention was not fully understood, or not faithfully implemented following completion of the programme. In addition, it is possible that one of these children had an undiagnosed ADHD or learning disorder as his mother reported that he did not understand consequences, which she interpreted as evidence of defiance.

Overall, despite their children's relapses, both parents believed they had derived a sense of confidence from participation in the group process; for example, one parent no longer felt so isolated whereas the other believed she would regain control of the situation at some stage. Both of these parents reported that they had not managed to improve their child's behavior by the 12-month follow-up, an outcome that was corroborated by their clinical scores on the ECBI at that juncture. Both of these parents had also reported clinically elevated scores on the ECBI at the six-month follow-up, which suggests that, despite obtaining some benefits from the programme, they struggled to manage their child's ongoing behavioural difficulties.

> "And then after the IY programme he changed. He was able to express his feelings rather than throwing tantrums. But then he went backwards, real aggressive and I didn't know why….You know it's cool to be using slang words and going on misbehaving. You're a man if you do that." *(Mother [19] of 6-year-old boy)*

> "I allow them out to play now but I can't relax because I'm listening, 'Are they okay?' The language of some of them and she picks that up, words you wouldn't even dream a child would know. Smoking, robbing, burning cars, flashing themselves and they're only six or seven…Some of the kids are so vicious that if I got the chance to move away I'd be gone tomorrow…I've tried talking to the parents but they won't do anything about it." *(Mother [32] of 6-year-old girl)*

> "He's getting worse. It worked for a while but that's the way he is, he gets used to something and then it doesn't matter anymore. It [the skills] won't work. It's just him. He doesn't understand consequences and he doesn't care. Like if he broke a window and I say, 'That's it. You're going to be punished', he'd look at me as if to say, 'What does that mean?' so he doesn't understand that if he does something that there is consequences to his actions…I still do it [the skills] all the time. I still put him in the corner for six minutes to let him know how bad he is. I still take his toys away. He doesn't get his treat once a month if he's not good. He doesn't care though." *(Mother [22] of 6-year-old boy)*

As noted earlier in Section 6.3.3, six of these eight parents reported that they had managed to reinstate positive outcomes for their children at the 12-month period (although one of these six parents reported a clinical level of conduct problems on the ECBI at the 12-month follow-up, which was a significant deterioration from the non-clinical score previously reported at the six-month follow-up). Despite the reported recovery from relapse, some of the parents reiterated their earlier request for post-course support at stressful junctures. Two parents sought support from the group facilitators during relapse, but others indicated that they would like the group facilitators to take a proactive role in contacting them, or in establishing intermittent follow-up meetings in order to help them overcome feelings of inadequacy and shame. In general, delivery of the IYPP does not incorporate follow-on booster sessions for participants. However, the ADVANCE programme is a secondary intervention recommended for parents experiencing additional difficulties that may impact on parenting (e.g. depression, conflict with partner) (Webster-Stratton & Reid, 2003). Regrettably, due to resource limitations, the ADVANCE programme is rarely delivered within the services in this study.

> "Things hadn't been going well for a couple of months and I was at a loss. So I contacted them in Tallaght [TFRC] and I was back on track after a couple of weeks." *(Mother [25] of 5-year-old boy)*

> "The only thing I felt let down by was that once the course was finished, there should have been meetings even once every three months, even just for the first year…I was going through a real bad patch and I'd gone so far out of the programme that I needed help. I know I should have rung them [the group facilitators] but what stopped me was that I hadn't heard from them since the end of the course and it's weird to speak to someone after that time and say, 'Do you remember me? I was the one in a session in April nine months ago'. I felt stupid that they wouldn't remember me or that they would be like, 'We gave you all the tools so you should know what to do'…They probably wouldn't have said that but I just felt so low and ashamed of myself." *(Mother [3] of 5-year-old boy)*

At the 18-month follow-up, two of the eight parents who were interviewed (one mother, one father) reported increased difficulties in applying the skills. These parents had previously reported a sustained period of relapse between the 6- and 12-month interviews, with one individual reporting partial recovery in child positive behaviour at 12-month follow-up and the other reporting continued deterioration. Both of these parents admitted at the 18-month interview, that they often found it easier to return to their old parenting methods rather than persevere with conscientiously applying the new skills. The father also said that he felt he had more of a "cultural licence" to leave the

bulk of the parenting responsibilities to his wife, thereby neglecting to fulfil his parenting role. There was also some evidence that both parents were confused in their application of techniques, such as rewards, ignoring and time out. Furthermore, both were experiencing a significant number of other personal and social stresses in their lives (e.g. marital difficulties, domestic abuse, and financial issues) which impacted on their capacity to focus on their child's behaviour. Both felt quite hopeless about their ability to recover their child's positive behaviour and had not considered seeking support. This further illustrates the need for service providers to establish post-course reinforcements for the most vulnerable parents.

> "He's [her child] gone downhill again. It worked for a while but he got used to it…I tried to get him to go to bed last week by letting him watch a DVD as a treat and he promised me he'd go then…and then he wouldn't go and was screaming for hours. I tried to put him back but I was exhausted. I'm exhausted all the time." *(Mother [30] of 5-year-old boy at 18-month follow-up)*

> "I don't really do it much now. Every so often I might play with him but that's about it…It shouldn't be an excuse but my mind has been on other matters…My wife and I are thinking about separating." *(Father [42] of 7-year-old boy at 18-month follow-up)*

7.3 Retention issues

The level of attrition within the parenting groups was a considerable source of concern for many group facilitators, as it meant that parents did not receive the full 'dosage' of the programme, which may, in turn, have underestimated its overall effect. Within the context of the overall RCT, almost one third (31%) of the parents dropped out after five or less sessions. However, there were varying rates of attrition amongst the nine parenting groups: by the final session, four groups had lost approximately 40% to 50% of parents; one group had lost 70% of parents, and four groups had lost just 10% of parents. Group facilitators, when interviewed, identified a number of reasons for such variation; these are important in terms of improving retention in the future and included: the high presence of parents who were experiencing many difficulties besides parenting (e.g. substance abuse); parental attitudes (e.g. learned helplessness); perceived difficulties related to running the programme as part of a larger RCT (e.g. lack of pre-programme contact with parents); circumstantial reasons (e.g. illness); lack of childcare on site; aspects of the programme that parents may have disliked (e.g. principle of positive attention); and fear of breach of confidentiality amongst parents living within a tightly knit local community. Some of these reasons were also identified by the eight parents who dropped out early from the IYPP (i.e. circumstantial reasons, fear of lack of

confidentiality and a dislike of certain aspects of the programme). One parent also alluded to seeking an alternative pharmacological treatment. Further details are provided below.

7.3.1 'Multiply-disadvantaged parents'

Four group facilitators attributed the high rates of attrition within their parenting group to the number of participants living in circumstances of extreme disadvantage (e.g. inadequate housing; at risk of poverty; alcohol and drug abuse; unemployed and/or low levels of educational attainment). Group facilitators believed that because these parents had too many other unresolved issues in their lives, they were unable to focus appropriately on parenting. These issues included drug and alcohol addiction, mental health issues, housing and eviction problems and financial difficulties. The four group facilitators (from two parenting groups, each delivered within a different organisation) said that, on reflection, they had underestimated the amount of wrap-around supports/services required to retain these parents. They reported that they had been mistaken in their belief that building a relationship within the confines of the programme was sufficient to retain parents with multiple markers of social disadvantage. They now believed that 'raw referrals'[14] were unsuitable and that more resources were required in order to build a pre-programme relationship with such parents. These group facilitators reported that, despite employing a variety of methods to reach non-attending parents, including, for example, organising individual catch-up sessions, meeting parents at school, and devising reward systems for attendance at the group sessions, they felt a sense of guilt that they could not retain these parents and especially when other research (e.g. conducted within Sure Start services in Wales) reported high retention rates for the IYPP amongst disadvantaged communities (Hutchings et al. 2007a). It should be noted, however, that Sure Start services provided a level of wrap-around support to parents not available to agencies within the Irish RCT[15].

[14] 'Raw referrals' was a term used by group facilitators to denote a process whereby an agency invites parents to participate in a parenting programme based on receiving a referral but without establishing a personal relationship with that parent in order to fully learn the readiness of that person to attend the programme.

[15] Sure Start provides a range of integrated, multidimensional, community-led early childhood services, including: (a) outreach and home-visiting services; (b) family support and health-related parenting information, delivered both at home and within group settings; (c) home and group-based advice on establishing secure parent-child relationships; (d) high quality crèche care; (e) primary and community health care and advice; (e) Early Years transition from preschool to school (Sure Start, 2012).

These additional support services (e.g. home visitors, primary care) may have enhanced recruitment and retention of parents within the Welsh study.

Moreover, the above four group facilitators seemed largely unaware that some of the other services delivering parenting groups within the RCT had more staff and wrap-around supports available to them and, also, had adopted a strict case-management/screening policy in order to assess the readiness of parents for the IYPP (See Table 7.2 for details on resources available to the five services within the RCT; also please refer to Sections 6.4.2 and 6.4.3 for more detail on the perceived benefits of screening and intra- and inter-agency supports). During the interview, two of the four group facilitators admitted that a more stringent screening process might have enabled them to assess the lack of readiness of these parents for the programme. These group facilitators said that they were now exploring various avenues to improve retention, including building a prior relationship with parents and screening unsuitable parents. They did not believe that they would have the capacity to develop more wrap-around supports within their service at the current time.

> "We retained the full 11 [parents] the last time round so it was a shock to us that despite the amount of work we put in, that we didn't succeed in retaining more parents…You question yourself, 'Could I have done something else? What could have worked?'…I think we probably underestimated the level of support that people needed outside of the IY programme to actually hold them in the programme. We had two participants who had drug issues and in hindsight, I would never have taken them on…In a context of wider support in resolving their drug issues, you might have succeeded in retaining them but we didn't have that." *(Group facilitator 2)*

> "I think given the level of need of the parents you would have needed a couple of months run into it, a relationship prior to it, a more in-depth relationship. I did meet some of parents and speak to them but it wasn't in-depth enough to influence their retention on the programme." *(Group facilitator 1)*

> "Supervision gave us support around our retention difficulties and helped us understand that we lacked the wrap-around services that Sure Start had, so that offset our feeling inadequate and blamed." *(Group facilitator 5)*

It is also interesting to note that one group facilitator went further and questioned whether parenting programmes were appropriate interventions in settings where basic needs around accommodation, employment and safety were not met. This individual believed that parents living in extreme disadvantage had little incentive to undertake a parenting programme when they and their children felt hopeless about the prospects of improving the material circumstances of their lives

"There are extreme levels of poverty in this area and that is never fully appreciated…I think it's disrespectful to say that a parenting programme could help a woman who's had her house burnt down…Sometimes it comes down to the basics – proper housing, proper heat, proper food, a prospect of getting a decent job, a right to feel safe in your home. Unfortunately we spend an awful lot of money on other things, like too many drug services in certain areas, when the money would be better spent on improving the houses that people live in." *(Group facilitator 6)*

Table 7.2 Resources available to the parenting groups within the RCT

Parent Groups	Host agency [a]	No. of parents	Childcare onsite	Screening of parents' suitability	Wraparound supports [b]
A	Agency 1	9			
B	Agency 2	10		√	
C	Agency 3	10	√	√	√
D	Agency 4	11	√	√	
E	Agency 1	12			
F	Agency 4	13	√		
G	Agency 3	13	√	√	√
H	Agency 2	12		√	
I	Agency 5	13	√	√	√

[a] The host services are not named in order to preserve participant confidentiality.

[b] Wrap-around supports within some agencies in the RCT included intra-agency services, such as family support mornings, which help with recruitment in establishing pre-programme relationships with parents. In addition, other intra-agency supports, such as family support workers, enhance retention through providing transport to disadvantaged parents, visiting parents who were absent from a weekly session and conducting 'catch up' sessions with the parent.

7.3.2 Parental attitudes

Most of the group facilitators (9/11) reported that certain parental attitudes, such as ill-informed expectations about what the programme entailed, a lack of commitment, helplessness and/or problem-solving difficulties, tended to lead to attrition. They explained that a few parents left after the first session as the programme was not what they expected. Despite information provided by the researchers, at baseline, on the nature of the IYPP, two parents expected to receive a diagnostic assessment of their children. Two others expected to receive one-to-one individual advice and did not wish to take part in a 14-week programme. Attrition also occasionally occurred when parents

were not actually committed to changing their own behaviour. Some parents either did not appear to understand that they needed to change their own behaviour, or would not accept responsibility for change, instead insisting on seeing the child as the problem. Furthermore, the facilitators reported that some parents understood the theory of change underpinning the programme, but were not committed to completing their homework. One facilitator was also adamant that she did not accept parents onto the programme unless she felt that they would take responsibility for changing their own behaviour. Moreover, two group facilitators believed that some parents were complicit in discouraging attendance amongst other parents:

> "We ended up with a core group of parents who were more mature about viewing their children…Some were lacking the grasp that they were the ones who needed to change and needed to put the work into it…Parents often say, 'I wouldn't shout or slap if my child would behave differently.' Now you need to turn it on its head. When you don't react anymore in the old way, then the child has to change their behaviour and their old way becomes obsolete." *(Group facilitator 3)*

> "They might see each other at the school and they were almost complicit in saying, 'Sure, you're not going, maybe I won't go today either.' It wasn't that they thought it wasn't worthwhile but it was easier not to go." *(Group facilitator 2)*

Five group facilitators reported that sometimes the most marginalised parents felt so depressed and helpless that they did not believe they could create any positive change within their lives, and consequently, had difficulty in finding the motivation to attend the programme. Moreover, some parents were considered to lack the necessary resourcefulness in overcoming everyday obstacles; for example, they lacked the problem-solving abilities to re-arrange an appointment if it occurred on the same day as the parenting programme. Furthermore, previous disappointments with services had instilled a sense of hopelessness, which might explain, at least in part, a culture of lack of engagement more generally with services within many disadvantaged communities.

> "I think a few parents have given up on their children, that they can change, have given up on the idea that services are going to be any use to them…They are overburdened, haven't the energy anymore, just feel pathetic and angry that other services aren't helping them with other areas in their lives" *(Group facilitator 2)*

> "This parent, she came to quite a few sessions but she didn't see it as important if she missed a session. If somebody was delivering a fridge to her that was more important than coming to IY…she was very casual." *(Group facilitator 8)*

7.3.3 Dovetailing service delivery to the requirements of the RCT

Ten of the group facilitators believed that, to some extent, the research process may have influenced overall levels of retention. Firstly, some group facilitators reported that they found it difficult to recruit the required number of parents within the time-frame allowed by the RCT schedule[16], and consequently felt obliged to accept parents with chaotic lifestyles, who were not ideally suited to the programme. Evidence suggests that socially disadvantaged populations may achieve positive outcomes from the IYPP (Webster-Stratton et al. 2004; Hutchings et al. 2007a), but some of the group facilitators believed that the presence of severe and multiply-disadvantaged parents in the current study undermined their retention within the programme. Interestingly, McGilloway et al. (2012a) reported that socioeconomic status did not predict differences in outcomes. However, this subgroup analysis did not differentiate between parents manifesting moderate or severe levels of social deprivation and so it is possible that attrition was higher amongst those evidencing multiple markers of extreme disadvantage.

Secondly, a similar number of facilitators (N=10) reported that they did not receive the names of the parents within their group from the researchers until a few days before the programme was due to commence and as such, they did not have sufficient time to establish a prior relationship with the parent[17]. This prior relationship was viewed as being an important element in successful programme delivery and also, to some extent, in promoting parental commitment. However, at the same time, the research team were placed under increasing pressure to complete the baseline assessments of all eligible parents as soon as possible, so that randomisation could take place (i.e. after baseline assessments had been completed). These kinds of difficulties typify the kinds of challenges in running RCTs of real-world services and in meeting the requirements of both the researchers and service providers. For example, it should be noted that the research process was delayed due to the difficulties in recruiting eligible parents and, therefore, it was not possible to undertake randomisation until a few days before the commencement of the programme.

[16] It should be noted that the RCT schedule was decided by Archways, the research commissioners.

[17] In this context, the 'prior relationship' refers to establishing contact with the parent a week or two before programme commencement. It is to be differentiated from the process of screening parents (which also necessarily involved a level of pre-programme relationship), as screening involved a more rigorous assessment of the parents' suitability for the programme before referring those names to the research team. The 'prior relationship' did not incorporate an initial screening procedure before referring parents' names to the research team.

Furthermore, it should be noted that the relationship between establishing prior contact with the parent and retention is unclear, as two groups that did achieve pre-programme contact still reported attrition levels of over 50%. Moreover, some groups had minimal attrition despite the lack of a proper opportunity to establish a prior relationship with the parent. Importantly, one group facilitator believed that the lack of time to establish a pre-programme relationship with the parents did not affect retention within their group as such, but that it did create stress and confusion for the facilitators. Nonetheless, despite the lack of clarity with regard to the importance of pre-programme contact as a predictor of retention, there is arguably a role within future 'real world' RCTs for more direct, ongoing liaison between researchers and facilitators in order to streamline the recruitment and randomisation process.

> "Because it was a research group it was a bit different than how we would engage with a typical group. We would usually have had telephone contact and meet them before the programme so as to build up some type of relationship first…It seemed a bit of a lottery as to whether participants would come the next week. It was difficult to have any confidence around it." *(Group facilitator 6)*

> "I don't know what kind of contact there was between research personnel and parents but I think some parents had unreasonable expectations about the course and seemed to expect the course to change the child's behaviour. The focus was on the child, very child-centred." *(Group facilitator 10)*

> "The initial stress would have been the short space of time between getting the names and linking with parents and then actually doing the programme. We didn't have the contact with the parents in a way we might have liked to have it…I don't think it impacted on the group of parents, it just created more stress for us." *(Group facilitator 7)*

7.3.4 Dislike of aspects of the programme

Group facilitators (N=9) also believed that some parents may have dropped out because they disliked aspects of the programme content or format. For example, four group facilitators reported that a few 'drop-out' parents were sceptical about the utility of the principle of positive attention and would have preferred a more disciplinarian approach to parenting. Most of the facilitators remarked that some parents did not engage well with the American tone and setting of the vignettes and that some discomfort around these may have been a factor in subsequent attrition. Four of the facilitators and one organisational manager also stated that the number of play sessions at the beginning of the programme could be reduced as it was difficult to keep parents engaged and interested in the programme when reiterating the same concept repeatedly. They also believed that the length of the new programme should be reduced as it can be tiring for

parents and allows more opportunity for circumstantial obstacles to arise (e.g. new job, sickness), whilst it also does not fit neatly into the school-term.

> "It's a challenge getting some parents to see that play and praise will work for tantrums…I think we've been brought up with the idea in our upbringing that you must be strict, you must discipline, that you can't praise too much, 'Spare the rod and spoil the child' is in our philosophy and we're nearly afraid to trust this idea that play and praise could actually bring change. It's nearly too easy and too fun." *(Group facilitator 2)*

> "The video-tapes are outdated and some of the parents found them too American and affluent. They tended to rate the vignettes more negatively every week than any other part…Also the language was rather difficult to understand in places and the preamble gave the answers to the questions…A lot of the parents didn't like them." *(Group facilitator 5)*

> "What happens within a 20 week period is that you're upping the chances that something is going to go wrong. Someone is going to get sick. Someone is going to leave to get a job…Of course people have to want to do it but you have to be fair to them too. Lots of people have children. It's just an awful long period and a lot of issues can arise in that time." *(Organisational manager 3)*

7.3.5 Other factors

A number of other potentially influential factors were identified. Ten of the group facilitators reported that some parents left the programme for circumstantial reasons involving sickness, family bereavement, starting a new job, or conflicting appointments. In addition, two parenting centres did not have an on-site crèche (See Table 7.2) and, for some parents, the reimbursement of child care costs was an insufficient means of incentivising them to remain with the programme (i.e. the parent had to pay childcare costs to the babysitter upfront and was reimbursed at a later date, which meant that attending the programme was financially prohibitive for some). Furthermore, many of the parents in one parenting group lived within a one-apartment complex and consequently, a few of this group expressed concerns about confidentiality.

> "One parent, her partner died so she wasn't in a space where she could take on the programme. Another lady got a part-time job. Someone's husband had bipolar and was quite ill. One woman was pregnant and wasn't well." *(Group facilitator 7)*

> "Her babysitter kept letting her down and so she couldn't come." *(Group facilitator 6)*

> "I suppose her ten-year old had caused a lot of trouble outside and she thought that people were gossiping about her…she was afraid to reveal personal stuff within the sessions she attended." *(Group facilitator 2)*

7.3.6 Parents' reasons for leaving the IYPP

Of the 33 parents interviewed at the six-month follow-up, eight had dropped out of the IYPP after completing less than five sessions; all were interviewed in order to explore their reasons for not completing the programme. The primary reasons (5/8) stated by parents for leaving the IYPP were predominantly practical or circumstantial in nature (i.e. starting a new job, illness, or having to care for a sick family member). One parent indicated that she was seeking an alternative pharmacological intervention for her son's conduct problems. Three parents also briefly mentioned potential intrusion of privacy as a concern since many parents within the group lived in the same area.

> "I didn't like that talking about personal stuff…It was too confidential…Everyone knows everyone here." *(Mother [35] of 5-year-old boy)*

> "I enjoyed the course but then I couldn't go… my Mam got a stroke and there was no-one else to look after her so I had to." *(Mother [36] of 5-year-old girl)*

Two parents (2/8) indicated that they would not return to the IYPP for a number of reasons: (1) they did not accept the ethos of positive attention; (2) they disliked the standardised format and would have preferred more individual, tailored advice for their problems; (3) they had previous experience of play (though psychology clinics) and had found it to be ineffective in reducing problem behaviour; and (4) they felt isolated from the other parents in the group, whom they perceived to have fewer problems with their children. One of the parents also seemed to struggle with attending the programme in the morning.

> "All I wanted to know was how to nip a temper tantrum in the bud before it turned into a full-scale war…I've no problems in any other areas. I play with him all the time. I don't need help with any of that. I just need help with his temper tantrums." *(Mother [5] of 5-year -old boy)*

> "I felt really cranky after those sessions. It took a lot of effort to get to the place, to get the kids up…People were sitting around moaning and crying, talking all around the place and I was getting no tips or advice about how to deal with my child…They were looking down on you, like they were looking at you if you said that you'd slap him sometimes because he was so bold." *(Mother [25] of 5-year-old boy)*

Although most of the 'drop-out' parents provided a practical/circumstantial reason for non-attendance, it is notable that six of the group came from severely disadvantaged backgrounds (characterised by maternal depression, risk of poverty and a history of substance abuse or criminality). Thus, the researcher experienced a sense that, in reality, other factors may have played a more prominent role in their drop-out from the

programme, such as depression and/or substance abuse or a lack of support; these may have made it difficult for them to get up in the morning and attend the programme. Indeed, this was subsequently corroborated by the interviews with the group facilitators (as indicated earlier in sections 7.3.1 and 7.3.2).

7.4 Challenges to implementation fidelity

The importance placed by organisational stakeholders on attaining and maintaining IF (through the development of intra- and inter-agency supports) was outlined earlier in Chapter Six (section 6.4.2). However, a number of challenges to standard IF were identified here, including a lack of organisational support and the perceived negative impact of the RCT process. Each of these is described, in turn, below.

7.4.1 Lack of organisational support

All of the group facilitators felt that their organisation did not allocate sufficient time to deliver the programme with fidelity. All reported heavy workloads, having to work outside paid hours and feeling, to some extent, unsupported by their organisation in implementing the IYPP. They believed that management did not understand how much time it actually took to implement the programme; facilitators were allotted 1.5 days per week to implement the programme, but reported that it actually required three days per week, when all components were taken into account. These included the recruitment of parents to the IYPP; delivery of the two-hour programme to parents; reviewing and analysing video-tapes for supervision; participating in supervision; pre-session preparation; mid-week follow-up phone-calls with parents; and conducting individual catch-up sessions with parents.

Most of the group facilitators reported difficulty in convincing their organisation to dedicate more time to the IYPP, given the scale of the other competing demands within their service. Thus, the IYPP was perceived by some of the group facilitators as not representing ‘core work’ within their agency and, as such, was vulnerable to changes in work priorities. As a more extreme example of a lack of organisational support, one group reported that their agency did not possess adequate resources to properly implement the programme; for instance, the room within which they delivered the programme was too small; they did not have enough chairs; and there was no money for materials or photocopying, childcare or tea-making facilities. Furthermore, two other

facilitators indicated that their organisation should realise the nature of the wrap-around services required for the retention of parents and to allow time to properly integrate the programme within the agency before undertaking an evaluation. However, it should be noted that all facilitators valued the programme and enjoyed delivering it, but believed that their work would be more fulfilling and less stressful if their organisation provided some emotional support in recognising the difficult nature of the work, particularly in working with disadvantaged parents. In addition, they indicated that they would appreciate acknowledgement from management that they worked outside paid hours, often up until 11.30pm, after working a full day, and having to work again the next morning. Most of the facilitators believed that, with sufficient time and resources, they could enhance retention to the programme and improve upon the positive outcomes achieved within the RCT.

> "I would like the amount of work we do to be recognised. I don't feel the midweek calls are valued even though they are part of the programme. We have to do them in our own time. We get no 'Well done' despite the intensive, draining nature of working with marginalised parents who have so many issues in their lives…We're meant to get our support from supervision but that's not enough…We're given 1.5 days per week to run the programme where it probably takes up 2.5 to three days per week… I don't think they see the bigger picture of how much time it takes to deliver a weekly session." *(Group facilitator 11)*

> "Within this kind of enterprise, you would assume that delivery would be the most important thing but it is clearly not…There are other things that are seen as worthier of input…We just don't have enough time to deliver the programme in the way we would like." *(Group facilitator 4)*

> "We had to fit in the calls and review of tapes within our own time, outside working hours. There is only so much that a person can give before they start falling ill. I was out sick for two weeks because I was having to bring too much work home for too long." *(Group facilitator 9)*

> "The room here isn't big enough for all the parents and we had to pay out of our own pockets every week to give them tea, even down to buying the cups." *(Group facilitator 2)*

7.4.2 The RCT process

As indicated earlier in Section 7.3.3, many of the facilitators (N=10) believed that the research process had compromised, to some extent, their 'normal' delivery of the programme and therefore, negatively influenced overall retention rates. Further perceived obstacles to standard delivery were also linked to the research process. For example, two group facilitators related that the tight RCT schedule meant that they could not reduce the pace of the programme for those parents who found it difficult to grasp the concepts. They reported that they usually had more flexibility to decelerate the pace for specific parents if required. Four facilitators also indicated that they had been

allocated particularly large groups (approximately 15 parents each[18]) through the randomisation process and, therefore, it was difficult to reach all parents equally within the two-hour session. One group also said that the research had impacted on their 'real world' running of the programme to the extent that, given the inordinately high attrition levels in one parenting group, they would have stopped running the programme in order to conserve increasingly scarce resources; of course, this would have impacted negatively on the research (and the findings) and did not, therefore, materialise.

> "We had a very large group and people have different rates of picking things up. Usually we would have the flexibility to slow down a bit to make sure that parents grasped the principles, but we had to move on within the context of the research as there wasn't time...It also meant that that parent kept coming back to the issue weeks after as they hadn't got it the first time." *(Group facilitator 7)*

> "One of the things that was coloured very much by the research was the pressure on us to recruit and retain parents…It meant that too many parents were taken on who really weren't ready for the programme at that time, and then we were actually too accommodating in doing 'catch-up' sessions with parents who missed sessions. It caused stress for us trying to make it all work within the time frame of the research." *(Group facilitator 3)*

7.4.3 Delivery of a new version of the programme

One of the most stressful experiences for group facilitators was the unexpected decision by Archways, the research commissioner (and funder), to evaluate the new version of the IYPP just days before programme delivery was due to commence. The RCT had been designed to evaluate the 12-14 session version of the IYPP. However, the new version comprised 22-24 weekly sessions, but still had to be delivered in the 14 weeks allocated by the RCT schedule. Group facilitators reported that it was extremely stressful for them to condense the longer programme into 14 sessions, without time to familiarise themselves with the new programme, which had several additional elements. It appears that the new version was introduced at this late stage because the programme developer (Webster-Stratton) and Archways were keen to implement and evaluate the newest version of the programme (The researchers were not involved in this decision.). A key strength of the IYPP is its commitment to constant improvement and development of the programme. However, the decision to evaluate the latest version of the IYPP at this particular juncture, meant that group facilitators were caught in a double-bind between an insistence on IF and the necessity to condense the programme into the RCT schedule (and thus reduce the time allocated to certain components within

[18] The number of parents randomised to each parenting group did not exceed 13 parents; however, partners of randomised parents decided to attend in some cases which increased group size.

the new version of the programme, such as problem-solving, time out, and social and emotional coaching) (See Appendix 1 for more detail).

Some facilitators reported the enormous pressure they placed on parents and themselves in initial sessions by trying to deliver all of the prescribed content, often by combining two sessions into one. Facilitators were concerned about re-organising the programme due to the need to maintain treatment fidelity, but eventually they concluded, with support from the supervision sessions, that delivering all of the content within 14 sessions was not feasible for the mental health of all concerned. Thus, the supervision was essential in allowing them to choose particular vignettes which conveyed the key principles and not to overburden parents or themselves by the pressure to show every vignette[19]. Overall, facilitators reported lower levels of stress in delivering the new version of the programme to the second cohort of parents[20] (N=63) as they had a chance to become more familiar with it and also had time to systematically condense the material into 14 sessions. Even so, many of the facilitators still reported that the pace of delivery of content was often rushed and that they could not cover the material as comprehensively as they would have desired, particularly with regard to parents who were slower in grasping programme principles.

> "We received our training a while ago and it was fidelity, fidelity, fidelity. You couldn't make the decisions, you literally had to follow the protocol, tick the boxes and so on. And then the new version was thrown in, and on top of that it was research which would be monitoring our fidelity…We tried to show the parents as many vignettes as was humanly possible within the time-frame but we necessarily had to leave some out...We pulled out the most relevant vignette which demonstrated the principle and supervision gave us the flexibility to not cram in the rest." *(Group facilitator 9)*

> "The new programme was rushed in a few days before we were starting…We had to combine two sessions into one so of course some material had to be left out…If you're making modifications as you go, you question the whole nature of the fidelity process…I think it put an unnecessary pressure on us." *(Group facilitator 4)*

[19] Group facilitators who deliver the IYPP generally report that it is not possible to show all recommended vignettes within a session (e.g. Aarons et al. 2012; Dunn, 2012). Often, several vignettes can refer to the same principle, and in the interests of efficiency, facilitators choose the most appropriate vignette to convey the key message. Thus there may be an argument for further refinement of programme content in order to enhance delivery of the IYPP.

[20] As a reminder to the reader, delivery of the IYPP to parents within the RCT occurred in two phases: the first group of parents (N=40) received the intervention between April to July 2008 and the second group (N=63) received it between September to December 2008. The control group (N=46) received the intervention at a later date.

It must also be remembered, though, that facilitators indicated that, overall, their involvement in the research evaluation enhanced the quality of programme delivery (see Section 6.5). These findings will be discussed further in Chapter Nine.

7.5 Programme sustainability

Sustainability of effective interventions is a key objective for service providers. Within the context of this study, almost all of the organisational managers (N=4) and group facilitators (N=9) were concerned that funding challenges may impair their future capacity to implement and expand the IYPP (with fidelity). All interviewees reported that it was the most effective programme they had ever delivered, but some also stressed that the IYPP demanded considerable commitment from their respective agencies, to such a degree that it impacted on the delivery of other services within their organisation.

> "If you take all the things that go into IY, all the resources, time and money, space here, childcare, taxis, providing IY as opposed to something else, like we can't do as much individual case-work because there's no time, then from a service provision point of view, is it value for money?...For me, personally, it's the best toolkit that I've ever been given in my work but there's just something in the enormous amount of resources, the high amount of energy put into it, that you wonder is it sustainable at this level all the time." *(Group facilitator 8)*

One manager felt confident that their service was sufficiently well funded for the future implementation of the IYPP, but the other managers (and group facilitators) feared that funding cutbacks would impact negatively on fidelity-related issues within their service whilst also affecting the future roll-out of the programme. For instance, they reported that cutbacks would affect their capacity to access training, supervision, materials and to pay for childcare. One manager stated that their agency will now depend on future inter-agency support to fund room-rental, staff and programme costs. Some of the managers talked about the need to become creative in finding low-cost ways of sustaining and expanding the programme by, for example, employing lower cost staff, finding low- or no-cost venues, such as community or church halls, and developing the capacity of inter-agency peer supervision.

> "We are allowed to run the IY morning, noon and night as long as we can find venues that don't cost anything, we don't look for babysitting money, we don't look for meals, programme materials, for costs of supervision and training…All these extra costs that Carolyn considers necessary for the successful roll-out of the programme, which we haven't got a hope in hell of getting (deep breath). Nice one! (laughs)" *(Organisational manager 1)*

> "We are going to have to think around corners, to think creatively about how we can find low-cost ways of delivering the programme. We can't afford to have psychologists giving

> their time to it so we're going to have to train up lower cost people…We have to find suitable large venues with facilities…It's going to be a challenging time." *(Organisational manager 2)*

In 2009, two managers were concerned that their efforts to expand the programme within other agencies had met with several difficulties. For example, one manager reported that she had attempted to work with other agencies in delivering the programme, but that these agencies were experiencing difficulties related to the loss of staff (who cannot be replaced under the HSE staff embargo), a failure to deliver the programme with fidelity and the non-attendance of staff for supervision. She also indicated that she was unable to co-facilitate within these other agencies due to staff shortages within her own service. Another manager similarly reported that he found it difficult to transfer the commitment to fidelity across agencies; he explained that many agencies do not realise the amount of work required and that they typically neglected essential elements, such as childcare provision, dedicated follow-up, supervision, and the importance of establishing a pre-programme relationship with parents living in disadvantaged areas. However, when this manager was re-interviewed two years later, he informed the researcher that they had succeeded in transporting the IYPP to a couple of other HSE and community-based services and that they had ensured fidelity by co-facilitating the programme within the agency. They also succeeded in both reducing costs and promoting a community-based approach by training parents as facilitators within the programme, who delivered the IYPP with an accredited facilitator. This illustrates that obstacles to implementation can be overcome where service managers demonstrate appropriate commitment and resourcefulness.

> "Attempting to expand the programme into other services has been extremely frustrating…They lack trained staff and we lack the staff to co-facilitate with them…They have no supervision, they don't follow up with people…I don't know where the funding is going to come from." *(Organisational manager 4)*

> "In order to get it widespread, to get it sustainable, it has to move away from us…We worked with another agency to deliver it but we stopped that because they weren't doing it in the right way. Fidelity is such an issue and then there's the difficulty of getting parents to the programme which they weren't looking at…You want to tell other people to change the way they're working and that's hard." *(Organisational manager 5 in February 2009)*

> "Since last year, we have focussed on training people in the community, in training parents to deliver the programme, who then work with an accredited facilitator…We hope to train six parents so that we can develop the programme within the community." *(Organisational manager 5 in January 2011)*

Many of the facilitators and managers also expressed concern in 2009 about the length and target age of the new programme. They felt it was unrealistic to expect organisations to deliver a 22-24 week programme when the previous version comprised 12-14 sessions. The previous version was popular with service providers because it fitted into the school term; this was viewed by most facilitators and managers as an important predictor of retention. Many believed that if the newer edition was retained that, in practice, fidelity would inevitably suffer as organisational constraints would demand that facilitators would be forced to select elements from the longer programme. In addition, many felt that it would be more difficult to retain parents for the duration of the newer version. Interestingly, however, the majority of attendee parents expressed a desire for a longer programme and most reported they would attend the *ADVANCE* programme if the prospect arose. Thus, from the perspective of parents, the longer version would not constitute a barrier to retention, but instead represented an opportunity for greater perceived benefits. However, it is likely that the additional resources required to implement the longer programme would be an unattractive proposition for underfunded, overburdened services. Indeed, all but one of the service providers stated that a new, shortened and manualised 12-14 week version should be devised which incorporated the best elements from the current longer edition, such as modules on problem-solving and social and emotional coaching, but with fewer sessions dedicated to play.

Only one facilitator believed that that the new version of the IYPP was of an appropriate length; she felt that this version was more suitable for a clinical population and stressed that services should change to accommodate the programme rather than vice versa. Lastly, some managers and facilitators expressed resistance to the newer edition as they felt the target age of three to six years was overly restrictive (the previous version was directed at children aged 2.5 to 12 years), whilst also incurring extra costs related to the purchase of a separate programme for older children. However, some managers believed that the principles might still work for children aged up to eight or nine years old, due to developmental delay, thereby avoiding these extra costs:

> "I think 12 weeks runs much better and fits better in terms of the organisation potential and resource…It fits into the school term which makes it easier for parents to come…I think if the new programme was shortened but still included the problem-solving and emotional coaching…I think you have to keep it within a 12-14 week period." *(Organisational manager 2)*

> "I think it's unrealistic of the developer to expect cash-strapped organisations to deliver the new longer version of the programme…Why can we not stay with the version we have already? We know that it works." *(Group facilitator 3)*
>
> "It's a huge pity that we can't deliver the whole 22 sessions…a lot of the children we're delivering the programme to, they are a clinical population, they need that…I'd like to find with the services, let's not just half do it, let's fully do it." *(Group facilitator 11)*
>
> "The other programme is a broader age range so it's more difficult to recruit with that very specific age range." *(Group facilitator 7)*

Reassuringly, however, despite the fears of the organisational providers and group facilitators (as reported in 2009), each service still continues to implement the IYPP, three of which are fully or partially funded by the Health Services Executive. In accordance with protocols established by the programme developer, a 12-14 week preventive version of the IYPP is now implemented with parents experiencing less difficulties, whilst the longer 22-week version is delivered to families from socially deprived backgrounds and/or with more complex problems[21]. Inter-agency collaboration amongst the services involved in the RCT - through peer supervision and sharing of staff and resources (e.g. suitable premises) – appears to have played a key role in promoting programme sustainability. Nonetheless, the provision of adequate childcare support is still an unresolved issue within two of the agencies, but it is encouraging in an era of economic austerity that these services have been continued.

7.6 Conclusion

Several potential barriers to the effective implementation of the IYPP, at an organisational level, were identified by parents, facilitators and managers in the short- and long-term. From the perspective of parents, challenges included discomfort with some programme principles, a lack of social support and a period of sustained relapse in the longer-term. Arguably, some of these difficulties may be specific to an Irish and socially disadvantaged population, although there is also some evidence that similar complications may arise in other jurisdictions. From the perspective of service providers, retention, fidelity and sustainability issues were the chief sources of concern in implementing the IYPP; as noted earlier, however, some organisations experienced more problems in these areas than others. Similarly, some interesting differences among the service providers were evident in terms of their commitment to rigorous screening of

[21] Protocols for group facilitators implementing the IYPP can be found at: www.incredibleyears.com/resources/PP.asp

parents and their capacity to offer wrap-around support services. The inclusion of such key components may shed light on the implementation difficulties encountered above and these will be further examined in Chapter Nine.

Themes Two and Three (Chapters Six and Seven), within Stage One of the study, related to the key drivers of, and barriers to, effective implementation of the IYPP within socially disadvantaged settings in Ireland. One of the key subthemes involved the importance of IF and the resources required to achieve it. The next chapter will present the findings from Stage Two of the study, which examines the quantitative assessment of fidelity.

CHAPTER EIGHT - RESULTS IV

STAGE TWO: MONITORING AND ASSESSING IMPLEMENTATION FIDELITY

In Stage One, group facilitators and service managers identified both the facilitative and inhibitive organisational/systems factors that influenced the implementation of the IYPP within their agency. This chapter reports on Stage Two of the study which was undertaken to: (1) assess the extent to which IF was achieved within the various parenting groups; and (2) to examine the relationship between various aspects of IF and the primary trial outcome of child behaviour. IF was evaluated against a number of benchmark criteria including: (1) adherence to programme protocols; (2) quality of programme delivery; (3) exposure of intervention to participants (i.e. attendance/retention); and (4) participant responsiveness and engagement with the programme (Mihalic et al. 2002). Each of these is discussed, in turn, below.

8.1 Adherence to programme protocols

Therapist adherence to the programme protocol was monitored by means of facilitator completed self-evaluation checklists. As indicated earlier in Chapter Four, the *Leaders' Weekly Checklist* (LWC) was completed by group facilitators after each weekly session to check and record that they had covered all prescribed material (e.g. showed vignettes, covered relevant topics, checked homework). The results showed that 90% (SD = 4%) of all material was covered across the 14 sessions. As indicated previously, the original programme contained 22-24 weekly sessions, but the programme was re-organised by the facilitators so that it was condensed into 14 weekly sessions (See Section 7.4.3). Thus, this study assessed adherence to the re-organised, condensed version of the programme.

Further questions relating to therapist adherence (e.g. exclusion of vignettes or role plays) were included on the *Implementation Fidelity Form* (IFF). Group facilitators reported that they showed all or most of the prescribed vignettes in 91% of the sessions, and showed some of the vignettes in 9% of the sessions. Similarly, they covered all or

most of the prescribed role plays 87% of the time and showed some of them 13% of the time. Group facilitators covered the group discussion 100% of the time.

8.2 Quality of programme delivery

The quality of programme delivery was assessed by facilitator self-report on the IFF. In general, facilitators reported that they found it 'easy' or 'very easy' to deliver the weekly sessions. However, they reported some difficulties (across 10% to 22% of sessions) in keeping the parents focused on the session topic, in tailoring the topic to the parents' needs and in promoting problem-solving abilities among parents. More detail is provided below.

There were no problems with respect to building rapport with parents across all sessions; all facilitators reported that they found this either 'easy' (70% of the time) or 'very easy' (30% of the time). Likewise, all reported that they felt either 'confident' (45% of the time) or 'very confident' (55% of the time) that they dealt successfully with parents' issues within sessions. A similar pattern was observed with regard to leading the group and conveying session themes. However, a more mixed pattern emerged with respect to keeping the group focused and, in particular, tailoring the session topic to the parents' needs and promoting problem-solving abilities. It was the last of these that elicited the largest proportion of 'mixed experience' responses (22% of the time). It is possible that the reported difficulties with problem solving could be related to insufficient time to fully deliver this component; as noted earlier in the findings from the qualitative analysis, parents indicated that problem-solving was 'rushed' and group facilitators also reported that occasionally they could not comprehensively cover all programme elements. The facilitators linked such time-management difficulties to the fact that they had to condense the content of the new version of the IYPP from 22 into 14 sessions.

Lastly, when asked about which parts of the delivery they felt most competent in, facilitators felt that they had delivered the group discussion most effectively, followed by role plays and vignettes. Reassuringly, they reported that they delivered all aspects equally 18% of the time. Difficulties with delivering vignettes were linked to problems in locating particular vignettes on DVDs (due to lack of numbering); their occasional

'longwinded' duration; answers being revealed within some preambles to vignettes, which undermined the learning capacity of the vignette; and that, sometimes, it was not possible within sessions to show all prescribed vignettes. Challenges with role plays were related to the discomfort of some parents in practicing new parenting strategies before other group members. These findings suggest that facilitators may require more advice or training in delivering vignettes and role plays, but also that the programme itself might benefit from further reorganisation of the vignettes.

8.3 Exposure

Exposure of participants to the intervention was monitored by calculating the mean parental attendance across the nine parenting groups (labelled here as groups A to I). The mean attendance was 8.23 (SD = 4.79) sessions out of 14 sessions. A one-way between groups ANOVA was conducted to explore whether attendance differed across the nine parenting groups. The results indicated a statistically significant main effect for the parenting group [F (8, 92) = 2.114, p = 0.043] and post-hoc comparisons using the Tukey HSD test indicated that the mean rate of attendance for group D (M = 11.44, SD = 1.67) was significantly greater than for group F (M = 5.08, SD = 4.35). Notably, the latter included more parents who were extremely disadvantaged. There were no statistically significant differences between any of the other groups (See Figure 8.1 for mean attendance across the nine parenting groups). Interestingly (as indicated earlier in Table 7.2 in Chapter Seven), parenting groups D and F were both delivered by the same group facilitators and in the same service setting which had on-site childcare facilities. However, in running group F, the facilitators did not screen for the readiness of parents to attend the programme (i.e. they accepted all interested parents, regardless of other problems within their lives) and this may have affected retention within this group.

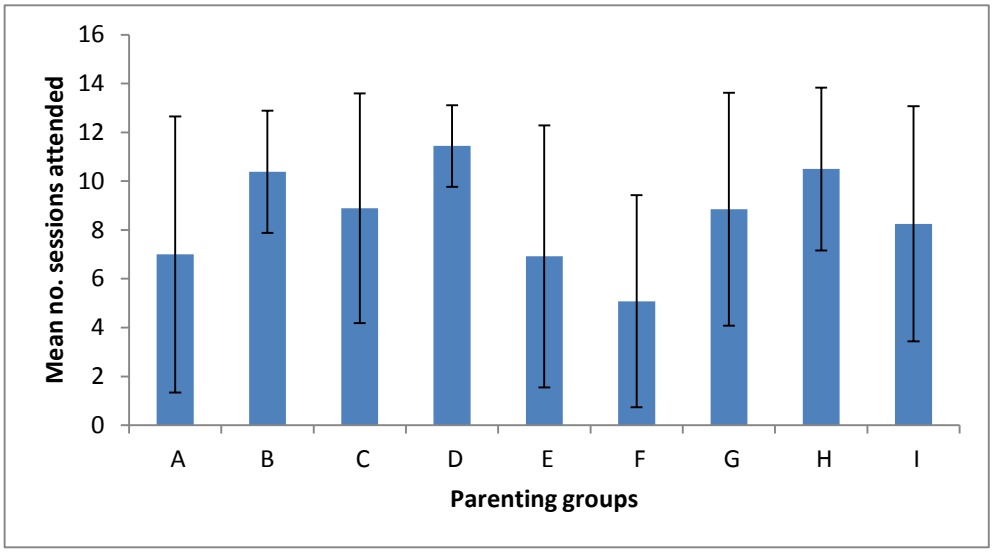

Figure 8.1 Mean parental attendance across the nine parenting groups

These findings corroborate the facilitator concerns articulated earlier in Chapter Seven regarding the low retention of parents in certain parenting groups. Factors that may have affected parental retention (as indicated in Chapter Seven) will be explored further within the Discussion.

8.4 Parental responsiveness to, and satisfaction with, the programme

As described earlier in Chapter Four, parental responsiveness to the IYPP was evaluated using the PWE, which measured the perceived usefulness of various aspects of the programme format (e.g. programme content, vignettes) and the PSQ which assessed parents' satisfaction with various aspects of the programme (e.g. teaching format, specific parenting techniques, competence of group facilitators). Parental engagement with the IYPP, as reported by group facilitators, was assessed using the IFF.

Parental engagement is a key aspect of monitoring IF (Mihalic et al. 2002) and this also links in to the findings reported earlier in Chapter Six (Theme Two), with regard to 'core intervention mechanisms'. Thus, parents at the six-month follow-up attributed the key mechanisms of change more to the acquisition of positive parenting practices (e.g. positive attention through play and praise; reacting calmly and problem-solving; and developing empathy through labelling emotions) than to limit-setting skills. Time out was particularly disliked and parents would have preferred if more time had been dedicated to teaching problem-solving skills. Another core intervention component

reported in Chapter Six, related to parental confidence, which was primarily derived from supportive relationships with the group facilitators and other group members.

8.4.1 Parent responsiveness (PWE)

Parents (N=89) reported satisfaction with all programme components on a Likert scale ranging from 1 (unhelpful) to 4 (very helpful). These components included: programme content, vignettes, teaching of group facilitators and group discussion (Figure 8.2). A mixed between-within groups ANOVA was conducted to explore the impact of programme component and parenting group on the perceived utility of the programme. The results showed a statistically significant main effect for programme component, with a medium effect size [F (3, 89) = 19.526, p = 0.000, eta squared = .429]. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for vignettes (M = 3.54, SD = 0.22) was significantly lower than for programme content (M = 3.78, SD = 0.19), teaching of group leader (M = 3.84, SD = 0.23) and group discussion (M = 3.81, SD = 0.18). The interaction effect also reached statistical significance, although with a very small effect size [F (24, 89) = 1.671, P = 0.03, eta squared = 0.146]. There were no statistically significant differences between any of the nine parenting groups [F (8, 89) = 1.148, p = 0.341).

These results support and validate the parents' subjective reports at the six-month follow-up interview which showed that they experienced several difficulties with the vignettes; for example, they were perceived by some parents as being overly 'American' and positive in tone. Likewise, the findings substantiate the facilitators' self-reports on the IFF whereby they expressed the view that they had delivered the vignettes less effectively than any of the other programme components.

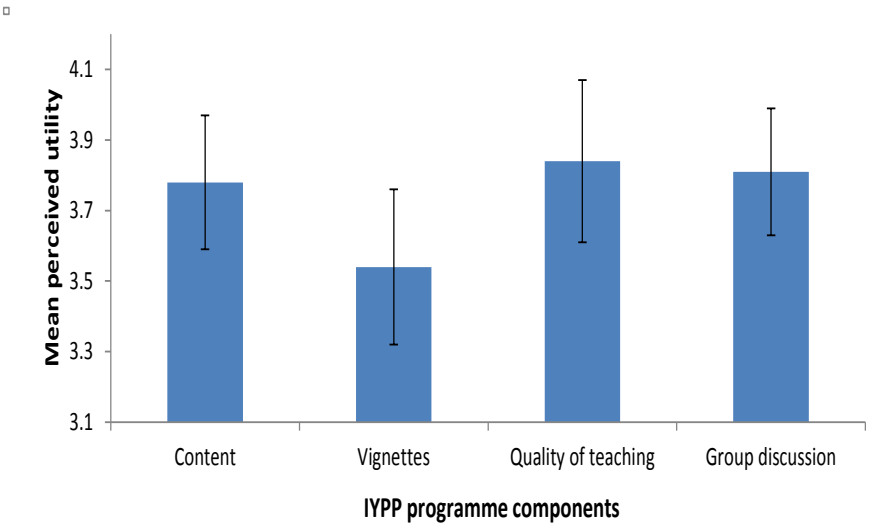

Figure 8.2 Mean perceived utility of programme components (PWE)

8.4.2 Overall satisfaction with the IYPP (PSQ)

Overall, parents (N=57) were highly satisfied (M=6.69, SD=0.14) with various aspects of the IYPP, including their child's improvement in behaviour, the teaching format, relationships with other group members and the usefulness of specific parenting techniques (Figure 8.3). The competence of the group facilitators was rated particularly highly and indeed, this was also reflected in a mixed between-within groups ANOVA which was conducted to explore the impact of programme component and parenting group on parents' satisfaction with the programme. The results showed a statistically significant main effect for programme component, with a medium effect size [F (4, 57) = 17.636, p = 0.000, eta squared = .605]. Post-hoc comparisons using the Tukey HSD test indicated that the mean satisfaction score for the competence of group facilitators (M = 6.91, SD = 0.19) was significantly greater than for reported improvements in child's behaviour (M = 6.65, SD = 0.36), teaching format (M = 6.58, SD = 0.33), specific parenting techniques (M = 6.60, SD = 0.35) and relationships with other group members (M = 6.74, SD = 0.33). In addition, the mean score for relationships with other group members was significantly higher than for teaching format and specific parenting techniques, although still lower when compared with the competence of group facilitators. The main effect for parenting group [F (7, 57) = 0.786, P = 0.60] and the interaction effect [F (28, 57) = 1.281, P = 0.17] did not reach statistical significance. Thus, of all the programme components, parents were most satisfied with the quality of

delivery and the relationships experienced with other group members. This finding highlights the importance of establishing supportive interpersonal relationships if the principles of the IYPP are to be received well by parents.

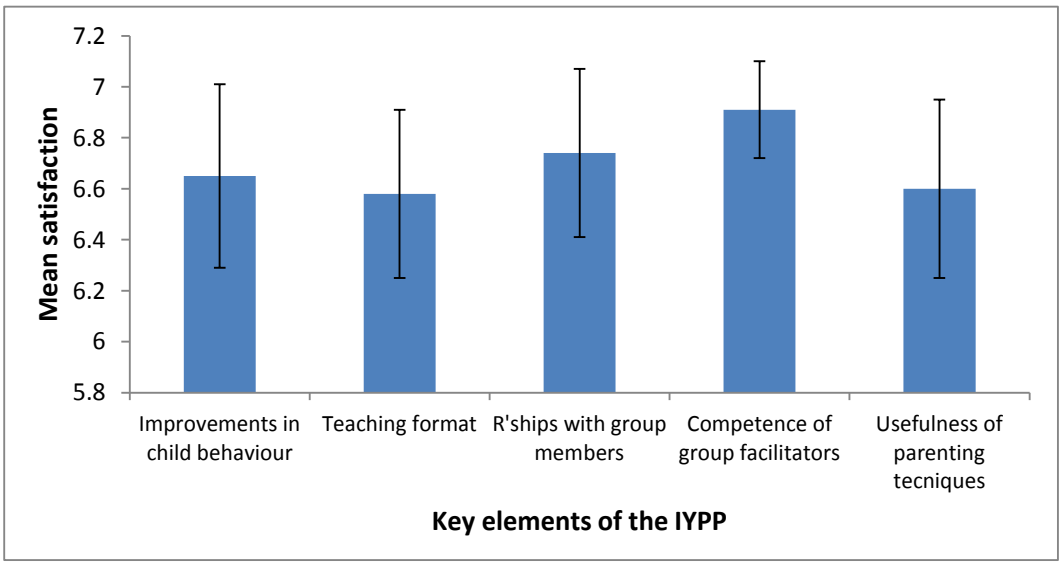

Figure 8.3 Parents' overall satisfaction with key elements of the IYPP (PSQ)

8.4.3 Satisfaction with teaching format (PSQ)

Parents' satisfaction with various aspects of the teaching format (e.g. content, vignettes, discussion, homework, buddy calls, role plays, and mid-week phone calls) was further explored using the PSQ (Figure 8.4). A one-way repeated measures ANOVA showed a statistically significant effect for teaching format, with a medium effect size [F (10, 57) = 9.943, p = 0.000, eta squared = .679]. Results indicated that parents (N=57) rated buddy calls as statistically significantly less useful than all other aspects of the teaching format. They were also statistically significantly less satisfied with role plays than with most other aspects. The group discussion and homework were rated statistically significantly more useful than many other programme components, including vignettes, reading book chapters, weekly hand-outs, buddy calls, role plays and mid-week phone calls.

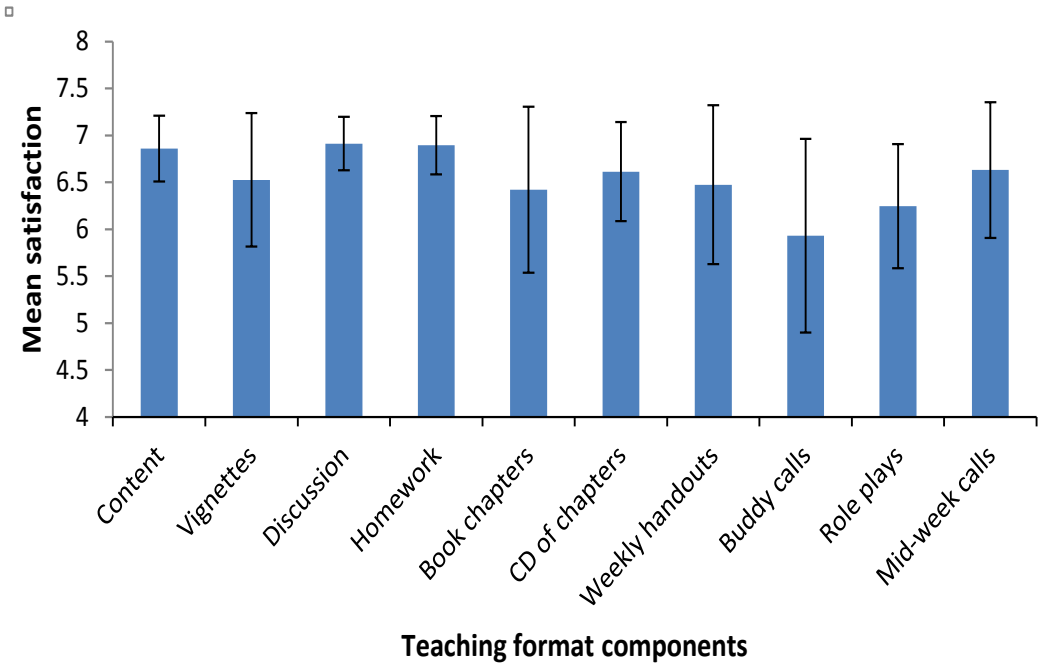

Figure 8.4 Mean (SD) parental satisfaction with teaching format components (PSQ)

8.4.4 Satisfaction with parenting techniques (PSQ)

A further one-way repeated measures ANOVA was conducted to explore the perceived utility of various parenting techniques (e.g. play, praise, ignore, time out, logical consequences), as reported by parents (N=57) on the PSQ (Figure 8.5). The results showed a statistically significant effect for parenting techniques, with a medium effect size [F (11, 57) = 7.074, p = 0.000, eta squared = .628]. Both time out and problem-solving with adults and teachers were rated as statistically significantly less useful than all other parenting techniques. Parents were statistically significantly more satisfied with the use of praise than with any other parenting skill. Play, rewards, positive commands and ignore were also perceived as statistically significantly more useful than other behavioural techniques. These results largely corroborate the findings from the qualitative analysis.

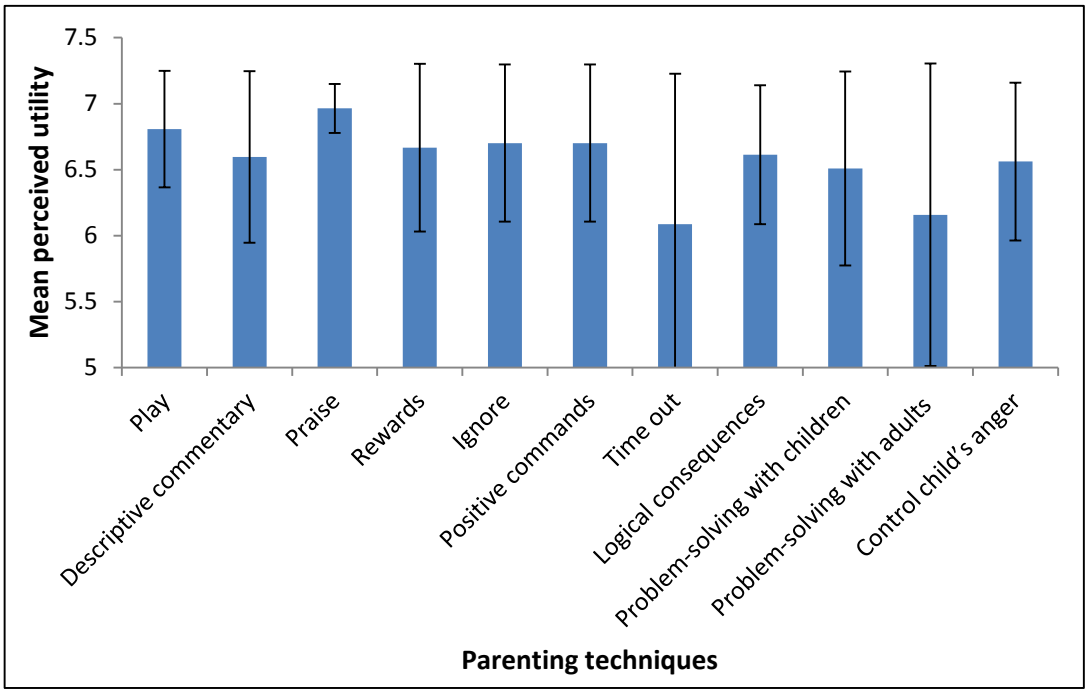

Figure 8.5 Mean perceived utility of parenting techniques

8.4.5 Parental engagement as reported by group facilitators (IFF)

Group facilitators were asked to rate parents' engagement with the programme material on the IFF after each session. Similar to parents' reports on the PWE and PSQ, facilitators believed that parents were most engaged with the discussions, followed by vignettes and role plays. Parents reportedly understood the programme content 'well' in 33% of sessions and 'very well' 67% of the time. Based on the role play practice, facilitators reported that they were confident that parents were able to implement the specific parenting skill in 75% of the sessions but were less confident about the competence of parents a quarter of the time. Similarly, group facilitators were satisfied that parents completed all of their homework activities for 73% of the sessions and had partial completion of homework 27% of the time. The group facilitators further reported that, of those parents who attempted to implement the skills at home, 80% did so with some success on a weekly basis, whereas 20% did so with total, or almost total success.

8.5 Relationship between implementation fidelity and outcome of child behaviour

This study also investigated the strength of the relationship between various aspects of reported IF and the outcome of child behaviour, as measured by parental report on the

ECBI, the main outcome measure. This is important in view of the emphasis placed on IF within the parenting field more generally (e.g. Hutchings et al. 2007b; Mihalic et al. 2002; Webster-Stratton, 2011). As indicated in Chapter Four (Section 4.3.4), the parenting group was used as the unit of analysis rather than the individual parent due to the anonymity of data for parents who completed the PWE and PSQ. However, despite parent anonymity, it was possible to calculate a mean score for the parenting group in relation to the PWE and PSQ. Similarly, the researcher did not have access to individual data on parental attendance, but mean attendance rates for each parenting group were available from the team statistician on the RCT study (McGilloway et al. 2012a). The availability of a mean score for the parenting group in relation to the relevant variables, meant that correlational analyses could be conducted, albeit with a reduction in power due to the small number of parenting groups (N=9) in the study. As such, the p-value was set at 0.10, rather than 0.05, in order to account for the reduction in power (Cohen, 1988; Howell, 2009).

Spearman's Rho was used in all correlational analyses due to the non-normal distribution of the data. Whilst no statistically significant relationships were identified from these analyses ($p>0.10$), there was a moderate relationship between overall parent satisfaction on the PSQ and the key outcome measure of child behaviour ($r= .32$, N=9, $p=.404$) (See Table 8.1).

Table 8.1 Results of the Spearman Rho analysis (N=9)

		Therapist adherence (LWE)	Parental attendance	Parental satisfaction (PWE)	Parental satisfaction (PSQ)
Child behaviour (ECBI)	**r**	-0.08	0.06	-0.09	0.32
	p	0.83	0.88	0.81	0.4

8.6 Conclusion

Fidelity within the RCT was monitored in a number of important ways, the findings of which are summarised below.

(1) Firstly, self-reported practitioner adherence to session protocols was high across all nine parenting groups, although group facilitators also indicated that adherence was partially compromised, in that occasionally they did not have time to show all prescribed vignettes or role plays.

(2) Self-reported quality of programme delivery was also high, although difficulties in some areas were indicated in 10% to 22% of sessions. These related to keeping parents focused on topic, tailoring topics to parents' needs and promoting the development of problem-solving competencies among parents. In addition, facilitators reported that they found it easier to hold group discussions than role plays and vignettes.

(3) Parental engagement with the programme is an important component of implementation fidelity. The results reported here, indicate that mean parental attendance was generally low at 8.23 (SD = 4.79) sessions. Attendance rates appeared consistent across all but two of the groups which appeared to differ with respect to the disadvantaged status of the parents in one group and the fact that these parents were not screened for suitability. These parents appeared less likely to attend the programme most probably due to the many other difficulties in their lives.

(4) Parents indicated generally high levels of satisfaction with the programme, although certain aspects of the IYPP (e.g. relationships with other group members, teaching of group facilitators, group discussions, homework) were identified as being more useful than other elements (e.g. vignettes, buddy calls and role plays). In addition, parents identified praise and play as the most useful parenting techniques and time out and problem-solving with adults/teachers as the least useful skills.

(5) The group facilitators' reports on parental engagement with the IYPP were also generally favourable. Thus, based on the role play rehearsal of parenting techniques, facilitators indicated that they were confident about parents' competence in implementing parenting skills in 75% of sessions. They also reported that parents

successfully completed all of their homework in a similar proportion of sessions. Furthermore, based on the weekly homework check-up, facilitators reported that parents implemented the skills with ‘some success’ 80% of the time and with ‘most/total success’ 20% of the time.

(6) Lastly, there were no statistically significant relationships between child behaviour and all measured aspects of fidelity, although there was a hint from the data, that parental satisfaction with the programme is related, at least to some extent, to child outcomes. Further research in this area is required.

These results support and extend the findings reported in Chapter Six (Section 6.2) which focused on the core intervention mechanisms of the IYPP. All of the findings are discussed in the final chapter.

CHAPTER NINE

DISCUSSION

The principal aim of this study was to identify and explore the causal mechanisms, processes of change and contextual factors associated with implementation of the IYPP within disadvantaged community-based settings. A secondary aim was to monitor and assess all aspects of implementation fidelity (IF) of the IYPP within the RCT evaluation. The study was conducted in two separate, but related stages in order to address each of these aims.

The findings from the larger Stage One, which was based on a qualitative analysis, provide important insights into parents' experiences of change (from learned helplessness to confidence and control), as well as identifying the key short- and long-term facilitative and inhibitive factors associated with trial outcomes. This study is one of only a handful of qualitative studies in the international literature that have examined the longer-term experiences of participants in parent training programmes/interventions (i.e. using qualitative methods), as well as implementation issues, from an organisational perspective. The results from Stage Two, based on a quantitative analysis of IF, indicated high therapist adherence and participant satisfaction (albeit with preferences for certain parenting skills). However, fidelity was partially compromised in that several parenting groups experienced considerable difficulties in retaining parents. The findings from Stage Two overlap with, and support, several of the findings and themes reported earlier within the qualitative analysis and, therefore, this chapter will synthesise and critically discuss the findings from both stages of the study. These will be presented under a number of major headings considered most relevant to the study objectives.

9.1 From pre-programme helplessness to post-programme benefits

The qualitative analysis supports and amplifies the results of the RCT (McGilloway et al. 2012a) in illustrating the enormity of the change achieved by parents in terms of moving from a high level of helplessness (and embattlement) at baseline to post-intervention confidence and control. Moreover, the findings reveal that the benefits obtained from participation in the IYPP validate and extend the positive outcomes

typically reported in other RCT evaluations of the programme. For instance, these generally examine changes in parental stress and/or depression, parenting practices and the child's behaviour in the home setting (e.g. Gardner et al. 2006; Larsson et al. 2008; Scott et al. 2001b; Webster-Stratton et al. 2004), although the current RCT was only one of two studies that also investigated the impact of the intervention on sibling behaviour (Hutchings et al. 2007a; McGilloway et al. 2012a). The qualitative analysis yielded similar positive outcomes to those reported in standard RCTs, but also identified several additional benefits for many participants, including enhanced marital, family and community relationships. Moreover, one fifth of parents reported improvements in their child's educational abilities and behaviour in school. These additional outcomes were largely corroborated by reports from group facilitators. Thus, the IYPP may potentially produce more benefits than is currently realised from the findings of RCTs alone. Therefore, it may be worthwhile for future RCT evaluations of parenting programmes to include measures on child educational/cognitive abilities, child behaviour within the school setting, parental social support, sibling behaviour and marital well-being, as recommended in a recent Cochrane review (Furlong et al. 2010; Furlong et al. 2012).

Quantitative studies of families with children displaying behavioural problems indicate that, at baseline, parents typically present as depressed, stressed and inclined to use aversive forms of discipline (e.g. McGilloway et al. 2012a; Webster-Stratton, 1984). While such data are certainly useful, the qualitative analysis reported here (and in the two qualitative studies conducted elsewhere), adds value by offering insights into the 'lived' experience of parenting a child with severe conduct problems. Arguably, the theory of learned helplessness (Abramson, Seligman & Teasdale, 1978) may encapsulate the experiences of the majority of parents within the current study. For example, recurring themes identified in this study are all hallmarks of learned helplessness including: a constant failure to link attempted parenting techniques to desired outcomes; a sense of powerlessness and victimisation; social isolation; fractious family and community relationships; and blaming of self (Abramson et al. 1978). Furthermore, learned helplessness theory posits that people learn that responses and outcomes are non-contingent when they cannot control the situation (Seligman, 1975). Most parents in the current study had struggled and failed for years to control their child's behaviour. Thus, they had learned to believe that there was no identifiable relationship between their disciplinary actions and the child's behaviour.

Parental learned helplessness is also evident in that parents tended to either blame themselves as being 'bad parents' or, instead, attributed the child's misbehaviour to the child's fixed negative personality. Neither of these attributional styles is likely to promote a belief in parents that they can effect positive change within their environment (Bandura, 1986). Furthermore, their sense of powerlessness often led to ineffective parenting behaviours. For instance, many parents responded angrily with excessive discipline in an effort to gain control, and thus, inadvertently acted as inappropriate models and reinforced similar (negative) behaviour in their children (Patterson, 1982).

In addition, this overwhelming sense of helplessness pervaded other elements of parents' lives, with parents generally reporting that their child's misbehaviour negatively affected their family and community relationships. As a result, many felt isolated, stigmatised and even rejected. Thus, their sense of hopelessness had become somewhat globalised rather than remaining specific to the child. Moreover, evidence indicates that many societies tend to place considerable importance on successful child-rearing (although often without providing the commensurate supports) and, therefore, a perceived failure in this area is likely to compound the experience of parental helplessness (Douglas & Michaels, 2004; Hays, 1996). Overall, the findings from this study are consistent with other qualitative research that has shown that parents of children with conduct problems exhibit symptoms of learned helplessness at pre-intervention (Patterson et al. 2005; Webster-Stratton & Spitzer, 1996).

Interestingly, and unlike the studies cited above (Patterson et al. 2005; Webster-Stratton & Spitzer, 1996), the experiences of three parents in the current study did not conform to the learned helplessness hypothesis. These parents certainly reported negative child behaviour, but they also emphasised the positive elements of their relationship with their child. Hence, their perception of the issue was more specific and less globalised than the experiences of the other parents (Seligman, 1975). These parents also reported some previous successes in controlling their child's behaviour, which may have increased their self-efficacy beliefs. In many ways, the coping style of these parents was similar to that shown by many parents at the post-intervention stage, in that they maintained confident self-belief even when faced with challenging child misbehaviour. It is not fully clear as to why this is the case, but the only identifiable difference, from the available data, appears to relate to their better socioeconomic status; all three had

attended third level education and worked in a professional capacity, which may suggest that they possessed more advantages than the other parents. However, as noted earlier, it is important not to overestimate the potential relationship between socioeconomic status and parental distress at baseline, as the other non-disadvantaged parents in the qualitative sample (N=6) reported levels of stress comparable to their socially disadvantaged counterparts. Alternatively, it may be simply that some parents experience less distress about their child's difficulties due to increased utilisation of social supports, or through more developed internal resources (Neenan, 2009; Owen, 2011).

The Theme One findings, reported in Chapter Five, have important implications for treatment. Firstly, they should help to sensitise group facilitators to the long history that parents have already experienced prior to seeking help for their problems. In particular, clinicians/practitioners need to be aware that a prolonged period of learned helplessness may lead parents to believe that they cannot change their child's behaviour, and especially in cases where no benefit from previous contact with psychology services is reported. It is hoped that by teaching effective parenting skills, parents should begin to develop some expectation that they will eventually be able to control their child's behaviour. In addition, the findings reported here, suggest that some parents believe that the crux of the problem lies in the child's character, or in the child's past, and therefore, they may resist the idea that they may need to change their own parenting behaviour. Furthermore, the findings illustrate that many parents within this study adhere to an implicit parenting strategy of punishing misbehaviour and ignoring positive behaviour. Consequently, it is imperative that facilitators articulate from the outset, convincing reasons as to: (a) why parents need to take responsibility for changing their own parenting behaviours; and (b) the benefits of attending to positive behaviour and ignoring/setting limits to misbehaviour. As shown in the Theme Three findings reported in Chapter Seven, parental attitudes and expectations of the programme (e.g. helplessness, lack of taking responsibility for change, and lack of commitment) were identified by group facilitators as negatively impacting retention within the RCT. Other research similarly indicates that parental engagement is linked to a mismatch between the implicit parental expectations and assumptions and the aims and objectives of the programme (Forehand & Kotchick, 2002).

9.2 Core intervention components

As indicated earlier, RCTs are the 'gold standard' methodology in demonstrating the effectiveness of an intervention (MRC, 2008). Although the RCT, within which this process evaluation was conducted, reported statistically and clinically significant improvements in child conduct problems (McGilloway et al. 2012a), there is a lack of specificity with regard to the core 'active ingredients' of the IYPP. Identifying the key intervention mechanisms of the IYPP is important so that active links within the programme can be strengthened and weak components that appear to add extra little value can be either improved, or removed (Craig et al. 2008).

Both the qualitative and quantitative findings within this study suggest that the key intervention mechanisms of the IYPP involve both the teaching of specific positive skills and the enhancement of parental confidence through the group process. Indeed, the quantitative results indicate that relationships with other group members and group facilitators were perceived as being more useful than the taught parenting techniques, although the latter were also highly valued by parents. This suggests that the interpersonal component may be as important as the programme content in producing positive outcomes. Other qualitative research (e.g. Patterson et al. 2005; Kane et al. 2007), and one quantitative study (Ogden, 2008), similarly emphasised increased personal confidence (derived from the group process) as being instrumental in removing guilt and isolation and instilling self-efficacy beliefs - factors that are also likely to be important in maintaining positive outcomes over time (Hutchings, Lane & Kelly, 2004; Hutchings, Bywater, Williams & Whitaker, in press). Interestingly, although RCTs typically demonstrate that the IYPP improves parental mental health, only one study, to date (Gardner et al. 2006), has investigated the mediating impact of parental confidence on trial outcomes. Indeed, of the few mediation studies conducted thus far (e.g. Gardner et al. 2006; Eames et al. 2010; Gardner et al. 2010), all have focussed only on investigating the mediating impact of parenting skills. Gardner et al. (2006) found that parental mood/confidence did not mediate child outcomes but, unlike most other RCTs (e.g. Hutchings et al. 2007a; McGilloway et al. 2012a), their study did not improve parental depression. Although enhanced parental confidence did not appear to explain child outcomes in that particular trial, future mediator analyses are necessary to assess the relative mediating effects of parental confidence and specific parenting skills.

The acquisition of specific parenting techniques was also perceived by both parents and group facilitators as a key mechanism of change. Both the qualitative and quantitative findings reported in the current study emphasised the importance of play and praise, while the qualitative component further identified empathy, emotional literacy and remaining calm as being particularly valuable. In addition, the current findings suggest that limit-setting strategies could be covered in fewer sessions (as parents did not regularly need to employ them), that time-out was disliked and was not generally implemented, and that more time could be dedicated to problem solving, which would improve parental mental health and conflict-resolution with partners. Although parents valued the relationship-building properties of play, they believed that this could be taught in fewer sessions. Consistent with other research in the field (e.g. Aarons et al. 2012; Kling et al. 2010), the capacity of parents to complete weekly homework was also identified as being an important ingredient in improving outcomes.

Interestingly, the results of the RCT did not indicate a statistically significant increase in the frequency of observed positive parenting skills (e.g. play, praise, clear commands, physical positives) at six-month follow-up; rather, there was a statistically significant reduction in the number of observed negative parenting practices (e.g. critical comments, overuse of warnings, physical negatives) at post-intervention (McGilloway et al. 2012a). By contrast, the findings reported here, as part of the process evaluation, suggest that parents perceived the acquisition of positive parenting skills as most useful in improving their child's behaviour. Thus, there was a disparity between the findings of the RCT and the process evaluation with regard to the importance of positive parenting skills in mediating outcomes. The reason for this discrepancy is not fully clear. It is possible that the 30-minute observations undertaken as part of the RCT were somewhat contrived in that parents may have felt uncomfortable in expressing themselves in a natural manner, especially in relation to 'faking good' at the baseline assessment. Alternatively, more than half of the parents indicated in the process evaluation that, while they found the positive skills very helpful, they also reported several difficulties in actually implementing play and praise skills as they had not been previously exposed to such parenting practices. Therefore, it is possible that parents were still relatively unpractised in implementing such skills at the six-month follow-up even though, at a cognitive level, they believed in the importance of such techniques. Although one other study (Beauchaine et al. 2005) also suggested that improved child behaviour was related

more to the reduction of critical, harsh and ineffective parenting than to the improvement of positive parenting skills, more research appears to corroborate our findings that an increase in positive parenting skills is a significant mediator of change in breaking the cycle of poor parenting (e.g. Eames et al. 2010; Gardner et al. 2006; Gardner et al. 2010).

Nevertheless, despite the emphasis on the mediating effect of positive parenting skills, very few studies have investigated the relative efficacy of various parenting techniques. One study (Eames et al. 2010) compared the mediating effects of different parenting skills within the IYPP and found that only parental praise and empathy were significantly related to improvements in child behaviour. In addition, and similar to the present study, Birk-Olsen and Horsted (2008) reported that parents valued the more positive-oriented skills (play, reward, positive commands) and disliked elements of limit-setting skills, such as time out. Interestingly, parents within the Webster-Stratton (1989) study reported that time out was one of the most useful techniques. The differing views on time out may potentially be attributed, firstly, to the fact that, due to time pressures within the current study, time out may not have been adequately covered, or parents may not have received sufficient reinforcement in persisting with this difficult strategy. However, this may not explain why time out was also disliked in the Danish study (Birk-Olsen & Horsted, 2008). Alternatively, the dislike of time out may be linked to the fact that more recent versions of the IYPP place less emphasis on time out when compared to the early years of programme development when time out was treated as a more central component (e.g. Webster-Stratton, 1984; Wiltz & Patterson, 1974). Thus, it is not clear at this stage whether time out constitutes a weak element in the causal chain, or whether this component was insufficiently taught by group facilitators. Overall, more rigorous research, such as mediator analyses, are required in order to identify which particular positive parenting skills are most instrumental in explaining outcomes.

Other research has indicated that reflecting on childhood experiences of being parented was an important mechanism of change within the IYPP (Levac et al. 2008). As evidenced in the current study (Theme Three), reflecting on such childhood experiences may be important for some parents in overcoming cultural and personal barriers to implementing play and praise skills. However, Levac et al. (2008) reported that such reflection was the principal mechanism of change within their study as parents came to

understand the origins of negative parenting practices, which allowed for the development of new insights and a shift toward more positive approaches. While ten parents in the current study talked about their childhood experiences, such reflection did not seem to operate as a primary mechanism of change for enhanced child outcomes but appeared, rather, to be a by-product of participating in the programme. The IYPP does not include a module that specifically directs parents to reflect on the origins of negative parenting, but it is possible that the group facilitators in the Levac et al. study (2008) led parents to reflect on the history of their particular parenting styles. Future qualitative research should explore the relative importance of reflection on childhood experiences as a mechanism of change across different cultural backgrounds.

Lastly, when investigating the core intervention mechanisms within the IYPP, it is also important to examine the extent to which the inclusion of extra sessions and components (e.g. social and emotional coaching; academic readiness) adds value to the programme. Previous research has evaluated shorter 9- and 12-session interventions with socially deprived families (e.g. Gardner et al. 2006; Hutchings et al. 2007a; Larsson et al. 2008; Webster-Stratton, 1984), whilst a smaller number of studies have evaluated a longer 20- to 22-session programme (e.g. Webster-Stratton & Hammond, 1997; Webster-Stratton et al. 2004). By contrast, the RCT conducted as part of the *Incredible Years Ireland Study*, assessed a condensed 14-week version of the 22-session programme. Despite these differences in treatment length, the effect sizes of the IYPP all fall within the moderate to large range; for instance, the effect sizes with regard to child behaviour (e.g. -0.7) that were achieved in the RCT, compare favourably with other research in the UK (-0.51; Gardner et al. 2006), Wales (-0.63; Hutchings et al. 2007a) and Norway (-0.60; Larsson et al. 2008). Indeed, the earlier 9-session version of the programme appeared to produce even larger effect sizes (e.g. -1.29 in Webster-Stratton, 1984); this study (which was conducted by the programme developer) used exemplary randomisation procedures and blind observational measures (Furlong et al. 2012), and, as such, the findings may be considered sufficiently robust to suggest that shorter versions of the IYPP produce equivalent results to those seen in longer versions of the programme.

Arguably, there is a need to elucidate more clearly, the critical ingredients of the IYPP in order to inform the development of briefer, more refined, low-cost versions of the intervention, and particularly when promoting the uptake of the programme by

mainstream services (Fixsen et al. 2005). Currently, there appears to be some contradiction in asking service providers to faithfully implement each new and longer version of the IYPP when it is not known whether or not the addition of extra components improves outcomes. It is possible, of course, that the evaluation of additional outcomes, such as child educational ability, may potentially capture benefits related to a component on, for example, academic readiness. More refined versions of the programme, focusing on the positive parenting skills mentioned above, would require testing by means of RCTs in order to ascertain the extent to which beneficial outcomes are achieved and maintained over time. Furthermore, more specific mediator analyses are vital for understanding both the key processes underlying treatment, and causal influences on child behaviour (Gardner et al. 2010).

9.3 Short-term challenges: contextual influences on outcomes

A key strength of this study lies in its focus on highlighting culture-specific issues of parenting and punishment and traditional Irish parenting values. Whilst many positive outcomes were achieved in this study from participation in the IYPP, the findings reported here underline the need for service providers to be alert to the cultural, personal and environmental challenges that exist for parents within disadvantaged settings when implementing evidence-based parenting programmes. Initially, the parents in this study were unconvinced that building a positive relationship with the child through play and praise would be an effective method of dealing with behavioural problems. They also expressed some discomfort that the praise and rewards, which are such an intrinsic part of the IYPP, might cause their children to become overbearing and arrogant. This theme of discomfort and disbelief around the idea of positive attention has not been reported in other qualitative studies of parenting programmes.

The fact that so many parents within the current study struggled with positive attention, is an interesting and unique finding. This might be best understood against a historical and cultural backdrop of common punitive parenting practices in Ireland (Greene, 1994; Littleton, 2009) and particularly within socio-economically disadvantaged settings where children are placed at an increased risk of intergenerational transmission of conduct problems (Fleming & Gallagher, 2002). However, resistance to positive attention is not exclusively a localised issue as there is evidence that other cultures demonstrate similar opposition to praise (e.g. Paiva, 2008). Thus, there is growing

awareness that providers of parenting programmes should attempt to become more culturally sensitive so that parents are encouraged in early sessions to share their family and cultural traditions and experiences of being parented as children (Dunn, 2012; Webster-Stratton, 2009). In addition, other research indicates that the materials used in parenting programmes may need to be slightly adapted in order to fit with cultural metaphors and perspectives (Forgatch & Degarmo, 2011). This approach, whilst not without its challenges, would be important in respecting different cultures and parenting styles, and in encouraging parents to talk about any resistances to the new parenting skills; this might, in turn, enhance retention rates. Furthermore, such cultural sensitivity would raise awareness that some parents may have experienced difficult childhood experiences and may require additional support from group providers in implementing the skills.

Another key contribution of this study lies in its exploration of aspects related to living in disadvantaged communities, which clearly leads to extra challenges for parents participating in a parenting programme and also for those delivering the programme. Recent research (e.g. Gardner et al. 2010; Reyno et al. 2006) has investigated how particular indicators of social deprivation (e.g. low income, lone parenthood, and maternal depression) may, or may not, moderate outcomes. Within the larger RCT undertaken by McGilloway et al. (2012a), outcomes did not vary according to socioeconomic status[22]. However, parents revealed within the qualitative analysis that the negative influence of antisocial peers within their neighbourhoods presented a barrier to maintaining outcomes at the short-term follow-up (and also, to some extent, in the longer term). Participants often felt unsupported by their peers in their parenting efforts and may, therefore, require additional post-course supports, such as the IY ADVANCE program (Webster-Stratton & Reid, 2010), or a multi-environment approach (Reid & Patterson, 2002), such as the Incredible Years child and teacher training programmes, to achieve optimal results and to prevent future relapse. Furthermore, this finding appears to be consistent with other research (e.g. Lundahl et

[22] As a reminder, a family was designated as 'socially disadvantaged' within the RCT if they obtained a risk factor score on two or more of the following six variables: employment status, parental status (lone vs. married or cohabiting), income divided by size of family, parental education, quality of housing, and levels of criminality in the participants' area of residence (Central Statistics Office, 2009).

al. 2006) which shows that high levels of social deprivation may affect retention rates. This issue will be discussed in more detail later in this chapter (Section 9.5).

An additional challenge reported by parents in the current study concerns the increased conflict with partners with regard to the introduction of new techniques. This theme has been reported in three other studies (Kelleher & McGilloway, 2006; Mockford & Barlow, 2004; Spitzer et al. 1991). Such parental tension is an undesirable side effect that may occur when only one parent participates in the IYPP and is a source of concern, given the effect of marital conflict on the emotional and behavioural well-being of children (Golombok, 2000). Some evidence suggests that targeting marital satisfaction, with sessions addressing inter-parental communication, support and problem solving, directly enhances the effects of parent training (Ireland, Sanders & Markie-Dadds, 2003). However, most of the parents who took part in the current study would have preferred their partner to attend the parenting programme at the same time and research indicates that the involvement of both parents, or a grandparent, enhances the long-term maintenance of results (Webster-Stratton, 1985; Webster-Stratton, 2009). It may be possible to promote the participation of more fathers in parenting programmes by training more male group facilitators and increasing the availability of evening courses. On a wider policy level, increased paternal leave and changes in employment law may be necessary to enable fathers to have more time for family life (OECD, 2010; Shulruf et al. 2009). This is an area in need of further research.

9.4 Long term processes of change

This study is one of a few to examine the longer-term experiences for parents following completion of the IYPP. The results of the larger RCT indicated overall maintenance of positive outcomes at 12-month follow-up, although approximately one third of families reported clinically significant behaviour problems at this juncture (McGilloway et al. 2012b). The findings from the process evaluation support and extend these results in the extent to which they show considerable variation in parental experiences in the longer term. For instance, one quarter of the interviewed parents (who may be referred to here as ‘Group One’) indicated that they had easily assimilated the parenting skills into their daily lives whereas one third of parents (‘Group Two’) reported that the maintenance of outcomes involved considerable conscious effort (‘hard work’), regular modification and fine-tuning of skills, as well as minor setbacks and relapses. Moreover, two fifths of

parents (‘Group Three’) related that they underwent a sustained period of relapse in child behaviour (from one to four months duration), with most reporting full or partial recovery by 12-month follow-up whilst a smaller number (‘Group Four’) reported non-recovery at both the 12- and 18-month follow-up periods. Other qualitative research has similarly found that positive outcomes may be maintained in the longer term, albeit with considerable difficulties (Webster-Stratton & Spitzer, 1996), and that some parents may also report significant relapses in child behaviour at 12-month follow-up (Morch et al. 2004).

The findings from the process evaluation suggest that variations in committed practice and resilience may partially explain the differential experiences of parents in the longer term. It is probable that parents who spoke of naturally incorporating the skills into their daily lives (Group One) were most committed to frequent practice of parenting skills since the completion of the programme. For instance, such parents demonstrated an impressive facility in identifying which skills could be employed in different situations. Research indicates that performance of a skill enters into implicit memory with requisite practice; that is, consistent and deliberate practice removes the long-term need for extensive use of explicit, conscious effort (Ericsson, 2008; Feltovich, Prietula, & Ericsson, 2006). Therefore, it is possible that parents who reported a reliance on conscious effort and explicit memory (Group Two) may have engaged in less frequent practice than parents in Group One. In support of this argument, these parents admitted that they tended to implement the skills only when their child misbehaved, but did not consistently employ them in order to prevent the occurrence of such misbehaviour. In a qualitative analysis of Norwegian parents, Morch et al. (2004) similarly reported variability in continued implementation of skills at 12-month follow-up.

Nevertheless, parents in Group Two demonstrated considerable resilience in remaining committed to the programme despite occasional relapses and setbacks. Such resilient behaviour was indicated, firstly, through reports of self-acceptance beliefs; for example, many parents frequently recounted that it was ‘human to make mistakes’ but that it was important to ‘move on from them’ and not dwell on negative thoughts of failure or anger with regard to themselves or their children. The fact that many parents reported this particular ‘recovery’ strategy suggests that the defusion of negative thoughts may have been taught implicitly within the IYPP. Research from the field of Acceptance and

Commitment Therapy (ACT) indicates that teaching non-engagement with negative self-evaluations may be an important component in preventing relapse post intervention (e.g. Bach & Hayes, 2002; Biglan, Hayes & Pistorello, 2008; Blackledge & Barnes-Holmes, 2009; Hayes, Strosahl, Wilson, 2003). Interestingly, the IYPP does not explicitly include a component on relapse prevention, although it clearly teaches techniques that promote the maintenance of skills in the longer term.

Parents from Group Two also demonstrated resilient behaviour through adopting a more balanced perspective of their child; for instance, misbehaviour was now interpreted in terms of the child's overall positive behaviour. In addition, resilience was evident in the long term in that parents engaged in the ongoing modification of parenting techniques in order to improve their assimilation into their daily lives. Such fine-tuning of skills was indicated at both the 12- and 18-month follow-ups, but was particularly evident at the 18-month follow-up, when parents explained how they often modified 'playtime' into 'spending time', reduced length of playtime and engaged in less avoidance of skills implementation. Moreover, resilience was facilitated by utilising the support of willing partners, family, and friends and through maintaining contact with other parents from the course. This supports other research from the psychological literature that suggests that seeking help, when required, is indicative of resilient behaviour (Neenan, 2009; Owen, 2011; Reich, Zautra & Hall, 2010).

Relapse in positive outcomes has been noted in other research (e.g. Stewart-Brown et al. 2004), but the reasons for such sustained relapses have received little research attention, to date. Within the current study, it appears that under conditions of stress (including busy lives, bereavement, illness, separation from partner), half of the parents in Group Three responded by reverting to using previous parenting behaviours and abandoned their newly learned skills, which still involved a considerable level of conscious effort. This difficulty in perseverance suggests that these parents had not yet consolidated the skills into their lives in a habitual manner and perhaps were less committed to doing so. It might also indicate a higher level of negative life stressors amongst these parents when compared to other parents in the study; however, many other parents in the study also experienced stressful life events in terms of separation, illness, financial difficulties and so forth. Overall, there appeared to be some evidence that parents who relinquished the skills at stressful junctures demonstrated less resilience in responding to setbacks.

For instance, some parents reported experiencing defeatist thoughts (e.g. 'I'm a failure, I should give up') and feelings (guilt, shame) when they failed to implement the skills for a couple of weeks. It is likely that such negative self-appraisals and lack of self-acceptance meant that these parents made it more difficult for themselves to recover from relapses (Hayes et al. 2003; Neenan, 2009). Moreover, these parents allowed weeks of non-implementation to turn into months of avoidance; indeed, research on ACT indicates that avoidance of valid pain (e.g. learning from mistakes) leads to negative longer-term consequences and trauma (e.g. Gold & Wegner, 1995; Hayes, Wilson, Gifford, Follette & Strosahl, 1996; Kehoe, Barnes-Holmes, Barnes-Holmes, Cochrane & Stewart, 2007; Luciano et al. 2010; Törneke, 2010).

Nevertheless, it is important to note that an underlying commitment to improve their parenting behaviour did not completely disappear. Once the stressful period had subsided, or parents had learned to cope more effectively, most were then able to re-introduce the parenting skills. Key indicators of the successful recovery of parenting skills included: overcoming feelings of guilt and worthlessness through self-discipline and self-empathy; being proactive in seeking support from kin and group facilitators; and developing self-efficacy beliefs from previous successes in implementing the programme. This pattern of behaviour suggests that the application of new parenting skills places extra demands on some parents, as it does not easily become second-nature to them. Reassuringly, however, their subsequent recovery demonstrates that they had not lost the skills or their newly acquired knowledge.

A few parents also reported that relapses in child behaviour were related to the negative influence of an unsupportive partner, family, school or neighbourhood, despite their reported ongoing application of the taught parenting skills. Although the challenges of dealing with an unsupportive (ex-) partner or antisocial environment had not changed much for these parents since the six-month follow-up, it is possible that long-term stressful conditions could have an accumulative negative effect. Additionally, participants felt that their initial enthusiasm for, and support from, the IYPP programme, was less evident at twelve months than at the six-month follow-up. The 'honeymoon period' had passed and parents felt more alone and missed the support of other parents and group facilitators. It is reassuring to note, however, that these parents managed to recover from relapse by employing various coping methods. These strategies included:

minimising the contact their children had with their ex-partners; investing more effort into their daily implementation of the skills; and attempting to educate their partners or schools (with some success) about positive management techniques. As such, these parents demonstrated considerable resilience in their capacity to deal with the challenges which emerge as children and families develop and experience transitions and change.

Only two parents failed to recover from a prolonged relapse in child behaviour. The relapse appeared to be connected to their confused understanding, and application, of positive parenting skills, and to some extent, to a lack of perseverance during stressful junctures. These parents did not appear to grasp the principle of positive attention; for example, they paid more attention to negative rather than positive child behaviours and emphasised limit-setting strategies at the expense of relationship building techniques. Thus, they found it difficult to understand why the child's behaviour had relapsed when they believed that they were implementing the skills in the correct manner. Consequently, one of the parents believed that the skills were not effective beyond a short-term 'novelty' effect. Nevertheless, despite such setbacks, both of these parents reported that they had gained confidence and self-esteem from the social interaction involved in the group training process. They both subsequently evaluated themselves as 'normal' parents, in contrast to their earlier negative self-appraisals at pre-intervention. Thus, they considered their participation to be a worthwhile experience, which suggests that the IYPP intervention may also meet the needs of parents in ways that go beyond any improvements (or lack thereof) in their child's behaviour.

The long-term findings have several implications for treatment. Firstly, it is important that facilitators assess the degree to which key principles are understood by parents throughout the intervention, particularly in relation to positive attention and also within an Irish cultural context where punishment-oriented parenting styles may be favoured (Williams et al. 2009). Extra sessions may be required for parents who experience difficulties in grasping key concepts, although such an extension of the programme was not possible within the context of the current RCT schedule.

Secondly, the results suggest that improving resilience capacities may enhance the long-term maintenance of positive outcomes. Psychological research indicates that resilience is not an innate ability, but may be developed by strengthening both internal and

external support systems (Neenan, 1999; Owen, 2011; Reich et al. 2010). Although the IYPP promoted self-efficacy beliefs and non-engagement with negative thoughts, it might be useful for the IYPP to also consider the inclusion of relapse prevention strategies, based on CBT and/or ACT techniques. Such techniques might include, for example: preparing parents to expect several challenges post-intervention and to adapt skills if required; being mindful of, and attempting to defuse negative thoughts and emotions; challenging catastrophic, defeatist thinking, where appropriate; committing to goals despite setbacks; promoting self-acceptance and self-efficacy; regularly practicing skills; and seeking support when required (Hayes et al. 2003; Owen, 2011). In order to create the most effective and refined version of the intervention (Craig et al. 2008), it is important, not only to critically evaluate the value of existing programme components, but also to investigate the possible (longer-term) benefits attached to the inclusion of a new module, such as teaching relapse-prevention skills.

Furthermore, there may also be a role for the IYPP to provide some level of additional support to parents at post-intervention. Such supports might include a booster session at a few months following programme completion in order to facilitate the maintenance of skills. The findings from the current study indicate that even a phone call to parents would ease the transition as a few parents reported discomfort and shame about initiating contact with the group facilitators. In any case, it is important that group facilitators stress their openness to being contacted by parents who might be (or who are at risk of) experiencing difficulties in the longer term. Moreover, as indicated earlier, participation in the IY ADVANCE programme may be appropriate for parents who are experiencing a number of challenges in their lives; this teaches strategies to deal with depression or ongoing conflict with others within the home. Collectively, these findings underline parents' concerns that the IYPP should prepare them for periods of relapse post-intervention and provide support beyond parent training for some of the most vulnerable parents.

Lastly, as noted earlier, the implementation of a multi-environment intervention (e.g. the IY Teacher Classroom Management and Child Dina programmes) may be necessary within some socially disadvantaged areas in order to reduce the influence of peer deviancy on the longer-term maintenance of outcomes (Reid & Webster-Stratton, 2002). Furthermore, the preservation of outcomes in socially deprived areas may require the

implementation of wider policy initiatives in relation to quality of housing and economic inequalities (and other indices of social exclusion), as a substantial body of research indicates that there is a clear association between such contextual influences and antisocial and criminal behavior (Axford & Morpeth, 2013; Farrington, 2002; Office for Social Exclusion, 2008; UNICEF, 2007; Webster-Stratton & Reid, 2003; Wilkinson & Pickett, 2006; 2009).

9.5 Implementation fidelity and organisational influences

This process evaluation is one of only a small number of studies within the parenting field that has: (1) monitored the degree of IF achieved within an RCT evaluation; and (2) examined the organisational and systemic influences that may affect treatment fidelity (Eames et al. 2009; Fixsen et al. 2005). The assessment of IF, and the identification of facilitative and inhibitive organisational factors, are crucial for the replication of positive outcomes within other service settings (Mihalic et al. 2002; MRC, 2008). Each of the above aspects of IF is discussed below.

9.5.1 'High fidelity'?: Measurement of key components

The level of fidelity achieved within this study was high with respect to treatment adherence (mean of 90% adherence in parenting groups) and engagement of attendee parents, but was less satisfactory in relation to retention of parents within the programme. With regard to the quality of therapist delivery, both parents and group facilitators indicated that perhaps 'time out' and 'problem solving' were covered less comprehensively than other components. In addition, group facilitators felt less confident in their delivery of role plays and vignettes, but were more assured with regard to their management of the group discussions. Interestingly, this was also reflected in the parents' comments and views, thereby indicating good triangulation of findings. These results are in line with a recent study that indicates that adherence by facilitators is lowest for role plays and vignettes than for other programme components within the IYPP (Aarons et al. 2012). Moreover, other research suggests that better outcomes are related to the degree of adherence and quality of therapist delivery achieved within a study (Eames et al. 2009). It is possible, therefore, that facilitators might profit from additional training on delivering the above components. Furthermore, the new version of the IYPP might benefit from further streamlining of vignettes as they were occasionally reported as somewhat cumbersome to use. Notwithstanding, it is

important to note that the RCT indicated clinically significant results (McGilloway et al. 2012a), so it is not clear whether or not even larger effect sizes would have been achieved with more complete fidelity.

Despite the body of research indicating that positive outcomes are related to higher levels of IF (Durlak & DuPre, 2008; Furlong et al. 2012), the current study did not find any statistically significant relationships between improved child behaviour and reported fidelity (i.e. treatment adherence, parental retention and satisfaction) across the nine parenting groups. It is possible, of course, that the small number of parenting groups may have reduced the power of the analysis, although the p value was set at 0.10 in order to address this reduction in power (Howell, 2009). Furthermore, the lack of a significant relationship may be partially explained in that no significant differences were detected among the parenting groups in terms of self-reported therapist adherence, or in relation to self-reported parental satisfaction with the programme; that is, all groups reported high adherence and high satisfaction, thereby producing 'a ceiling effect'. Moreover, it is important to note that therapist adherence, quality of delivery and parental satisfaction relied on self-report measures and, thus, these results may potentially be somewhat biased. Research indicates that objective measures of fidelity are more likely to be linked to outcomes than self-report data (Durlak & DuPre, 2008). For example, Eames et al. (2009; 2010) devised a comprehensive observational measure of therapist performance and found differences among group facilitators in terms of adherence and quality of delivery. Such variations in performance also partially mediated differences in group outcomes. Further research is required to investigate the extent to which fidelity variables are related to trial outcomes.

An interesting finding emerged in relation to retention and outcomes, in that the rate of retention differed significantly between two parenting groups (mean parental attendance of 5 versus 11 sessions) and yet, similar improvements in child behaviour were reported on the ECBI within these groups. There are two possible explanations for this finding; firstly, parents in the high-attrition group may have obtained some benefit from the programme despite not attending many sessions and/or, secondly, those parents who remained as attendees in the high-attrition group achieved remarkable improvements in child behaviour when compared to parents in other groups (which seems unlikely). Thus, it might be useful for future research to investigate whether there is an attendance

threshold beyond which there is no added benefit. This analysis might also contribute to the debate on identifying the critical components of the IYPP with a view, possibly, to offering shorter but equally effective versions that can be more easily incorporated into mainstream service provision.

9.5.2 Organisational and systems influences on implementation fidelity

Several organisational components were identified as facilitating or inhibiting the implementation of the IYPP within the services in this study. Facilitative factors included: the necessity for appropriate harmonisation between the values of the IYPP and the service provider; adequate intra- and inter-agency support; and a suitable screening policy. Challenges involved retention and fidelity difficulties, as well as sustainability issues. Likewise, preliminary research in this area has highlighted the importance of such organisational factors in influencing intervention outcomes (e.g. Breitkrenz et al. 2011; Fixsen et al. 2005). This section will focus primarily on core organisational challenges to implementing these kinds of programmes and will discuss possible solutions.

9.5.2.1 Addressing attrition: screening and wrap-around supports

One of the primary concerns for group facilitators in this study was the relatively high attrition of parents in the RCT (i.e. only 69% of parents attended half or more of the sessions). Even though variations in group retention were not related to differential group outcomes in this study, the overall rate of retention was lower than levels reported elsewhere. For instance, other research in the UK and the US has indicated, respectively, that 88% and 83% of parents attended more than half of total sessions of the IYPP (Hutchings et al. 2007a; Webster-Stratton, 1998). According to the evidence presented here, the most prominent factors related to attrition in this study involved: the participation of many 'multiply disadvantaged' parents with depression, marital problems and economic difficulties; a lack of readiness amongst some parents for the programme due to personal attitudes and circumstances; research contamination; and lack of childcare. Interestingly, retention varied, to some extent, among the parenting groups and the analysis reveals that the presence of suitable screening and adequate wrap-around supports may play a key role in reducing parental attrition.

Screening for parental readiness was recognised by some managers within this study as being important in improving attendance. A rigorous screening policy would reduce the intake of 'multiply disadvantaged' parents, who may be overwhelmed with substance abuse, eviction and other issues, and as such, are unsuitable to engage with a parenting programme at that time (Forehand & Kotchick, 2002). Similarly, screening would identify whether parents: have an appropriate understanding of the programme's group format; are open to its basic tenets; are committed to the behavioural change required; and are actually able to attend the programme (Dunn, 2012). This last variable is particularly pertinent in cases where the service does not provide an onsite crèche and the parent lacks adequate childcare support. The significance of screening is indicated in that the three groups with the lowest retention rates (i.e. mean attendance less than seven sessions) were not subjected to a rigorous screening process. Furthermore, one parenting group had no wrap-around supports (nor any onsite crèche facilities), but had very low attrition due to its rigorous screening approach. In addition, the only difference between the two parenting groups with the most and least retention (mean attendance of 11 versus 5 sessions), was the implementation of a screening procedure; both groups were delivered by the same pair of group facilitators, in the same service which provided onsite childcare, but the readiness of disadvantaged parents was screened in one parenting group and not in the other.

Other preliminary research in this area has also emphasised the importance of screening in retaining parents (Marcynyszyna et al. 2011). As implicated in this study, a suitable screening process may require the establishment of a pre-programme relationship in order to properly assess the readiness of the parent to attend the IYPP (Gardner et al. 2006). Indeed, other research similarly suggests that enhanced parental retention may be linked to additional pre-programme input (Hutchings et al. 2004; Kazdin & Whitley, 2006). Unfortunately, many of the group facilitators believed that pressures to recruit sufficient parents for the RCT (combined, occasionally, with an inaccurate belief that the IYPP could retain any parent, regardless of their circumstances) meant that they accepted too many 'raw referrals' and did not employ adequate screening and relationship-building procedures. Further research is required to investigate the impact of screening on retention and outcomes.

However, the findings from this study, and other research, suggest that screening may be a necessary, but not sufficient, element in retaining socially disadvantaged parents. Arguably, it is not appropriate for organisations to exclude 'hard-to-reach' parents who might benefit from the programme, especially if the presence of suitable wrap-around supports could enhance the retention of such parents (Hutchings et al. 2007b). The available evidence indicates that the IYPP improves its retention of disadvantaged parents when the host service addresses access barriers (transport and childcare), and particularly within organisations where high quality wrap-around support systems are available, such as in Head Start (Webster-Stratton, 1998) and Sure Start services (Hutchings et al. 2007a). Such wrap-around models of care comprise sustainable intra- and inter-agency alliances; engage in individualised, person-centred care within a multidisciplinary team-based approach; and provide ongoing quality supervision, training and funding (Burchard et al. 2002; Fixsen et al. 2005). Although none of the agencies in the current study possessed the level of wrap-around supports evident in the Sure Start or Head Start services (McGilloway et al. 2012a), some of the services had elements of a wrap-around model, which may have improved retention for several multiply-disadvantaged parents. For instance, the presence of intra-agency services within two of the organisations (such as family support mornings) meant that pre-programme relationships were more easily established with such parents. In addition, two of the five services in the present study employed family support workers to help parents access the programme in the morning. Furthermore, such family support workers also provided occasional individual home coaching to parents who were experiencing difficulties in grasping the parenting skills. Thus, these wrap-around services enriched the retention of some of the most disadvantaged and vulnerable families within this study (Burchard et al. 2002; Fixsen et al. 2005).

9.5.2.2 Lack of organisational support for staff

All of the group facilitators reported that programme delivery was conducted within an organisational environment that they sometimes perceived as unsupportive. Facilitators indicated that they were not allocated sufficient time to implement the programme with full fidelity, particularly in relation to the midweek phone-calls to parents, reviewing of videotapes for supervision, and conducting 'catch-up' sessions with parents who missed a weekly session. Occasionally, facilitators reported that they had to deliver the programme within inappropriately sized rooms and with inadequate resources. Although

group facilitators succeeded in delivering positive outcomes for most parents (McGilloway et al. 2012a), such success appeared to be at personal cost to their own sense of work-life balance and emotional wellbeing. All of the facilitators reported that their organisational managers did not fully appreciate the amount of work actually involved in delivering an effective programme and, particularly, where extremely disadvantaged families were involved. Worryingly, issues such as understaffing, overwork and lack of resources are all linked to high staff turnover and burnout (Sanders & Turner, 2005), and this suggests that the implementation of the IYPP is not yet fully integrated into normal service delivery - factors which could potentially delay the longer term sustainability of the IYPP within some Irish service settings (Fixsen et al. 2005; Nutley, 2010). In an era of economic austerity, it may be difficult for health and social services to increase capacity but, in most cases, it appeared that worker satisfaction could be substantially enhanced through 'no cost' verbal acknowledgement and praise of their contribution.

It is also important to note that group facilitators experienced substantial additional stress within the context of the RCT evaluation due to the unexpected decision by service managers and the programme developer to implement the new version of the IYPP programme. Fidelity to the new programme was compromised as facilitators were given very little time to condense 22 sessions into 14 sessions. This incident illustrates the need for all participating players in a research evaluation to be aware of, and sensitive to, the objectives and wellbeing of all other 'actors', including the welfare of staff and the importance of not undermining a rigorous research design.

9.5.2.3 Sustainability and mainstreaming issues

The findings from this study are consistent with other research which indicates that programme delivery needs to be situated within a context of partnership and sustainability (Fixsen et al. 2005; O' Donoghue, 2012). Evidence suggests that sustainability depends on the ability of services to develop strategic inter-agency alliances in order to facilitate the ongoing funding and referral streams needed to support the future high quality implementation and evaluation of evidence-based parenting programmes (Fixsen et al. 2005). Within an Irish context, Archways have

identified Local Development Companies[23] as potential partners for implementation because of their ability to work with key stakeholders and to leverage funding (O' Donoghue, 2012). It is important to note, however, that several difficulties have been reported with regard to inter-agency collaboration amongst children's services, both in Ireland and elsewhere, and particularly where such services have previously operated in silos (Paulsell et al. 2009). Typical barriers to effective inter-agency partnership include: poor leadership; lack of consensus on goals; territorialism; poorly defined roles and responsibilities; lack of commitment from staff; and funding constraints (Dowling, 2004; Sloper, 2004; Statham, 2011). Nevertheless, steps are being taken within Ireland to strengthen cooperation; for instance, the roll-out of county-level Children's Services Committees is committed to establishing appropriate inter-agency alliances, although it should be noted that these developments remain at an early stage (Start Strong, 2012). In addition, several of the organisations within this study have succeeded in developing internal and inter-agency capacity despite such documented challenges, and are reaching the stage where running the IYPP becomes part of 'normal practice' within their service (Fixsen et al. 2005). For example, the five agencies within this study now facilitate their implementation of the IYPP through sharing staff and premises, and in providing peer supervision to each other. In an era of economic austerity, such inter-agency collaboration may be instrumental to the sustainability of the IYPP in Irish settings (Start Strong, 2012; Statham, 2011).

The demonstrated effectiveness and cost effectiveness of the IYPP across several different service settings in Ireland (e.g. Furlong et al. 2012; McGilloway et al. 2012a; O' Neill et al. 2011), suggest that it is likely to be beneficial to 'roll out' the implementation of the IYPP to scale within children's services both nationally and internationally (Start Strong, 2011). However, as evident from this study, and other research, efforts to mainstream evidence-based parenting programmes (EBPPs) may meet with several challenges, including: a reluctance among services to implement EBPPs; a failure to deliver EBPPs with fidelity; and a lack of clear policy guidance with regard to the implementation and monitoring of effective parenting programmes more

[23] Local Development Companies operate under the Irish Local Development Network and currently their membership involves 51 companies. The network promotes a bottom-up and inter-agency approach to social inclusion and local development issues and liaises with both national and European groups in order to leverage funding for the development of their local communities (www.ildn.ie).

generally (Hutchings et al. 2007b; Sheppard, 2012). Each of these issues will be discussed in more detail below.

Reluctance among some services to implement EBPPs

A reluctance to adopt EBPPs among some Irish professionals, has been fuelled, at least in part, by concerns regarding the appropriateness of manualised, non-Irish programmes for Irish clinical populations (O'Donoghue, 2012). Other potential barriers include concerns about associated costs, fears that programme implementation would require a revolution in existing service infrastructure, and resistance in relinquishing ineffective, but familiar interventions (Axford & Morpeth, 2013; Sheppard, 2012; Start Strong, 2012). However, this study and other research (e.g. Furlong et al. 2012) indicate that the IYPP is acceptable to parents across many countries (including Ireland), and that, with some inter-agency support, the programme can be faithfully integrated into the existing infrastructure of several different types of health, social and educational settings, including Social Work, Psychology, School Completion, Public Health Nurses and Family support services. In addition, there are a growing number of experienced individuals and agencies in Ireland (e.g. IY mentors) who can provide expertise to interested organisations. Moreover, research, such as that reported here, highlights the key facilitative and inhibitive factors/components involved in implementing the IYPP within mainstream healthcare settings, which should inform and expedite delivery elsewhere.

Difficulties in promoting fidelity within new services

The current findings complement other research that indicates that the IYPP can be successfully transported to mainstream service settings, provided that careful attention is paid to the quality of implementation (e.g. Fixsen et al. 2005). Within this study, two managers reported interim difficulties in importing the IYPP into other services due to poor quality delivery and insufficient staffing within the new host agencies. In addition, the high attrition rate within these agencies was related to a failure to provide the necessary wrap-around components, including childcare, transport, pre-programme relationship with parents, suitable assessment of parental readiness, and adequate supervision for therapists. Fortunately, one of the managers reported improved fidelity and retention two years later as they had succeeded in acquiring staff to co-facilitate and monitor programme implementation within the host agency. From an economic

perspective, high quality parenting interventions may be more costly to implement than low quality ones, but the higher returns with regard to long-term health, social and legal outcomes more than compensate for the additional expenditure (Burchinal et al. 2010; Marmot Review, 2010).

Lack of policy guidance on parenting supports

Currently, the absence of clear policy guidance within Ireland means that the provision of EBPPs within mainstream services remains sporadic and of poor quality (Paulsell et al. 2009; Shulruf et al. 2009; Start Strong, 2012). In general, there is no coordination to ensure availability to all families who want or need parenting supports (Start Strong, 2012). Although the DCYA has provided some funding for the evaluation of parenting programmes within disadvantaged areas in Ireland, effective mainstreaming of such programmes would involve the establishment of a national policy initiative which would create local and national funding avenues for the wide scale implementation of EBPPs, as in the UK (Hutchings et al. 2007b), or in Norway (Ogden et al. 2009). Worryingly, however, even in those countries, policymakers sometimes fail to utilise research that identifies best-practice parenting programmes even though service providers are frustrated by the lack of policy guidance (Axford & Morpeth, 2013; Hutchings et al. 2007b; Sheppard, 2012). Moreover, there is a troubling trend among some Irish policymakers whereby parenting programmes with an inferior evidence base (e.g. lack of randomised controlled trials; high attrition and lack of intention-to-treat analyses) are given a similar status to those with rigorous research support (Start Strong, personal correspondence May 20th, 2012). The most recent and robust evidence, to date, indicates that the IYPP is one of the most effective and cost-effective parenting programmes in treating childhood conduct problems (Furlong et al. 2012). The quality of research with regard to preventive parenting programmes has not yet been investigated within a systematic review. Such research is necessary in order to inform the establishment of a continuum of universal and targeted parenting supports, from which all parents can benefit (Start Strong, 2012).

However, identifying effective parenting programmes is not enough. Research from the UK indicates that there is also a need for explicit policy guidance for the implementation, regulation and evaluation of effective parenting programmes (Gardner, 2012; Hutchings et al. 2007b). Arguably, state monies should not be wasted on

ineffective programmes, but should be protected for the implementation and monitoring of parenting programmes that are genuinely evidence-based (Hutchings et al. 2007b).

Indeed, there may be a role for researchers in enhancing the mainstreaming of EBPPs. Public-academic collaborations (such as evidenced in the partnership among NUI Maynooth, Atlantic Philanthropies, and a range of community-based organisations) can be critical to the successful translation of research findings into clinical practice (Quill & Aday, 2000). As indicated in the current study, this partnership encouraged agencies to adopt the IYPP, provided funding for expert training and supervision, involved a frank discussion of issues and concerns of all stakeholders, and was instrumental in building sustainable alliances among these agencies. Such successful partnerships play a key role in disseminating the IYPP within mainstream services (Aarons, Hulburt & Horwitz, 2011).

In addition, we know that the production of high quality applied research does not inevitably translate into policy and practice and, consequently, researchers must make special efforts to collaborate with key stakeholders in order to disseminate best-practice implementation strategies (Nutley et al. 2007; Nutley, Morton, Jung & Boaz, 2010). Thus, in order to influence policy development in this area, it may be important for researchers to utilise a number of 'entry points' in the health and social care system and to liaise with a variety of strategic players, including other researchers, clinicians, service providers, managers, policy-makers/civil servants, media and service-users (Weyrauch & Langou, 2011). In addition, research utilisation may increase if researchers can identify and evaluate methods and models of knowledge exchange/collaboration among policy makers and professionals (Bostrom, Kajermo, Nordström and Wallin, 2009; Ward, House & Hamer, 2008). For instance, current models indicate that strategies to enhance research use among professionals should focus on access to, and adequate training in using information sources; increased knowledge on research methodology within services; a supportive organisation, within which unit managers are open to implementing evidence-based interventions; and provision of user-friendly reports by researchers (Boström, Kajermo, Nordström & Wallin, 2008; 2009).

9.6 Impact of research process on outcomes

The findings from this study suggest that involvement in a research evaluation may have both enhanced and hindered 'normal' service delivery and outcomes. On the one hand, group facilitators indicated that the ongoing monitoring that was conducted as part of the research may have improved their usual performance, especially with respect to the receipt of regular rigorous supervision (involving videotaped analysis) and weekly completion of fidelity checklists. They also reported that the research interviews helped them to identify key implementation barriers and to devise potential solutions. Other research has also found that the monitoring of programme delivery can improve programme adherence, a potential mediator for child outcomes (Eames et al. 2009; Forgatch & Degarmo, 2011). Thus, it is important that services integrate regular monitoring and quality supervision into their schedules in order to maintain positive outcomes (Gardner, 2012). Reassuringly, the agencies involved in the RCT within which this study was located, have trained several of their most skilled staff as IY trainers, who can now provide supervision to other group facilitators. In addition, they are reportedly committed to monitoring programme fidelity (O' Donoghue, 2012). These are important steps in maintaining the quality and sustainability of the IY programme within mainstream service settings (Webster-Stratton, 2011).

The value of the research process was also illustrated in the comments of a small number of parents who indicated that the research interviews acted as mini 'refresher' courses in promoting reflection and problem solving in relation to various parenting techniques. However, it is unlikely that such interviews unduly enhanced outcomes within the RCT as the collection of qualitative data occurred after both the 6- and 12-month follow-up quantitative assessments. Nevertheless, given the perceived beneficial effects of brief interviews, it might be advisable for group facilitators to contact parents following programme completion in order to monitor their longer-term outcomes.

The group facilitators also indicated that the RCT process may have potentially undermined usual programme implementation. Arguably, the tight RCT schedule may have impaired parental retention through the pressures to recruit numbers in too short a timeframe (and hence accept unsuitable parents) and through the failure to establish a prior relationship with the parent, an element that is increasingly viewed as being important in retaining parents (Hutchings et al. 2007b). Fortunately, usual delivery

should not have to meet the demands of a research programme. Nevertheless, this issue highlights the challenges of conducting applied research where funding and scheduling constraints meet with 'real world' recruitment difficulties (Robson, 2011).

The findings from this study also suggest that regular face-to-face contact between researchers and facilitators may be important in streamlining an evaluation process. For instance, although Archways acted as a mediator of communication between group facilitators and researchers, the research team were not aware of several 'on the ground' implementation issues, including: (1) some facilitators had not screened parents for suitability before referring them to the RCT study; nor (2) the perceived necessity of meeting parents just before programme commencement. In addition, researchers did not realise the level of stress experienced by facilitators until after programme completion. Therefore, relationships with future collaborators might be enhanced, and retention outcomes improved, if researchers engaged more directly and frequently with facilitators throughout the course of an RCT evaluation. Another recent study has also underlined the importance of holding regular feedback sessions between the research team and personnel from different levels within grantee organisations in order to establish positive relationships and to scrutinise the practical implications of the evaluation on day-to-day working within the agency (Sneddon, Kehoe, Harris, Owens, Sheehan & Mac Evilly, 2012).

9.7 Evaluation of the study

9.7.1 Strengths of the study

Process evaluations that are conducted alongside RCTs of parenting programmes are relatively rare, even though such evaluations are necessary to explore and replicate the causal mechanisms and contextual factors associated with trial outcomes (MRC, 2008). This longitudinal, multi-informant, mixed-methods process evaluation is one of the first and largest studies to assess the 'on-the-ground' implementation of the IYPP within mainstream service settings, and the first within an Irish context. The study findings represent an important addition to both the national and international literature, particularly through its analysis of the key facilitative and inhibitive factors associated with programme implementation and outcomes. For instance, the findings of this study: illuminated pre-programme experiences in parenting a conduct-problem child;

investigated and critically analysed core intervention components; highlighted contextual variables (e.g. cultural, socioeconomic, commitment and resilience factors) that may influence short- and long-term outcomes; examined key fidelity and organisational processes, as well as socio-political influences; and considered how the research process may have impacted upon trial outcomes. These findings will be invaluable in informing service delivery of the IYPP both in Ireland and elsewhere (See Box 9.1).

The validity of the findings was enhanced through the use of a multi-informant, longitudinal approach, whereby parents, group facilitators and service managers were interviewed both in the short- and longer-term. In addition, the utilisation of a mixed-methods strategy strengthened the validity and reliability of the findings, particularly in relation to consistency (and contrast) of themes and results across both the qualitative and quantitative elements of the study. Moreover, a diverse sampling strategy was employed, such that selected parents were generally representative of the overall RCT sample, including those who did not complete the programme. Furthermore, the credibility of the findings was augmented through the recruitment of large samples of parents and participants at each time-point (Charmaz, 2006). Other strengths of the study have already been noted in Chapter Four, including: audiotaped and verbatim transcription; the provision of detailed description of participants and settings; transparency with regard to the analytic approach; respondent validation and empowerment; examination of themes and coding with colleagues; and dissemination through international peer-reviewed publication and presentations at national and international conferences (see Appendix 22).

9.7.2 Limitations of the study

This study also had a number of limitations. Firstly, the fact that this study did not find any statistically significant relationships between improved child behaviour and reported fidelity may be related to the utilisation of self-report questionnaires rather than objective measures. Although it was not feasible within the resource constraints of this study to utilise objective measures, other research indicates that objective measures of fidelity are more likely than self-report data to detect differences in therapist delivery and to predict variations in outcomes (e.g. Eames et al. 2009; 2010). Furthermore, due to delays in receiving self-report questionnaires from three facilitators, it is possible that

these individuals completed their questionnaires on a retrospective basis rather than immediately following the weekly sessions (as requested), thereby suggesting that some form of recall bias may be present, albeit in only a small number of cases. In addition, the quantitative assessment of parental satisfaction with the programme (another fidelity component) was partially compromised in that only 57 of the 103 parents randomised to the intervention group completed the PSQ self-report questionnaire on the last session of the IYPP. Thus, the sample was arguably restricted to those parents who were sufficiently satisfied with the programme to have stayed until the last session and did not include parents who dropped out of the programme early. Although it is normal practice for group facilitators to administer the PSQ to parents on the last session, it may have been preferable, in order to avoid demand characteristics and attendance effects, if this questionnaire had been administered to all parents who attended any sessions of the IYPP, regardless of whether or not they were present at the last session.

On a related point, all self-report data (questionnaires, interviews) may be subjected to the criticism that recall may be biased and that memory tends to fit into a narrative preferred by the participant (Neisser & Winograd, 1992). However, this study does not claim to attain ontological realism, but upholds the validity of the subjective construction of participant experiences, particularly when integrated with other sources and types of data (Creswell, 2009). Such participant perceptions gain legitimacy when, as reported here, they are consistent with themes identified in other independent research (e.g. Patterson et al. 2005; Webster-Stratton & Spitzer, 1996) and/or when idiosyncratic findings resonate with the experience of the individual reader (Charmaz, 2006).

The generalisability of findings to other settings is a key issue within qualitative research (Charmaz, 2006). Although conceptual rather than numerical generalisability is a cornerstone of qualitative research (Creswell, 2009), vigorous efforts were made to recruit a large number of parents whose demographic characteristics were generally representative of the overall RCT sample. A careful description of participants and settings was also provided in order to help readers realise the extent to which the current findings may be transferable. The generalisability of the findings is further enhanced in that they are largely consistent with other published research in the area (e.g. Mockford & Barlow, 2004; Patterson et al. 2005; Webster-Stratton & Spitzer, 1996). Nevertheless,

it is important to note that the results may only be applicable to the implementation of the IYPP when delivered to families with children who have clinically significant conduct problems at baseline. Thus, it is possible that the themes may not generalise to families participating in preventive parenting interventions based on a different theoretical model, or to children with any serious co-morbidities (e.g. severe physical or intellectual impairment). Furthermore, it is possible that cultural resistance to play and praise components of the IYPP may be a peculiarly Irish phenomenon, although other research suggests that such discomfort is not exclusively a localised issue (Forehand & Kotchick, 2002; Paiva, 2008).

A final potential limitation of the study relates to the demographic characteristics of the parents interviewed at 18-month follow-up. These eight parents were somewhat older and more affluent when compared to those interviewed at 6- and 12-month follow-ups, As a result, they were less representative of the sample of parents recruited for the overall RCT, and, arguably, were more likely to report positive outcomes in the longer-term (Reyno et al. 2006). Interestingly, however, moderator analyses revealed that socioeconomic status and age of parent did not predict differences in child behaviour outcomes at short- or longer-term follow-ups (McGilloway et al. 2012a; 2012b).

9.8 Implications of the study

Some of the following recommendations for research and practice have already been intimated in earlier sections. Thus, the purpose of this section is to draw more explicit attention to key areas.

9.8.1 Directions for further research

Research indicates that the IYPP translates across several settings, but less is understood about the core intervention mechanisms involved in attaining such outcomes (Furlong & McGilloway, 2011). This study illustrates that a more precise clarification of the active psychological ingredients of the IYPP is necessary, especially when shorter versions of the IYPP (nine sessions in Webster-Stratton, 1984) appear to produce equivalent effect sizes to longer editions (24 sessions in Webster-Stratton et al. 2004). This study contributed to the investigation by identifying the perceived primacy of certain parenting techniques. However, more research (such as mediator analyses, RCTs and qualitative analyses) is required in order to ascertain which particular positive parenting

skills are most instrumental in explaining outcomes. Identifying the key intervention components may help to inform the development of briefer, refined, cost-effective versions of the programme, which, in turn, should facilitate its dissemination within mainstream services (Axford & Morpeth, 2013; Gardner et al. 2010).

Study Strengths

- This process evaluation is one of the first studies to assess the 'on-the-ground' implementation of the IYPP within mainstream service settings
- The qualitative findings are based on a relatively large sample size
- The study adopted a longitudinal, multi-informant and mixed-methods approach in order to identify the key facilitative and inhibitive factors associated with programme implementation and outcomes
- This is one of the first studies to investigate the longer-term experiences of parents as well as organisational/implementation processes
- Key factors investigated included: pre-programme experiences; core intervention components; contextual variables (e.g. cultural, socioeconomic and resilience factors); implementation fidelity and organisational/socio-political mechanisms; and impact of research processes on trial outcomes
- The findings highlight the feasibility of implementing the IYPP within the existing infrastructure of mainstream service settings.

Study Limitations

- Lack of objective measures to detect variations in facilitator fidelity.
- Potential bias in sample of parents who completed the PSQ.
- Findings may potentially only be generalisable to disadvantaged families presenting with clinically significant conduct problems.
- Differential parental demographics at 18-month follow-up

Box 9.1 Key strengths and limitations of study

This study also highlights the need for further investigation into the factors associated with long-term relapses. Forty per cent of parents who were interviewed at the 12-month follow-up experienced a sustained relapse in child positive behaviour. This study found that such relapses tended to occur in contexts where parents relinquished their newly acquired skills in stressful times, through the influence of an unsupportive environment (e.g. conflict with partner, antisocial peers), or where they were confused about the behavioural principles underpinning the techniques. As indicated above, this research is

one of only a very small number of qualitative studies (Morch et al. 2004; Webster-Stratton & Spitzer, 1996) that has investigated the longer-term experiences of parents, and, consequently, future research might examine the contexts and conditions associated with relapse and recovery.

Furthermore, this study also suggests that a theoretical framework of 'resilience and commitment' might promote the longer-term maintenance of positive outcomes. More specifically, it might be useful for the IYPP to consider including a component that explicitly teaches relapse prevention and resilience strategies, based on CBT and/or ACT techniques, as noted earlier (Hayes et al. 2003; Neenan, 1999). To date, these strategies do not appear to be included within any other parenting programme. In addition, it may be helpful for researchers to consider investigating the utility of other post-programme supports (e.g. booster sessions) for enhanced maintenance of outcomes for more vulnerable parents in the longer term (McGilloway et al. 2012b; Patterson et al. 2005).

The findings from the current study indicate that the IYPP may potentially produce more benefits (and side-effects) than is currently realised. At present, RCTs in the area tend to only measure outcomes of child behaviour within the home setting, parental stress/depression and parenting practices (e.g. Hutchings et al. 2007a; Larsson et al. 2008; McGilloway et al. 2012a). However, the findings from this study indicate that it may be worthwhile for future RCT evaluations of the IYPP to consider examining, in more detail, outcomes about which we know relatively little, such as child educational/cognitive abilities, child behaviour within the school setting, parental social support, marital well-being, as well as any potential adverse outcomes (e.g. conflict with partner or any financial or psychological burden associated with attending a parenting programme). Testing for adverse and unintended side-effects is a priority within medical research. Similarly, social and psychological researchers should not assume that non-medical interventions cannot cause harm (Zwi, 2012), especially when other qualitative research confirms the prevalence of increased familial conflict that may occur as a result of participating within a parenting programme (Furlong & McGilloway, 2011; Mockford et al. 2004).

The current study also highlights other potential avenues for exploration. Firstly, several prospective moderators/mediators of outcomes were identified, which could be investigated in future RCT evaluations of parenting programmes. These relate particularly to organisational factors and programme characteristics, which have received very little research attention to date. Organisational factors could be examined with regard to: the provision of appropriate screening; establishing a pre-programme relationship with parents; the provision of appropriate supervision and skills-based training of facilitators; onsite childcare, and developing wrap-around support services and/or inter-agency alliances. With regard to programme characteristics, as well as examining the 'active' modules of the intervention, it might be useful for future research to investigate whether variations in facilitator skill or number of sessions attended by parents, affects outcomes. Lastly, this study suggests that certain participant characteristics might act as a moderator/mediator on outcomes, such as a lack of social support due to living in an antisocial environment; disruptive family life; attitudes and (cultural) beliefs that impede engagement with the programme; and long-term resilience and commitment factors.

To date, only two of the above variables (i.e. disruptive family life and facilitator skill) have been investigated as a moderator/mediator of programme outcomes, with both factors being associated with differences in child behaviour effects (Beauchaine et al. 2005; Eames et al. 2009). Many other potential moderators (mostly relating to participant characteristics) have been previously examined in other RCT evaluations of the IYPP, including: child age, child gender, and indices of socioeconomic disadvantage (i.e. lone parent, employment status, size of family related to income, parental education, parental depression, and parental history of drug abuse or criminality) (Baydar et al. 2003; Beauchaine et al. 2005; Drugli & Larsson, 2009; Gardner et al. 2010; McGilloway et al. 2012a). Such subgroup analyses have produced equivalent results, with some studies indicating a moderating impact (e.g. Beauchaine et al. 2005; Drugli & Larsson, 2009) and other studies finding no such effect (e.g. Baydar et al. 2003; Gardner et al. 2010; McGilloway et al. 2012a). Therefore, future research in this area might benefit from examining the moderating effect of variables about which we know relatively little.

Secondly, despite the emphasis placed on the importance of IF within the parenting field, this study is one of very few that has actually examined the extent to which fidelity variables (e.g. facilitator adherence, parental attendance, engagement and satisfaction) predicted programme outcomes. Therefore, there is a need for more accurate measurement of IF within the parenting field, and particularly since preliminary research suggests that variations in therapist skill may mediate outcomes (Eames et al. 2009). Although the current study did not find any statistically significant relationships between improved child behaviour and reported fidelity among the nine parenting groups, this could be due to the various limitations mentioned earlier (i.e. reduced power, and 'ceiling effects' produced by the self-report measures). It might also be helpful for future research to consider utilising objective fidelity measures, as developed by Eames et al. (2009). The development and utilisation of such objective measures could enhance the supervisory process in monitoring programme fidelity within mainstream services. In order to avoid administrative burden, these measures should not be too onerous and should only be collected when necessary and useful (Axford & Morpeth, 2013).

Thirdly, further research might investigate the extent to which intervention and implementation mechanisms may vary with regard to other service settings in Ireland (and elsewhere), and in relation to other populations, including those of differing socioeconomic status or with less severe child conduct problems. Moreover, there is a need for a systematic review to examine the effectiveness of preventive parenting programmes in improving child and family outcomes. Such research would be helpful in informing the provision of evidence-based parenting supports for both universal and targeted populations (Start Strong, 2012).

9.8.2 Implications for policy and practice

As indicated earlier, one of the primary strengths of this study is that it identifies the key facilitative and inhibitive factors associated with implementation of the IYPP within mainstream healthcare settings. Furthermore, it underscores the feasibility of implementing the programme within existing health and social services in Ireland, and, as such, should inform the 'scaling up' of EBPPs within Ireland and elsewhere. The following discussion highlights more specific implications for policy and practice.

The analysis of parents' pre-programme experiences has several implications for practice. Firstly, it emphasises that most parents enter the programme in a state of learned helplessness, and consequently, facilitators may need to be sensitive to, and patient with, parents' lack of self-efficacy. In addition, the study revealed that many parents commence the IYPP with implicit attitudes that could potentially undermine their engagement with the programme, such as believing that they do not need to change their behaviour (i.e. the child has the problem rather than the parent) and adhering to a punishment-oriented parenting approach. Thus, it is important for group facilitators to address such issues from the outset. At the same time, it is important for facilitators to recognise the importance of not patronising parents, in the sense that a small cohort of parents who begin the programme, may already be implementing some of the taught parenting techniques and do not show any signs of learned helplessness.

Several barriers to the acquisition and maintenance of positive parenting skills were also noted here, the most important of which included discomfort with the principle of positive attention, conflict with partners around the introduction of new parenting techniques, and dealing with attritional issues related to social disadvantage. Firstly, there is a growing awareness that, within countries with culturally distinctive child-rearing traditions, retention within programmes may be enhanced if parents are encouraged by therapists to share their current parenting practices and to discuss any disagreement with new and unfamiliar parenting skills throughout the course of the programme (Webster-Stratton, 2009). Secondly, services may circumvent conflict with the non-attending partner if they increase efforts to recruit that partner (usually the father) onto the parenting programme. Service managers within this study advised that paternal participation increased if the programme was held in the evening. Thirdly, it is important that services are aware that vulnerable parents with more complex needs may require additional wrap-around supports in order to secure their full participation in the programme (Bruns & Walker, 2011; Burchard et al. 2002).

Services that implement the IYPP may also need to consider relapse prevention approaches for the longer-term maintenance of positive outcomes. Although clinicians and service managers rarely discussed this issue within interviews, this study found that 40 per cent of parents reported a sustained relapse at 12-month follow-up, and many others also reported some more minor difficulties. As mentioned earlier, one option that

might benefit from further research, relates to the inclusion of a component on relapse prevention within the IYPP. Other possibilities include the provision of post-intervention support (e.g. booster sessions) for more vulnerable parents, and particularly those who live with an uncooperative partner or in an antisocial environment (McGilloway et al. 2012b). Moreover, services may need to consider providing the IY ADVANCE programme, and/or the IY suite of multi-environment teacher and child interventions, for parents experiencing a number of additional challenges, such as mental health issues and the negative influence of peer deviancy (Furlong & McGilloway, 2011; Hutchings et al. 2007b).

The findings from this study also highlight the importance of implementing the IYPP with fidelity in order to replicate positive outcomes. Full implementation is important as, currently, the active components of the IYPP are not wholly understood (Eames et al. 2010; Mihalic et al. 2002). Furthermore, the current study demonstrates that agencies may need to consider a range of fidelity components in order to avoid retention difficulties, achieve positive outcomes and enhance sustainability. These components include: skills-based training; regular quality supervision; appropriate screening and/or wrap-around supports for vulnerable parents; strategic inter-agency alliances for maintaining a stable referral and funding infrastructure; and focussed monitoring of fidelity within the agency. These findings are consistent with best-practice implementation strategies for complex interventions in real-world settings (e.g. Nutley et al. 2010). Indeed, the evidence suggests that the incorporation and monitoring of best-practice fidelity procedures may reduce by half, the average time needed to help a site achieve full implementation (Fixsen et al. 2005). The importance of monitoring and evaluating fidelity within mainstream services cannot be overstated as it is the key preventive mechanism for programme drift and skills decay among facilitators (Eames et al. 2009; Forgatch & Degarmo, 2011; Hutchings et al. 2007b).

Lastly, the issue of parenting, and the provision of supports for parenting, needs to be placed higher on the policy agenda, both in Ireland and elsewhere. As indicated earlier, the lack of clear policy guidance has typically led to the sporadic and low quality implementation of EBPPs across many countries worldwide (Paulsell et al. 2009; Sheppard, 2012; Shulruf et al. 2009). Currently, international policy (including Ireland) tends to place more emphasis on providing financial supports to families (e.g. maternity

leave, parental leave, subsidies for early childcare) than on offering training and support in parenting skills (DCYA, 2012; OECD, 2010; Shulruf et al. 2009; Start Strong, 2010). Encouragingly, there are signs that Irish policymakers are beginning to recognize the importance of EBPPs in supporting families. For instance, as indicated earlier in Chapter Two, the AP/OMCYA-funded Centre for Effective Services has set up a *Special Interest Group in Supporting Parents in their Parenting Role*. This group comprises service and academic representatives with an interest in promoting parenting programmes/interventions generally and it is hoped that the work of this group will help to more effectively inform policy and practice on parenting in Ireland. In addition, Start Strong placed a greater priority within their most recent policy brief on identifying EBPPs that could potentially be implemented within Irish services (Start Strong, 2012). It is important to note that this was due, at least in part, to focused efforts by the researcher and her supervisor, to disseminate (and discuss) their recent findings to (with) this organisation and in a way that would more effectively reach and potentially influence key policy-makers. However, much further work in this area is required.

One of the primary obstacles to policy development within this area appears to be related to a concern as to whether or not parenting programmes researched elsewhere can be implemented to scale within the existing health and social services in Ireland (Start Strong, 2010; O' Donoghue, 2012). The findings of this study (coupled with those from the RCT), show that it is likely to be feasible to roll out the IYPP within mainstream service settings. EBPPs, such as IYPP, are currently underutilised, and particularly given the relative dearth of evidence of impact for most 'services as usual' (Axford & Morpeth, 2013; Sheppard, 2012). Of course, taking EBPPs to scale would involve the challenge of making healthcare systems 'programme ready' (Axford & Morpeth, 2013). For example, more investment is needed in the development of staff resources and skills to implement EBPPs with fidelity. In addition, innovations in contracting, such as payment by results and social impact bonds[24], are likely to make systems more outcomes-focused and therefore a better fit for EBPPs (Axford &

[24] Social impact bonds (SIBs) are new and innovative financing mechanisms to help reform public service delivery. These tools effectively invert traditional government financing for preventive social services; instead of paying upfront for programmes or activities that may or may not have their anticipated effects, government pay only for real, measurable social outcomes after those results have been achieved. Internationally, there is a growing interest in SIBs as a means of attracting private capital for public benefit, with government agreeing to provide a return to investors if the intervention is successful (e.g. www.gov.uk/social-impact-bonds).

Morpeth, 2013; Little & Axford, 2012). Moreover, cost benefit analyses indicate substantial, positive returns on investment in EBPPs (Aos et al. 2011; Melhuish, 2010; O' Neill et al. 2011). This latter issue is particularly pertinent in the current climate of public sector austerity. Consequently, it is imperative that policymakers pay closer attention to the provision of EBPPs, such as the IYPP, within mainstream health settings, and especially given the potential long-run psychological, societal and economic benefits associated with such programmes (Aos et al. 2004; Farrington & Welsh, 2007; Furlong et al. 2012; Marmot Review, 2010; O' Neill, 2011). Lastly, 'scaling up' of EBPPs may require the identification of the most appropriate and effective forms of knowledge transfer/exchange in order to inform policy and practice in this field.

9.9 Conclusion

This process evaluation, which was conducted in parallel to an RCT of the IYPP, is one of the first studies to conduct a comprehensive investigation of the core intervention and implementation mechanisms associated with trial outcomes. This study provides important insights into the pre-programme experiences of parenting a child with conduct problems, as well as identifying the short- and long-term facilitative and inhibitive factors related to programme implementation within disadvantaged settings. In particular, it is one of only a handful of studies that has investigated the longer-term experiences of parents, as well as organisational processes involved in implementing the IYPP under 'real-world' conditions. Several implications for research, practice and policy were highlighted and a number of recommendations are identified, as follows:

- A more thorough investigation of the 'active' ingredients within the IYPP, including potential moderating and mediating variables;
- The evaluation of outcomes about which we know relatively little, such as child educational/cognitive abilities, child behaviour within the school setting, and parental social support;
- The promotion of cultural sensitivity and the greater involvement of fathers within the programme;
- The development of relapse-prevention strategies/supports that will facilitate the longer-term maintenance of outcomes for vulnerable families;

- The importance of implementing the IYPP with fidelity within mainstream service settings (which may require the incorporation of several organisational elements, such as regular quality supervision, appropriate screening, strategic inter-agency alliances, and monitoring of fidelity);
- Enhancing monitoring procedures through the development of user-friendly and objective measures to detect variations in therapist fidelity;
- The development, implementation and evaluation of other wrap-around supports alongside the IYPP that will enhance retention and outcomes for socially deprived families;
- Placing EBPPs higher on the policy agenda in Ireland and elsewhere; and
- Addressing issues involved in 'scaling up' EBPPs, such as the IYPP.

Overall, these findings represent an important addition to the literature and should help to inform the future implementation of the IYPP within Ireland and elsewhere. Importantly, the findings of this study (combined with those from the RCT) demonstrate that the majority of families gained substantial benefits from participating in the IYPP. By implementing such EBPPs, families have a chance at a better future, society becomes a little less violent, and public money is used more efficiently. Thus, it is essential that both practitioners and policymakers support the mainstreaming of such programmes so that more families have the opportunity to improve the quality of their lives.

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Appendix 1. Full and abbreviated versions of the IYPP

The RCT was originally designed for the evaluation of the 12-week version of the IYPP, but just before programme delivery was due to commence, various actors (programme developer and organisational managers) indicated their preference to evaluate the newer, longer edition of the programme. However, the original RCT schedule only allowed for a maximum of 14 weeks for programme delivery and, therefore, the group facilitators had to condense the longer version of the IYPP into 14 weekly sessions.

The abbreviated version of the IYPP evaluated within the RCT (and this study) is shown below. Some sessions were combined within the abbreviated programme (e.g. session three on play incorporated sessions three and four in the original programme), which meant that less time was dedicated to play within the revised IYPP than was originally allocated in the longer version of the programme.

Full version of IYPP

Session 1: Play
Session 2: Play
Session 3: Play and academic coaching
Session 4: Play and academic coaching
Session 5: Play-social and emotional coaching
Session 6: Play-social and emotional coaching
Session 7: Praise and encouragement
Session 8: Praise and tangible rewards
Session 9: Reward Programmes
Session 10: Routines and household rules
Session 11: Limit setting
Session 12: Limit setting, follow through
Session 13: Ignore
Session 14: Time out to calm down
Session 15: Time out for aggression
Session 16: Natural and logical consequences
Session 17: Teaching children to problem solve
Session 18: Teaching children to problem solve
Session 19: Adult problem solving
Session 20: Review and celebration

Abbreviated IYPP evaluated in RCT

Session 1: Play
Session 2: Play
Session 3: Play
Session 4: Social and emotional coaching
Session 5: Praise and rewards
Session 6: Praise and rewards
Session 7: Praise and rewards
Session 8: Routines and household rules
Session 9: Limit setting
Session 10: Ignore
Session 11: Natural and logical consequences
Session 12: Time out
Session 13: Problem solving
Session 14: Problem solving, review and celebration

Figure. Comparison between the content of full and abbreviated versions of the IYPP.

Appendix 2. Baseline (pre-intervention) interview schedule for parents

1. Describe your child and his/her behaviour at home/school/with others.
   (Prompts may include: 'What is he like in comparison to his siblings?', 'Would you say s/he is overactive, obedient, unpredictable etc.')
2. Describe your relationship with your child when he is behaving well.
3. Describe your relationship with your child when he is misbehaving.
4. What are the main difficulties you have in parenting your child?
5. What techniques do you use/what do you do when he misbehaves? Do any work?
6. What ways do you have of coping with your child's behavioural difficulties?
   (Prompts may include: 'Does your partner/family support you?', 'Do you have ways of thinking about it that makes it somewhat easier to deal with?').
7. How does your child's behaviour's affect (a) your relationship with your partner; (b) their sibling's behaviour; (c) the extended family and community?
8. How did you hear about the *Incredible Years' programme*?
9. Have you tried any other services to address your child's behaviour?
10. What are your expectations around the *Incredible Years' Parenting programme*?
11. What quality do you like most in your child?
12. Is there anything you would like to add?

Appendix 3. Six-month follow-up, one-to-one interview schedule for parents

1. Can you tell me about your experience of the Incredible Years Parent Programme?
2. What did you like best about the programme?
3. What did you like least about the programme?
4. Can you tell me about your child's behaviour at home/school? How different is it compared to before you went on the programme?
5. Which part(s) of the programme, if any, has been of value to you in handling your child's behaviour (Probes: What do you do differently now that you didn't do before?)?
6. Which parts of the programme, if any, were less helpful to you in managing your child's behaviour?
7. How would you describe your relationship with your child now?
8. What did you think of the group leaders and how they delivered the programme?
9. What did you think of the content taught on the programme?
10. What did you think of the manner in which the programme was delivered (e.g. the vignettes, role plays, discussions, homework exercises, 'buddy calls', follow-up calls from group facilitators)?
11. How supportive did you find the group of parents?
12. What difficulties, if any, did you encounter in learning and carrying out new techniques? (e.g. techniques not working initially, little support from partner, etc).
13. How did/do you cope with these difficulties?
14. How easy did you find it to attend the programme on a weekly basis? Any childcare or access issues?
15. To what degree has the Incredible Years programme helped with other personal or family issues not directly related to your child (e.g. your marriage; siblings' behaviour; relationship with extended family and community)?
16. What changes have you noticed in yourself since taking part in the programme (e.g. less stressed, depression levels, problem-solving coping mechanisms)?
17. To what extent were there any negative outcomes from participating in the programme?
18. Can you tell me how the programme might be improved for the future, if at all?
19. Overall, to what extent did the programme meet your needs?
20. How confident are you in your ability to manage any future behavioural problems with your child?
21. Is there anything you would like to add?

Additional questions for fathers who attended the programme

22. What made you decide to come to the parenting programme?
23. To what extent did the programme cater for your needs as a father?
24. To what extent did the programme change your parenting practices?

Appendix 4. Six-month interview schedule for parents who dropped out early from programme

1. Can you tell me why you decided not to attend the programme (Prompts: What, if anything, did you dislike about the programme? To what extent were there childcare/access issues? To what extent did the programme meet your expectations?)?
2. What, if anything, would you change about the programme?
3. Can you tell me a little about your child's behaviour at the moment?
4. What services, if any, are you using to help you manage your child's behaviour?
5. How hopeful are you that your child's behaviour will improve?
6. How likely is it that you will try going to a parenting programme again?
7. Is there anything that you would like to add?

Appendix 5. Twelve-month follow-up interview schedule for parents

1. Tell me a little about child's behaviour during the last six months (at home/school/with others)?
2. What parts of the programme, if any, do you still find useful in helping you manage your child's behaviour?
3. What parts, if any, do you find less useful?
4. How easy do you find it to remember and apply the techniques that you learned on the programme (e.g. do they take up much time or commitment? Are you supported by your partner?)?
5. Looking back on it all, what was the best thing that you got from the programme?
6. To what extent have there been any other positive changes within the last six months?
7. To what extent have there been any setbacks in the last six months?
8. How easy or difficult do you find it to be a parent with this child now?
9. How confident are you about managing any future behavioural difficulties that may arise?
10. Is there anything that you would like to add?

Appendix 6. Eighteen-month follow-up interview schedule for parents

1. Tell me a little about child's behaviour during the last six months (at home/school/with others)?
2. How useful or relevant do you find the parenting skills at this stage?
3. How often do you implement the techniques?
4. To what extent have there been any modifications in how you implement the skills?
5. How supportive do you find your partner/extended family etc?
6. To what extent do you think the programme has impacted on other areas of your life, e.g. (i) marriage; (ii) siblings' behaviour; (iii) personal mood and confidence; and (iv) extended family and community relationships?
7. What, if any, have been the primary challenges in parenting over the last six months?
8. Is there anything that you would like to add?

Appendix 7. Interview schedule for interviews with group facilitators

1. Tell me a little about your experience in running these parenting groups?
2. What were the main issues or challenges that arise for you in running the programme (e.g. fidelity constraints)?
3. How did your
4. experience of running the second research group compare to the first research group (If appropriate, what factors made it different?)?
5. Can you tell me how the supervisory process impacted on how you ran the programme?
6. To what degree was it necessary for you to make changes to the programme protocol?
7. How would you describe your relationships with the parents (any difficulties arise and how were they dealt with?)?
8. Which element(s) of the programme do you think work best for parents?
9. Which parts of the programme are perhaps less useful?
10. To what extent di the size of the group impact on outcomes for parents?
11. To what extent do you think the group worked for different types of parents (e.g. parents with substance abuse or family issues; socioeconomic status, etc)?
12. Can you tell me about the levels of support that your organisation provided for you when running the programme?
13. What in your opinion were the primary reasons for parental attrition?
14. To what extent did issues arise in relation to parents' access to the weekly sessions (e.g. childcare provision, transport)?
15. To what extent did the research process help or hinder how you ran the programme?
16. If you were to do it all again, what would you change in running the programme?
17. Is there anything that you would like to add?

Appendix 8. Interview schedule for organisational managers

1. Can you tell me a little bit about how your organisation came to know about and implement the *Incredible Years Parenting programme*?
2. What do you consider to be the primary benefits of the IYPP?
3. Tell me a little about the kind of parents that you recruit to the IYPP (e.g. targeted or preventive population, age of child, family's socioeconomic status, etc).
4. In your experience, does the IYPP work better for some parents than others?
5. What are the main challenges in implementing the programme?
6. To what extent is retention of parents an issue?
7. What improvements, if any, would you make to the programme?
8. How does the IYPP compare to other parenting programmes that you know about or have implemented?
9. How does the IYPP link in with other child and family/school services that you provide within your agency?
10. To what extent do you receive funding/partnership support for the running of the IYPP?
11. To what extent do you plan to continue to implement the IYPP within your service into the future?
12. Is there anything else that you would like to add?

Appendix 9. Topic guide for six-month follow-up focus group with parents

- At start – Explain purpose of discussion and recording
  Confidentiality among participants outside of discussion
  Informed consent forms

1. Experiences of the Incredible Years Parent Programme – "Tell me about…"
   (Prompts – what did you like most/least about the programme?)
2. Child's current behaviour in different settings – home/school
   (Prompts – how different is it compared to before you went on the programme?)
3. Which part(s) of the programme, if any, has been of value to you in handling your child's behaviour?
   (Probes: What do you do differently now that you didn't do before?)
4. Which parts of the programme, if any, were less helpful to you in managing your child's behaviour?
5. Views on group leaders and how they delivered the programme
6. Views on content taught on the programme
7. Views of format of programme
   (Prompts – views on the vignettes, roleplays, discussions, homework exercises, 'buddy calls', follow-up calls from group facilitators)
8. Views on sharing the group with other parents
9. What difficulties, if any, did you encounter in learning and carrying out new techniques?
   (Prompts - techniques not working initially, little support from partner, etc).
10. Childcare or access issues?
11. To what degree has the Incredible Years programme helped with other personal or family issues not directly related to your child (e.g. your marriage; siblings' behaviour; relationship with extended family and community)?
12. What changes have you noticed in yourself since taking part in the programme (e.g. less stressed, depression levels, problem-solving coping mechanisms)?
13. To what extent were there any negative outcomes from participating in the programme?
14. Can you tell me how the programme might be improved for the future, if at all?
15. Overall, to what extent did the programme meet your needs?
16. How confident are you in your ability to manage any future behavioural problems with your child?
17. Is there anything you would like to add?

Appendix 10. Topic guide for focus group with group facilitators

- At start – Explain purpose of discussion and recording
  Confidentiality among participants outside of discussion
  Informed consent forms

1. Tell me a little about your experience in running these parenting groups?
2. What were the main issues or challenges that arise for you in running the programme (Prompts: fidelity constraints)?
3. How did your experience of running the second research group compare to the first research group (If appropriate, what factors made it different?)?
4. Can you tell me how the supervisory process impacted on how you ran the programme?
5. To what degree was it necessary for you to make changes to the programme protocol?
6. How would you describe your relationships with the parents (any difficulties arise and how were they dealt with?)?
7. Which element(s) of the programme do you think work best for parents?
8. Which parts of the programme are perhaps less useful?
9. To what extent did the size of the group impact on outcomes for parents?
10. To what extent do you think the group worked for different types of parents (Prompts: parents with substance abuse or family issues; socioeconomic status, etc)?
11. Can you tell me about the levels of support that your organisation provided for you when running the programme?
12. What in your opinion were the primary reasons for parental attrition?
13. To what extent did issues arise in relation to parents' access to the weekly sessions (e.g. childcare provision, transport)?
14. To what extent did the research process help or hinder how you ran the programme?
15. If you were to do it all again, what would you change in running the programme?
16. Is there anything that you would like to add?

Appendix 11. Parent Information sheet and informed consent form

THE INCREDIBLE YEARS IRELAND STUDY

Parent Information Sheet for interview discussion

The information provided here is designed to supplement the consent form that you have just read and provides additional information on another part of the Incredible Years study that is being conducted at NUI Maynooth. During this part of the evaluation, a smaller number of parents will be invited to take part in a brief, informal one-to-one chat with a researcher, or in a group discussion with other parents and the researcher. The information gathered during this part of the research is designed to provide us with parents' expectations of the Incredible Years programme as well as their views of the programme, once completed.

In total, up to four discussions may take place – one before the programme starts, one at six months following the programme, one at twelve months following the programme, and one at eighteen months following the programme. Parents may take part in any or all of these discussions. The discussions will be relatively informal. For example, in the first, you will be asked questions about your experiences in parenting and your expectations around what the Incredible Years' programme has to offer you. In the follow-up discussions, you will be asked questions about your experience with the group and its usefulness in helping with parenting. If you would prefer to take part in the focus group discussion, it will last approximately one hour and will involve other parents who have taken part in IY training. If you agree to take part in the individual interview, it will last between 30-45 minutes. Parents will be given 15 euro for each discussion (in addition to the 25 euro for the other questionnaire assessments) as a token of our gratitude for your time and co-operation with this research.

Interviews will be tape-recorded so that we can be sure of what parents are saying. All information provided during the discussions will be treated with total confidentiality and your anonymity is guaranteed at all times, including within the final report. We would ask only that you can be as honest as possible in your responses.

You are free to withdraw from the study at any time (and/or withdraw your data) without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your right to access the parent support service provided by Archways or other support services in your area.

If you have any questions about the research, please contact either: (1) Mairead Furlong (Researcher) at 087 9368199; or (2) Yvonne Leckey (Project Co-ordinator) at 087 9368733.

If you would like to take part in this research, please complete and detach the consent form overleaf.

If during your participation in this study, you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the National University of Ireland at Maynooth Ethics Committee at pgdean@nuim.ie or telephone (01) 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.

THANK YOU FOR YOUR HELP.

Appendix 11 continued. Informed consent form for parents

THE INCREDIBLE YEARS RESEARCH STUDY

CONSENT FORM FOR DISCUSSION WITH PARENTS

I (name) _____ have read and understood the information sheet dated _____ for the above study and have had the opportunity to ask questions.

I agree to take part in this study and to provide information to the researcher for use in the study.

I understand that I can withdraw from the study (or withdraw my data) at any time and that my withdrawal will not affect my access to any current or future Archways service or any other support services.

Signature of participant: _____

Date: _____

Signature of researcher: _____

Date: _____

Appendix 12. Informed consent form for group facilitators and service managers

THE INCREDIBLE YEARS RESEARCH STUDY

CONSENT FORM FOR DISCUSSION WITH PROGRAMME PROVIDERS

I (name) _____ agree to take part in this interview and to provide information to the researcher for use in the study. I understand that my data is confidential and that I can withdraw from the study (or withdraw my data) at any time.

Signature of participant: _____

Date: _____

Signature of researcher: _____

Date: _____

Appendix 13. Excerpt of line-by-line coding of parent at six-month follow-up

Appendix 13. Example of line-by-line coding

	R: and how easy was it to get Michael on board with what you were doing?	471
X Conflict with partner re new parenting style	P: it was very difficult, very difficult. We had several rows about it. Not big rows but sitting down and talking about it. Like he said	
Partner's disbelief in new method as child still misbehaving	'it's not working. I don't know what you're doing but it's not working. Like he's (Steve) still going on mad'. Like in the	475
Lengthy process of improvement. Stayed committed despite difficulties	fourteen weeks it did take time. Like even now, I still think times 'oh God' but I'd kind of have to say, 'no, we have to go back on track and blah blah blah and go back to the book'. But for him, it	
Hard for partner to understand course. Wanted partner to attend course but he had work commitments.	was so much harder for him because he hadn't done the course. And I wanted him to do the course but he wouldn't do it. Well it's not that he wouldn't do it. He works far away and he works overtime so he said 'I'm not going to put my name down when you know I won't be able to attend it'. So I just kind of…I just with said 'Well, will you just look through the homework that I've done and try to refrain from shouting at the kids'. Like for him it was the shouting. It was very hard for him. He had had a long day and he'd come in and if one of them had done anything he'd be like 'Gruuuugh'. But I said to him 'But you're doing everything what I'm actively trying to stop them doing'. But he's alright now, he's got the gist of what I'm doing and he does see that it works.	480
Wanted partner to engage with skills but partner struggled.		485
Partner using disciplinary strategies opposite to principles of IYPP. Understands course now + sees that it works		490
	R: and does he do now any of the things that you do now, like praising or	

Appendix 13 cont'd. Example of line-by-line coding

Perhaps copied has learnt + implements skills

P: ah yeah. He follows suit. He gets the gist of it now. It was hard in the beginning but now

R: That's a common problem when a partner doesn't go on the course

Perception that parent attendee is acting supervisor parenting

P: yeah like he must've been feeling like I was dictating to him how he should change because I'm after doing this 'New Course,' you know

R: yeah yeah

Going on course hard for his parents

P: and it was hard as well for our parents

R: oh right?

Grandmother involved in family life - meals

P: Like myself and my Mam are very close. She lives around the corner from me and she works fulltime. So she's home early Tuesday and Thursday. So on Mondays, Wednesdays, Fridays and Saturdays I make the dinners and on Tuesdays, Thursdays and Sundays she'll do the dinners. She'll come around here on those days and vice versa. So it was kind of like sit down and tell your Mam who just believes in the good old smacking. It was so hard to do that because I didn't want to offend her. And I didn't want her to think that I thought I had a miserable childhood or anything like that. But I said it was just that for me it's not working. For them it's not working. I just have to do it. I was so surprised when she said 'No, you're right'. She was delighted with what I was doing and wanted me to continue with it. She does it too. She uses our houserules

R: right right

See each other often

Difficult not to offend mother over new parenting strategies. Didn't want to imply has mother's parenting style was wrong or that she had 'miserable childhood'.

Surprised that has mother was delighted with new techniques

Her mother uses skills too

Appendix 14. Example of focussed coding for a parent at six-month follow-up

Retrospective view of own parenting behaviour at baseline
Issued meaningless warnings (154-9, 390-7); lack of routine (176-7); assumed that children should just know the right way to behave without being instructed (180-5, 390-2, 558-60); used to be frustrated that parenting was difficult as she expected it to be easy (332-46); felt she couldn't cope and that something was wrong with her that she couldn't control her own children (826-9).

Retrospective view on child's pre-intervention behaviour
Hyperactive (272-3, 275-280), unpredictable anger (323-5).

Expectations/feelings at start of course
Anxiety and low self-esteem about being a bad parent and needing to go on a parenting programme (572-81).
Felt defensive at the beginning in group - that therapists would treat parent as being inferior (592-4; 797-801); and not trusting that programme would actually help (592-603; 696-700; 744-59).

Perceived benefits from programme:

Benefit for child – more obedient (131; 168-9); not hyperactive and running away from her (144, 151, 555-60), sleeps and eats better (169-71).
Benefit for parent-child relationship – more empathic of child, more affectionate, less stress, (318-20, 329-30). Understands how her behaviour impacts on child (322-9). More warmth as no slapping of child now (383).
Benefit for parental well-being – less stressful in home now, more calm as understands reasons for any misbehaviour (319; 332, 349, 352-3, 360-1, 373, 380-5).
Does not feel guilty now about being 'bad parent', feels less isolated and more 'normal' if she experiences any parenting difficulties (339-40, 571-2, 580-5, 668-73) .
More self-respect as can deal with their behaviour now and children listen to her (710-13, 724, 744-6).
Generally feels more able to cope with other things in her life (773-80, 816-26).
Benefit for siblings –realised she'd been overlooking the 'good kids' as preoccupied with misbehaving child so gives more time to siblings now (238-9). Realised 'good child' had low self-esteem so helps her with that now (202-3, 221-2, 228-9, 237, 239-45).
Benefit for whole family – houserules helping everyone's behaviour (500-503); skills help her get on better with her own parents as less arguing about children's behaviour (639-41, 684-95, 700-5)

Skills that helped most in achieving positive outcomes
Empathy with child – understand things from their point of view (186-7, 330-385).
Rewards and praise for behaviour, e.g. bedtime and not running away (161-2, 270-1, 288, 293-6).
Clear instruction of her expectations (139-144).
Following through on consequences and setting boundaries (190-4).
Try to stay calm and problem-solve what to do rather than reacting without thinking (381, 387-8, 397-402). Plans more and is more organised, think ahead (560-1)
Recover from mistakes quickly and understand that parenting can be difficult (797-822).

Group process contributed to positive outcomes-
Supportive group leaders who really understood her issues and were always available to help. Did not judge and normalised parenting difficulties (27-8, 80-9, 91-2, 103-7, 439-443, 674-7, 783-7, 789-95, 797-822).
Group format helped – vignettes helped to empathise (450-461); homework kept her focussed all week (463-7).

Onsite childcare indispensible – (659-61).

Challenges with programme:

Disliked aspects of format – patronising to give stickers as rewards in session**,** believes it led to parents to drop out of programme (9-21, 24-5, 31-47, 50-2, 69-78, 118-25); disliked buddycalls, awkward to contrive a relationship (414-20, 425-32, 447-9); thought some vignettes were unrealistically 'happy clappy' and 'too American', alienates parents who feel depressed at the start of the programme (60, 62-3, 67-81, 144).

Difficulty with learning some skills – found it difficult to ignore misbehaviour (83-8, 248-58, 609-19); kids rebelled against change of routine, especially with consequences (592-603, 727-30); thought praise would make her kids cocky or cheeky (229-35); did not like rewards as thought children should just behave without getting a reward, different compared to her own upbringing (297-300, 302-9, 310-15).
Exhausting to persist with programme when it wasn't working - had to organise herself and plan more (148-51, 176-8, 509-11, 595, 622-30)

Conflict with partner and own parents over new parenting techniques – partner didn't support her when he didn't see immediate results (505-9, 526-7). Partner followed her lead once the children's behaviour started to improve (511-24).
Feared she would offend her own parents about introducing new rules about parenting. Her own parents are quite involved in minding her children – brought in new rules around slapping and consequences (531-44, 681-4).

Recommended changes to course - change the stickers part (733-5).
Would like longer programme, thinks 12-14 weeks is too short to relearn all the mistakes you've made in a lifetime (736-41).

Appendix 15. Leaders Weekly Checklist (Session one)

LEADER CHECKLIST

Session One

Session One: ***How to Play with Your Child***

"Promoting Your Child's Self-Esteem and Encouraging Cooperation"

Vignettes: ***Play Part 1: 1- 6***

SITE: _____ DATE: _____

LEADER NAMES: _____ TIME: _____

VIGNETTES COVERED: Play Part 1:

1 2 3 4 5 6
(7 8 9 10 11 12 13 14 15)

Vignettes in parentheses are optional. Use if you have time.

(Circle which vignette you finished with.)

DID I	YES	NO
1. Write the agenda on the board	_____	_____
2. Welcome and make introductions	_____	_____
3. Review parents' goals	_____	_____
4. Brainstorm group ground rules	_____	_____
5. Present program goals	_____	_____
6. Explain format for meetings	_____	_____
7. Brainstorm benefits and barriers to parent/child play	_____	_____
8. Highlight key principles from parents' discussion	_____	_____
9. Role play the play skills	_____	_____
10. Explain importance of home activities and reading assignments	_____	_____
11. Review this week's home assignment	_____	_____

Handout Pads:

Home Activities for the Week – How to Play with Your Child
Refrigerator Notes about Play with Your Child

Xerox:

Play Time Record Sheet
Checklist for Evaluating Play

Self-Evaluation

"Gems" of Session—Reminder of things to pursue next session

Appendix 16. Implementation Fidelity Form (session one)

This questionnaire addresses several components involved in running a parenting programme with fidelity. Answers are confidential. Please answer all questions as accurately as possible.

Programme details:

What was the length of this session? _____
How many parents were due to attend today's session?_____
How many parents, if any, were missing from this session? _____
If yes, why do you think the parent(s) was missing? _____

Adherence:

1. I covered all prescribed content for this session:
All of content Most of content Some of content Little/none of content

2. I covered all relevant vignettes:
All of vignettes Most of vignettes Some of vignettes Little/none of vignettes

3. I covered all role-plays:
All of role-plays Most of role-plays Some of role-plays Little/none of role-plays

4. I covered group discussion: Yes No

5. I added some elements to the session:
No Unsure Yes, specify reason _____

6. I subtracted some elements from the session:
No Unsure Yes, specify reason _____

7. I over-ran in time on some components:
No Unsure Yes, specify reason _____

Participant engagement:

1. Overall, how responsive were parents on a scale of 1 to 10 in today's session?
1 (Not responsive) 2 3 4 5 6 7 8 9 10 (Very responsive)

2. Which part of today's session did they engage in most?
Discussion Vignettes Role-play Other, please specify _____

3. Which part of today's session did they engage in least?
Discussion Vignettes Role-play Other, please specify _____

4. How many parents did not appear to engage actively with the programme?_____
5. Overall, how would you describe the atmosphere of the session?
Enthusiastic Engaged Flat Unfocused (e.g. off topic) Other

6. How well did parents understand the themes presented today?
Very Well Well Unsure Not Well

7. From the role-plays was it apparent that parents could implement the skills learned today?
   Yes Unsure No

8. Did all parents report completion of homework activities?
   All Some One-Two None

9. How difficult/easy did parents find implementing skills at home?
   Total success Some success Little success No success

Delivery of session:

1. How easy was it to build rapport with each parent?
Very Easy Easy Mixed Difficult Very Difficult

2. How confident do you feel that you dealt successfully with parents' different issues?
Very confident Confident Some Confidence Low Confidence

3. How easy was it to lead the group today?
Very Easy Easy Mixed Difficult Very Difficult

4. How easy did you find it to tailor today's themes to clients' specific issues?
Very Easy Easy Mixed Difficult Very Difficult

5. Which part of today's programme did you feel you delivered particularly well?
Discussion Vignettes Role-play Other, please specify _____

6. Which part of today's programme did you feel you delivered least well?
Discussion Vignettes Role-play Other, please specify _____

7. How easy was it to keep the group focused on today's theme?
Very Easy Easy Mixed Difficult Very Difficult

8. How easy did you find it to impart today's themes to parents?
Very Easy Easy Mixed Difficult Very Difficult

9. How easy did you find it to promote parents' problem solving abilities?
Very Easy Easy Mixed Difficult Very Difficult

10. Compared to other sessions, how successfully did you feel you delivered today's session?
More Successful Similar Less Successful

11. Did any issues arise in sticking to today's session-specific checklist?
_____

Experience:

1. What training do you have for the programme? _____
2. How many years' experience have you in running parenting programmes? _____
3. How often do you attend supervision for IY parenting programme? _____
4. If you have any further comments or wish to elaborate on any of the above points please do so here _____
_____

Appendix 17. Parents' Weekly Evaluation

INCREDIBLE YEARS PARENT PROGRAMME

Parent Weekly Evaluation

Session _____ Date: _____

1. I found the content of this session to be:

Not helpful Neutral Helpful Very helpful

2. I felt the video-examples were:

Not helpful Neutral Helpful Very helpful

3. I feel the group leader's teaching was:

Not helpful Neutral Helpful Very helpful

4. I found the group discussion to be:

Not helpful Neutral Helpful Very helpful

Additional comments:

Appendix 18. Parent Programme Satisfaction Questionnaire (PPSQ) – Page 1

Incredible Years
Parent Program Satisfaction Questionnaire
BASIC Parent Program

(Hand out at end of the program)

Participant's Name _____ Date _____

The following questionnaire is part of our evaluation of the Incredible Years program that you have received. It is important that you answer as honestly as possible. The information obtained will help us to evaluate and continually improve the program we offer. Your cooperation is greatly appreciated. All responses will be strictly confidential.

A. The Overall Program

Please circle the response that best expresses how you honestly feel at this point.

1. The problem(s) that originally prompted me to take this program for my child is (are)

considerably worse | worse | slightly worse | the same | slightly improved | improved | greatly improved

2. My child's problems which I/we have tried to change using the methods presented in this program are

considerably worse | worse | slightly worse | the same | slightly improved | improved | greatly improved

3. My feelings about my child's progress are that I am

very dissatisfied | dissatisfied | slightly dissatisfied | neutral | slightly satisfied | satisfied | greatly satisfied

4. To what degree has the Incredible Years program helped with other personal or family problems not directly related to your child (for example, your marriage, your feelings in general)?

hindered much more than helped | hindered | hindered slightly | neither helped nor hindered | helped slightly | helped | helped very much

5. My expectation for good results from the Incredible Years program is

very pessimistic | pessimistic | slightly pessimistic | neutral | slightly optimistic | optimistic | very optimistic

6. I feel that the approach used to change my child's problems in this program is

very inappropriate | inappropriate | slightly inappropriate | neutral | slightly appropriate | appropriate | greatly appropriate

Handout 7-1

7. Would you recommend the program to a friend or relative?

strongly not recommend | not recommend | slightly not recommend | neutral | slightly recommend | recommend | strongly recommend

8. How confident are you in managing *current* behavior problems in the home on your own?

very unconfident | unconfident | slightly unconfident | neutral | slightly confident | confident | very confident

9. How confident are you in your ability to manage *future* behavior problems in the home using what you learned from this program?

very unconfident | unconfident | slightly unconfident | neutral | slightly confident | confident | very confident

10. My overall feeling about achieving my goal in this program for my child and family is

very negative | negative | slightly negative | neutral | slightly positive | positive | very positive

B. Teaching Format

Usefulness

In this section, we would like you to indicate how useful each of the following types of teaching is for you *now*. Please circle the response that most clearly describes your opinion.

1. Content of information presented was

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

2. Demonstration of parenting skills through the use of videotape vignettes was

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

3. Group discussion of parenting skills was

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

4. Practice of play skills at home with your child was

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

5. Other home activities (e.g., practice praise, positive comments, list of behaviors) were

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

Handout 7-2

6. Reading chapters from the book was

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

7. If you used the CD/audiotape of the chapter, did you find them

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

8. Weekly handouts (e.g., refrigerator notes & others) were

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

9. I found the "buddy calls" to be

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

10. Use of practice or role plays during group sessions were

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

11. Phone calls from the group leaders were

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

C. Specific Parenting Techniques

Usefulness

In this section, we would like to get your ideas of how useful each of the following techniques is in improving your interactions with your child. Please circle the response that most accurately describes the usefulness of the technique.

1. Child-Directed Play

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

2. Descriptive Commenting (academic, social and emotional coaching)

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

3. Praise

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

Handout 7-3

4. Rewards (sticker, charts, etc.,)

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

5. Ignoring

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

6. Positive Commands (e.g., "when-thens")

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

7. Time Out

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

8. Loss of Privileges, Logical Consequences

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

9. Problem solving with children

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

10. Problem solving with adults and teachers

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

11. Helping child control his/her anger

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

12. This Overall Group of Techniques

extremely useless | useless | slightly useless | neutral | somewhat useful | useful | extremely useful

Handout 7-4

D. Evaluation of Parent Group Leaders

In this section we would like you to express your opinions about your parent group leader(s). Please circle the response to each question that best describes how you feel.

Group Leader #1 _____

(name)

1. I feel that the leader's teaching was

very poor | poor | slightly below average | average | slightly above average | high | superior

2. The leader's preparation was

very poor | poor | slightly below average | average | slightly above average | high | superior

3. Concerning the leader's interest and concern in me and my child, it was

extremely dissatisfied | dissatisfied | slightly dissatisfied | neutral | slightly satisfied | satisfied | extremely satisfied

4. At this point, I feel that the leader in the program was

extremely unhelpful | unhelpful | slightly unhelpful | neutral | slightly helpful | helpful | extremely helpful

If more than one group leader was involved in your program, please fill in the following. (Go to Section E if only one leader was involved.)

Group Leader #2 _____

(name)

1. I feel that the leader's teaching was

very poor | poor | slightly below average | average | slightly above average | high | superior

2. The leader's preparation was

very poor | poor | slightly below average | average | slightly above average | high | superior

3. Concerning the leader's interest and concern in me and my child, it was

extremely dissatisfied | dissatisfied | slightly dissatisfied | neutral | slightly satisfied | satisfied | extremely satisfied

4. At this point, I feel that the leader in the program was

extremely unhelpful | unhelpful | slightly unhelpful | neutral | slightly helpful | helpful | extremely helpful

Handout 7-5

E. Parent Group

In this section, we'd like to get your ideas about your group. Please circle the response that describes how you feel.

1. I feel the group was

very unsupportive	unsupportive	somewhat unsupportive	neutral	somewhat supportive	supportive	very supportive

2. Concerning other group members' interest in me and my child, I felt they were

very uninterested	uninterested	somewhat uninterested	neutral	somewhat interested	interested	very interested

3. I would like to keep meeting as a group

YES NO

4. How likely is it that you will continue meeting with one or more of the parents in your group?

highly unlikely	unlikely	somewhat unlikely	neutral	somewhat likely	likely	very likely

F. Your Opinion

1. How could the program have been improved to help you more?

2. At this time do you feel the need for additional further parenting assistance? Please elaborate.

3. What did you see as the main benefit of the Incredible Years program?

Thank you for your patience in filling out all of these questionnaires. Your input is very much appreciated, and really helps us to plan future programs.

Handout 7-6

Appendix 19. Eyberg Child Behaviour Inventory (ECBI), page 1

ECBI™ Eyberg Child Behavior Inventory™

Parent Rating Form by Sheila Eyberg, PhD

Your Name _____ Relationship to Child _____ Today's Date ___/___/___

Child's Name _____ Child's Gender _____ Child's Date of Birth ___/___/___

Directions: Below are a series of phrases that describe children's behavior. Please (1) circle the number describing **how often** the behavior **currently** occurs with your child, and (2) circle either "yes" **or** "no" to indicate whether the behavior is **currently a problem for you**.

For example, if seldom, you would circle the 2 in response to the following statement:

	Never	Seldom	Sometimes	Often		Always	Is this a problem for you?
1. Refuses to eat vegetables	1	(2)	3	4	5	6	7	YES (NO)

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

1. Refuses to eat vegetables	1	(2)	(X)	4	5	6	7	YES (NO)

	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often			Always		
1. Dawdles in getting dressed	1	2	3	4	5	6	7	YES	NO
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	YES	NO
3. Has poor table manners	1	2	3	4	5	6	7	YES	NO
4. Refuses to eat food presented	1	2	3	4	5	6	7	YES	NO
5. Refuses to do chores when asked	1	2	3	4	5	6	7	YES	NO
6. Slow in getting ready for bed	1	2	3	4	5	6	7	YES	NO
7. Refuses to go to bed on time	1	2	3	4	5	6	7	YES	NO
8. Does not obey house rules on own	1	2	3	4	5	6	7	YES	NO
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	YES	NO
10. Acts defiant when told to do something	1	2	3	4	5	6	7	YES	NO
11. Argues with parents about rules	1	2	3	4	5	6	7	YES	NO
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	YES	NO
13. Has temper tantrums	1	2	3	4	5	6	7	YES	NO
14. Sasses adults	1	2	3	4	5	6	7	YES	NO
15. Whines	1	2	3	4	5	6	7	YES	NO
							Page 1 subtotals		

OVER →

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Appendix 19 cont'd. ECBI, page 2

	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often	Always				
16. Cries easily	1	2	3	4	5	6	7	YES	NO
17. Yells or screams	1	2	3	4	5	6	7	YES	NO
18. Hits parents	1	2	3	4	5	6	7	YES	NO
19. Destroys toys and other objects	1	2	3	4	5	6	7	YES	NO
20. Is careless with toys and other objects	1	2	3	4	5	6	7	YES	NO
21. Steals	1	2	3	4	5	6	7	YES	NO
22. Lies	1	2	3	4	5	6	7	YES	NO
23. Teases or provokes other children	1	2	3	4	5	6	7	YES	NO
24. Verbally fights with friends own age	1	2	3	4	5	6	7	YES	NO
25. Verbally fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
26. Physically fights with friends own age	1	2	3	4	5	6	7	YES	NO
27. Physically fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
28. Constantly seeks attention	1	2	3	4	5	6	7	YES	NO
29. Interrupts	1	2	3	4	5	6	7	YES	NO
30. Is easily distracted	1	2	3	4	5	6	7	YES	NO
31. Has short attention span	1	2	3	4	5	6	7	YES	NO
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	YES	NO
33. Has difficulty entertaining self alone	1	2	3	4	5	6	7	YES	NO
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	YES	NO
35. Is overactive or restless	1	2	3	4	5	6	7	YES	NO
36. Wets the bed	1	2	3	4	5	6	7	YES	NO
							Page 2 subtotals		
							Subtotals from page 1		

Scores	Raw score	T score	Exceeds Cutoff (✔)
Intensity			
Problem			

Comments:

Appendix 20. Information consent form given to parents in overall RCT: page 1

THE INCREDIBLE YEARS RESEARCH STUDY

PARENT INFORMATION SHEET AND CONSENT FORM A

We would like to invite you to take part in an important research study. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take a few minutes to read carefully through the following information. Also, please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?

Since 2003, the Clondalkin Partnership and more recently, its newly established organisation, *Archways*, has supported parents in the Dublin area through the *Incredible Years* program. The purpose of the IY program is to help support parents in the difficult task of childrearing.

NUI Maynooth has been commissioned to undertake a large, three-year research study of the Incredible Years program in Ireland in order to see how it is working and how effective it is. As part of this research, we are now beginning to talk to parents who have indicated that they would like to attend a parenting group. These groups are intended to support families with young children. Each group will consist of a group of parents like yourself who will be invited to attend 12 weekly sessions (childcare, transportation costs etc. will be covered). The group will be led by a trained professional who will talk with parents about ways in which they can help your child's development.

In the group, parents will explore ways that they use at home to manage their child's behaviour without getting too stressed. DVDs of typical family situations will be shown which illustrate common childhood behaviours and possible ways of dealing with them. Parents will have the opportunity to discuss the DVDs and also to practise the techniques they learn both in the group and at home. Two groups will be run, one beginning soon and the other in about six months' time.

Why have I been asked to take part?

We understand that, as a parent of a young child aged 3-6 years, you have expressed an interest in attending one of the *Incredible Years* parent support programmes provided by *Archways*. As part of their programme delivery, Archways are supporting us in our research and so we are inviting some parents to take part in our study.

Who has approved this study?

The study has received ethical approval from the *National University of Ireland at Maynooth Ethics Committee.*

Do I have to take part?

No, you are under no obligation whatsoever to take part in the research. However, we hope that you will agree to take part and give us some of your time to complete a few brief and easy-to-complete questionnaires. Our researcher will be there to help you with this if necessary. It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason and/or to withdraw your

Appendix 20 cont'd. Information consent form: page 2

you are still free to withdraw at any time without giving a reason and/or to withdraw your information up until such time as the research findings are made publicly available. If you withdraw from the research part of the study, you can still carry on with the parenting group.

If you are unable to complete the parenting course, we would still like you to remain part of the study, even if you move from the area, and to continue to assist the researcher.

A decision to withdraw at any time, or a decision not to take part, will not affect your right to access the parent support service provided by Archways or other services in your area.

What will happen to me if I take part?

Firstly, you will be offered a place on one of two parenting groups that will run during the next 6-12 months. A researcher will visit you at home (or at the *Archways* support centre) sometime during the next three months and again six months later. Some of the parents taking part will be visited a third time, six months after the second visit. At each visit, the researcher will ask you to complete some questionnaires about your child and yourself. In some cases, she may also ask you and your child to take part in some activity such as playing a game and then tidying up so that she can watch and record (write down) what the child does during these activities. Each visit will last about one hour with a further 30 minutes (if required) for the observation. You will receive €25 for each visit as a token of our gratitude for your time and co-operation with the study.

You will be told which of the two groups you will be attending after the researcher has completed the first visit and collected the information provided by you.

All the information you provide will be kept at NUI Maynooth in such a way that it will not be possible to identify you or your child. When the findings of this study are reported, information from the families taking part will be reported as a group rather than as individuals.

NB. Please note that the research interviews do not constitute any kind of counselling or therapy.

How long will the whole process take?

The total length of the time you will spend assisting with the research is approximately one hour, although it may be shorter than this depending on how you get on.

Will my taking part in this research be kept confidential?

All information which is collected about you during the course of the research will be kept **strictly confidential**. No names will be identified at any time. All information will be held in a locked cabinet at the researchers' place of work and will be accessed only by the research team; no information will be distributed to any other unauthorised individual. The data that you provide will be made available at your discretion.

What will happen to the results of the research?

The research will be written up in report format and may be published in journals and presented at conferences. A copy of the research will be available upon completion.

Who do I contact if I experience any discomfort or stress as a result of the study?

In the first instance, please feel free to contact your group leader/facilitator.

Appendix 20 cont'd. Information consent form: page 3

Who do I contact if I have a question?

Please feel free to address any questions to Ms Yvonne Leckey who is also available on the telephone to discuss the study with you (Tel:).

Alternatively, you may contact the Principal Investigator/Research Director, Dr Sinéad McGilloway, at 708 6052/4765 or write to her at the Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare, Ireland.

If you would like to take part in this research, please complete and detach the consent form overleaf.

If during your participation in this study, you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the National University of Ireland at Maynooth Ethics Committee at pgdean@nuim.ie or telephone (01) 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.

THANK YOU FOR TAKING THE TIME TO READ THIS.

Appendix 20 cont'd. Information consent form: page 4

THE INCREDIBLE YEARS RESEARCH STUDY

CONSENT FORM

I (name) _____ have read and understood the information sheet dated _____ for the above study and have had the opportunity to ask questions.

I agree to take part in this study and to provide information to the researcher for use in the study.

I understand that I can withdraw from the study (or withdraw my data) at any time and that my withdrawal will not affect my access to any current or future Archways service or any other support services.

Signature of participant: _____

Date: _____

Signature of researcher _____

Date: _____

Appendix 21. Portion of Guidance for Safe Working, page 1

- Supervisors MUST provide a list of visiting researchers to the departmental office.
- If you are interviewing, assessing or testing a participant in the department, please ensure that you have a landline telephone number (or at the very least a mobile number) and address for them before they come in. Please telephone in advance to confirm that this is a correct number. Ensure that this is filed in a place known to your supervisor or to a colleague.
- Make sure that someone knows: (a) that you are seeing this person; (b) where the assessment or testing is being conducted; and (c) when you are due to finish. Please introduce the participant by name to this colleague if possible.
- Wherever possible, try to ensure that you are seated nearest to the door. If possible, leave the door slightly ajar.
- If you have any doubts or worries about the prospective participant, please terminate the session immediately and inform your supervisor. In some cases, it may be better to leave the room and to let the participant finish while reporting the difficulty to your supervisor or the Head of Department. Please ensure that you inform all of these people of the difficulties after the event. If, at any time, you feel ***under physical threat***, find a plausible excuse, ***leave the room immediately*** and call security on ***Ext. 3589/3929*** (***01 708 3589/3929*** from a mobile).
- If a participant faints, or becomes visibly ill or distressed, contact the University Medical Centre immediately (Ext.3878) and report to departmental office or phone Ext.3333 for campus emergencies. In some situations, you should take care to screen for medical conditions and check if any participants have epilepsy as a seizure may be triggered by a visually demanding or flickering computer screen. Consult the appended University document containing first aider details and instructions regarding medical emergencies.
- Testing should not take place outside of departmental office hours i.e. Mon to Fri 9a.m. to 5p.m.
- Should you see anyone in the building whom you regard as behaving suspiciously, or in the department whom you do not recognise, do not confront, but phone security on ***Ext. 3589/3929*** and seek assistance/advice from any available source.
- Please note that prospective participants have not been 'vetted' and that people recruited from posters on campus may not necessarily be students. Therefore, you must be aware of the pitfalls of handing out a **personal mobile phone number.** A safer alternative might be to recruit using a temporary email account, e.g., readingstudy@hotmail.com. Researchers should report any cases of inappropriate or persistent calls or contact from participants to their supervisor and Head of Department.
- If any participant asks for help or advice for psychological or other problems, please state firmly that it is not appropriate for you to give such advice because you are not qualified to do so, and direct them to their GP, or to their local A&E department.

5.2 CONDUCTING ASSESSMENTS OR INTERVIEWS OUTSIDE THE DEPARTMENT

The Head of Department must ensure that those appointed to undertake fieldwork are authorised, adequately trained and judged to be sufficiently competent to do so. The supervisor must inform the Head of Department of those undertaking fieldwork and their

Appendix 21 cont'd. Portion of Guidance for Safe Working, page 2

training requirements. However, the supervisor is primarily responsible for assessing the level of risk involved and implementing safe systems of work. With regard to the latter, the following guidelines must be adhered to at all times by students and staff.
Where possible, the research should be conducted in a convenient and preferably quiet public place (e.g. a quiet café/restaurant or a hotel lobby). Supervisors should ensure that undergraduates do not test participants who are not known to them outside the department in non-public places. For postgraduates and research staff, the following precautions must be taken when ***making a home visit***:

- Staff/students must always carry a charged mobile phone.
- There should be a clear 'checking-in' procedure with the supervisor, or another member of staff or colleague where appropriate (this includes postdoctoral fellows) when undertaking a home visit. The designated contact person must have a record of the time of the visit, the name and address, and the telephone number. They must also know the mobile phone number of the researcher.
- All students and staff should carry photographic ID that clearly indicates their status and affiliation. This should be shown before entering anyone's home.
- As part of the introduction to the participant, the researcher should say '*I just have to call my supervisor (or another staff member or colleague who can be available at the time)*. The researcher should then ring the designated staff member, or available colleague, in the presence of the participant and say: 'I'm in xxxx's house, and will be finished at approximately xx'.
- If a researcher fails to ring the designated person at the appointed time, that person should immediately try to make contact with him/her. If unsuccessful, a member of staff should be contacted and/or, where appropriate, the relevant emergency services phoned.
- If you have any doubts or worries about the prospective participant, please terminate the session immediately and find a plausible excuse to leave. You should inform your supervisor as soon as possible afterwards. If, at any time, you feel under ***physical threat***, find an excuse to leave the room immediately and call the appropriate services. Try not to panic – if you stay calm, you will be more able to think clearly and stay safe.
- A personal alarm should be carried at all times and the relevant services contacted in the event of an emergency. Some personal alarms are available within the department. Please contact your supervisor if you require one.
- See the leaflet entitled '*Working Safely in other People's Homes*' published by the Suzy Lamplugh trust (see Appendix 2).
- If any participant asks for help or advice for psychological or other problems, please state that it would not be appropriate for you to provide such help because you are not qualified to do so. Instead, direct them to their GP, or to the A&E department at their local hospital. In specific projects, it may also be advisable to provide some or all participants with information leaflets and help line numbers etc. (e.g. of mental health support organisations).

Appendix 21 cont'd. Portion of Guidance for Safe Working, page 3

5.2.1 Further guidelines for assessing patient participants and other vulnerable groups (e.g. people with mental health problems)

- Patients should be well briefed about what to expect of the session before the visit in question.
- A first home visit by staff or students to participants with a brain injury or mental health problem MUST always be made by two people.
- All patient participants must be provided with an Information Sheet which should, where possible, be distributed to them and their families at least 48 hours before the first visit.
- In general, patient participants should not be tested, or be required to complete questionnaires or engage in any other research activity for more than one hour without a break. A maximum of two 60-minute sessions in any one day is a reasonable guideline, although there are exceptions where people have travelled a long distance.
- People who have had a stroke, or who are terminally ill (or have some other illness or disability) may often develop pain and discomfort when, for instance, being asked to stare for long periods at a computer screen, or when asked to complete lengthy questionnaires or interviews. Therefore, they should be frequently monitored for pain and discomfort, and testing/assessment stopped if necessary.

5.2.2 A brief note on research with children: protecting their safety

This section deals with issues of safety when conducting research with children. The Department recognises that it has a duty of care to children with whom it is in contact for research purposes. Ethical guidelines on conducting research with children may be obtained from the departmental office.

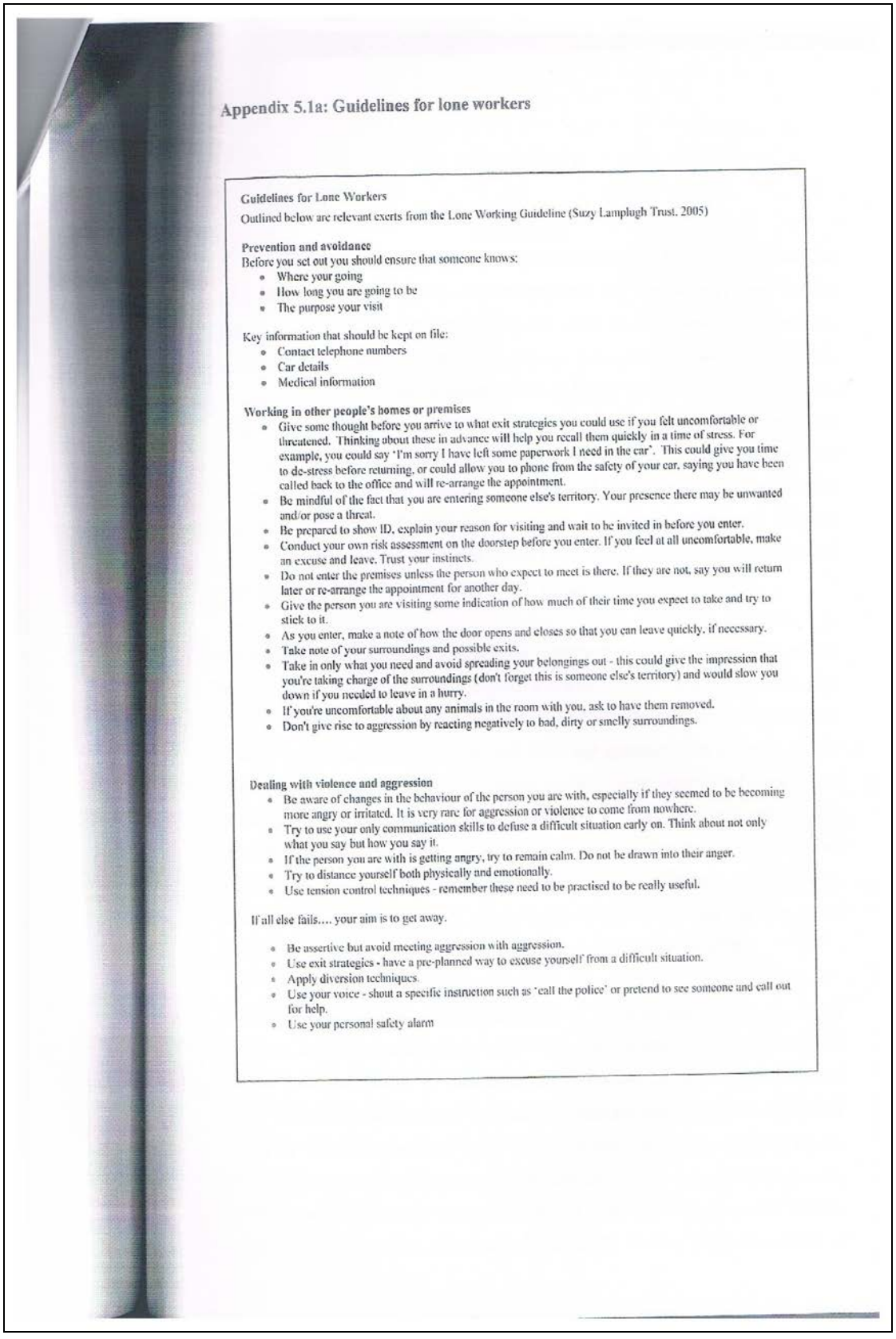
- It is important to make clear and documented plans for data collection. Records should be kept of arrangements made with parents/guardians, teachers and schools. Records of written permission should be retained.
- A parent/guardian or school teacher/principal must be present at all times.

NB. For further information on personal safety when dealing with human participants, please refer to the departmental copy of ***Personal Safety for Health Care Workers*** (1995) by P. Bibby (Ashgate: Suzy Lamplugh Trust). (In particular, see Chapters 14-16). A copy of ***Lone Working*** (2005) (Ashgate: Suzy Lamplugh Trust) is also available from the departmental office.

5.3 Guidelines for conducting electrophysiological research with human participants (EEG/ERP)

All personnel working with EEG/ERP may do so only after they have received adequate training in the use of electrophysiological techniques, either at NUIM, or one of the collaborating institutions of the Department of Psychology (e.g. TCD, St. Vincent's Hospital, Fairview, Nathan Kline Institute, NY). New postgraduates and all undergraduates may only carry out electrophysiological data acquisition in the presence of a trained postgraduate student, trained postdoctoral researcher, or staff member with

Appendix 21 cont'd. Portion of Guidance for Safe Working, page 4



Appendix 5.1a: Guidelines for lone workers

Guidelines for Lone Workers

Outlined below are relevant exerts from the Lone Working Guideline (Suzy Lamplugh Trust. 2005)

Prevention and avoidance

Before you set out you should ensure that someone knows:

- Where your going
- How long you are going to be
- The purpose your visit

Key information that should be kept on file:

- Contact telephone numbers
- Car details
- Medical information

Working in other people's homes or premises

- Give some thought before you arrive to what exit strategies you could use if you felt uncomfortable or threatened. Thinking about these in advance will help you recall them quickly in a time of stress. For example, you could say 'I'm sorry I have left some paperwork I need in the car'. This could give you time to de-stress before returning, or could allow you to phone from the safety of your car, saying you have been called back to the office and will re-arrange the appointment.
- Be mindful of the fact that you are entering someone else's territory. Your presence there may be unwanted and/or pose a threat.
- Be prepared to show ID, explain your reason for visiting and wait to be invited in before you enter.
- Conduct your own risk assessment on the doorstep before you enter. If you feel at all uncomfortable, make an excuse and leave. Trust your instincts.
- Do not enter the premises unless the person who expect to meet is there. If they are not, say you will return later or re-arrange the appointment for another day.
- Give the person you are visiting some indication of how much of their time you expect to take and try to stick to it.
- As you enter, make a note of how the door opens and closes so that you can leave quickly, if necessary.
- Take note of your surroundings and possible exits.
- Take in only what you need and avoid spreading your belongings out - this could give the impression that you're taking charge of the surroundings (don't forget this is someone else's territory) and would slow you down if you needed to leave in a hurry.
- If you're uncomfortable about any animals in the room with you, ask to have them removed.
- Don't give rise to aggression by reacting negatively to bad, dirty or smelly surroundings.

Dealing with violence and aggression

- Be aware of changes in the behaviour of the person you are with, especially if they seemed to be becoming more angry or irritated. It is very rare for aggression or violence to come from nowhere.
- Try to use your only communication skills to defuse a difficult situation early on. Think about not only what you say but how you say it.
- If the person you are with is getting angry, try to remain calm. Do not be drawn into their anger.
- Try to distance yourself both physically and emotionally.
- Use tension control techniques - remember these need to be practised to be really useful.

If all else fails.... your aim is to get away.

- Be assertive but avoid meeting aggression with aggression.
- Use exit strategies - have a pre-planned way to excuse yourself from a difficult situation.
- Apply diversion techniques.
- Use your voice - shout a specific instruction such as 'call the police' or pretend to see someone and call out for help.
- Use your personal safety alarm

Appendix 22. List of publications and presentations

Peer-reviewed publications:

Furlong, M. & McGilloway, S. (in press). Challenges and future directions in the evaluation of parenting programmes. In P. Barberis, & S. Petrakis (Eds.), *Parenting: Challenges, Practices and Cultural Influences*. NY: Nova science publishers.

McGilloway, S., Ni Mhaille, G, Bywater, T., Furlong, M., Leckey, Y., Kelly, P., Comiskey, C., & Donnelly, M. (2012a). A parenting intervention for childhood behavioural problems: A randomised controlled trial in disadvantaged community-based settings. *Journal of Consulting and Clinical Psychology*, *80* (1), 116-127.

McGilloway, S., Leckey, Y., Ni Mhaille, G., Furlong, M., Kelly, P., Bywater, T., Comiskey, C. & Donnelly, M. (2012b). *Proving the power of positive parenting – 12 months on: An evaluation of the longer-term effectiveness of the Incredible Years BASIC parent training program in Ireland.* Dublin: Archways.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2012). Behavioural and cognitive–behavioural group-based parenting programmes for early onset conduct problems in children aged 3 to 12 years. *Cochrane Database of Systematic Reviews 2012, 2*. Art. No.: CD008225. DOI: 10.1002/14651858.CD008225.pub2.

Furlong, M., & McGilloway, S. (2011). The Incredible Years Parenting Program in Ireland: A qualitative analysis of the experience of parents living in disadvantaged areas. *Clinical Child Psychology and Psychiatry.* DOI: 10.1177/1359104511426406. Retrieved from http://ccp.sagepub.com/content/early/2011/11/14/1359104511426406.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., Donnelly, M., & O' Neill, C. (2010). Behavioural and cognitive–behavioural group-based parenting programmes for early onset conduct problems in children aged 3 to 12 years (PROTOCOL). *Cochrane Database of Systematic Reviews 2010, 1*. Art. No.: CD008225. DOI:10.1002/14651858.CD008225.pub2.

McGilloway, S., Ni Mhaille, G., Bywater, T., Furlong, M., O'Neill, D., Comiskey, C. & Donnelly, M. (2009). *Proving the power of positive parenting: A randomised controlled trial to investigate the effectiveness of the Incredible Years BASIC Parenting program in an Irish context (Short-term outcomes).* Dublin: Archways. Retrieved from http://iyirelandstudy.ie

Non peer-reviewed publications:

Furlong, M. (2012). Economic inequality and psychological wellbeing. *Experimentation*, Issue 3. Available at http://www.experimentation-online.co.uk

Furlong, M. (2012). Exploring the differences between ADHD and conduct problems in young children. *Experimentation*, Issue 2. Available at http://www.experimentation-online.co.uk

Furlong, M. (2012). Understanding and preventing antisocial behaviour. *Experimentation*, Issue 1. Available at http://www.experimentation-online.co.uk

Papers planned or in preparation:

Furlong, M., & McGilloway, S. (in preparation). *The longer-term experiences of families following the Incredible Years Parenting programme (working title).*

Furlong, M., & McGilloway, S. (in preparation). *Organisational processes involved in implementing the Incredible Years Parenting programme in disadvantaged settings (working title).*

Furlong, M., &…….(in preparation). *Parenting programmes: a systematic review of qualitative research.*

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S.M. & Donnelly, M. (in preparation). A systematic review of behavioral and cognitive-behavioral group-based parenting interventions for early-onset conduct problems in children age 3-12 years.

Presentations:

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *Parenting programmes for conduct problems and antisocial behaviour* Invited speaker at the Health Research Board's launch of 'Picture of Health 2012', Dublin, Ireland, 6 December 2012.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *The effectiveness of behavioural parenting programmes for childhood conduct problems.* Poster presentation at the 1st annual Children's Research Network Conference, Dublin, Ireland, 26 September 2012.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *Reviewing the effectiveness of behavioural group-based parenting programmes for childhood conduct problems: Some key methodological challenges.* Invited speaker at the Campbell Collaboration Colloquium, Copenhagen, Denmark, 29-31 May 2012.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *Behavioral and cognitive-behavioral group-based parenting interventions for early-onset conduct problems in children age 3-12 years.* Poster presentation at the 2012 Campbell Collaboration Colloquium, Copenhagen, Denmark, 29-31 May 2012.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly: *The effectiveness and cost-effectiveness of behavioral group-based parenting interventions in treating early-onset conduct problems in children age 3-12 years.* Poster presented at the 8th Annual Cochrane in Ireland Conference, Dublin City University, Dublin, Ireland, 27 January 2012.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly: *Investigating the evidence for behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems: A Cochrane*

review. Poster presented at the 34th Annual Congress of Psychology Students, Queens University Belfast, N. Ireland, 23-24 March 2012.

McGilloway et al. **Research Symposium (4 papers):** Halting the development of conduct problems in childhood: Community-based early intervention and research. Research presentations at the 41st Annual Psychological Society of Ireland Conference, Salthill, Co. Galway, Ireland, 10-13 November 2011.

S. McGilloway, G. Ni Mhaille, T. Bywater, M. Furlong, Y. Leckey, P. Kelly, C. Comiskey and M. Donnelly: *Evaluating the effectiveness of the Incredible Years BASIC parent training intervention within an Irish context.*

M. Furlong and S. McGilloway: *"My life is completely different between this time last year and now": A qualitative study of the experiences of Irish parents in implementing the Incredible Years BASIC Parenting Programme in disadvantaged settings.*

M. Furlong and S. McGilloway: *Challenges and successes in implementing the Incredible Years Parenting Programme at long-term follow up: A qualitative study of the experiences of Irish parents in disadvantaged settings*. Research presentation at the 2011 Annual Conference of the British Psychological Society, Glasgow, Scotland, 3-5 May 2011.

McGilloway et al. **Research Symposium (4 papers):** Halting the development of conduct problems in Ireland: Evaluating the effectiveness of the Incredible Years Parent and Teacher training series within a 'high risk' community-based setting. Research presentations at the 25th All-Ireland Social Medicine Meeting, Belfast, 9th September 2010.

S.McGilloway, G.Ni Mhaille, T.Bywater, M.Furlong, D.ONeill, Y.Leckey, P. Kelly, C.Comiskey and M. Donnelly. S. *Preventing conduct problems in disadvantaged communities: A randomised controlled trial to investigate the effectiveness of the Incredible Years BASIC parent training programme in an Irish context.*

M.Furlong and S.McGilloway *How and why does the Incredible Years' Parenting Programme work?A Qualitative analysis of Irish parents' experiences within a 'high risk' context.*

McGilloway et al. **Research Symposium (4 papers)**: Emotional and behavioural difficulties in childhood: Context, communities and evidence-based intervention. Annual Conference of the British Psychological Society, Stratford-upon-Avon, UK, 14-16 April 2010.

M. Furlong and S. McGilloway: *Parents' experiences of the Incredible Years' Parenting Programme within an Irish community-based context.*

S.McGilloway, G.Ni Mhaille, T.Bywater, M.Furlong, D.ONeill, Y.Leckey, P. Kelly, C.Comiskey and M. Donnelly. S. *A randomised controlled trial of the Incredible Years Parenting programme in Ireland.*

S.McGilloway, G.Ni Mhaille, T.Bywater, M.Furlong, D.ONeill, Y.Leckey, P. Kelly, C.Comiskey and M. Donnelly. S. *A randomised controlled trial of the Incredible Years Parenting programme in Ireland: Short-term outcomes.* Research presentation at the 2009 Annual Archways conference, Dublin, Ireland, 21 September, 2009.

M. Furlong and S. McGilloway. *Parents' experiences of the Incredible Years Parenting programme: A qualitative analysis.* Research presentation at the 2009 Annual Archways conference, Dublin, Ireland, 21 September, 2009.

Presentations (in submission):

M. Furlong and S. McGilloway. *Organisational processes for quality implementation of evidence-based parenting programmes.* 10th Annual Psychology, Health and Medicine conference, School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland, 1 May.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *Preventing antisocial and criminal behaviour: A Cochrane review of the effectiveness and cost-effectiveness of group-based parenting programmes for childhood conduct problems.* Research presentation submitted to the 21st Annual Conference of the Society for Prevention Research, San Francisco, California, 29-31 May, 2013.

M. Furlong, S. McGilloway, T. Bywater, J. Hutchings, S. Smith and M. Donnelly. *Are group-based parenting programmes effective in the treatment of childhood conduct problems? A Cochrane review.* Research presentation submitted to the 15th International Congress of the European Society for Child and Adolescent Psychiatry, Dublin, Ireland, 6-10 July, 2013.

M. Furlong and S. McGilloway. *Implementing an evidence-based parenting intervention in mainstream health services: A process evaluation of stakeholder experiences.* Research presentation submitted to the 15th International Congress of the European Society for Child and Adolescent Psychiatry, Dublin, Ireland, 6-10 July, 2013.