# An Evaluation of the Effectiveness of Intervention in Families with Children with Behavioural Problems within the Context of a Sure Start Programme

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Research reported in this paper was carried out in part fulfilment for the Master's Degree in Social Learning Theory at the Queen's University of Belfast.

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## Abstract

Sure Start is a Government project that aims to prevent social exclusion by targeting children between 0 and 4 years of age living in areas of social and economic deprivation. This study examined whether a Tier 2 Behaviour Support Service within a local Sure Start project was able to bring about improvements in children's behaviour and the levels of stress experienced by parents.

Children and their families referred to a Sure Start Behaviour Support Service between October, 2001 and April, 2002 were assessed. Intervention with the families took the form of Parent Management Training with Solution Focused Brief Therapy.

Thirteen children were referred and intervention took place with ten. Some initial improvement was found in all cases, however, efficacy appeared to be low in multiproblem families and six children required further referral for multidisciplinary assessment and treatment. Due to the small size of the study, it was not possible to carry out a statistical analysis. This study, however, raises questions about the level of behavioural support available to multiproblem families and the strength of links between Sure Start and core services.


(Word count – 6419 words).

## Introduction

### Sure Start

Sure Start is a Government programme to prevent social exclusion and aims to do this by targeting very young children living in poverty. Government funding is available to local cross-agency partnerships in areas of deprivation, which are identified on the basis of recognised deprivation measures. Such partnerships include statutory and voluntary service providers, community groups and local parents. The statutory providers in the Northern Ireland context are Health and Social Services Trusts while the voluntary service providers include bodies such as Barnardo's, the N.S.P.C.C. and Home-Start. Partnerships evaluate existing services for preschool children in the area and, in consultation with the local community, draw up a plan to develop and augment services. On the basis of such plans funding is allocated. Local programmes are encouraged to improve children's life chances through better access to family support; advice on children's development; health services; and preschool educational services (Roberts, 2000; DfEE, 2001; Eistenstadt, 2001). Although there are nationally agreed aims and long-term objectives for Sure Start, each programme must set out its own targets and objectives and develop its own philosophy and ethos.

Much of the thinking behind Sure Start came from studies of previous programmes that aimed to bring very young children out of poverty and give them a good start in life, for example, the US-based Head Start and High/Scope (Schweinhart et al, 1993; Sylva, 1994; Schweinhart and Weikart, 1997).

Not all Sure Start programmes will have a community-based programme for behavioural intervention. During the planning of this particular Sure Start

programme it was felt that there would be sufficient demand in the area for a Tier 2 behaviour support service, which is described below. This study sets out to evaluate whether provision of such a service is justified.

## Child Mental Health Difficulties

Due to the increasing pressure on Child and Adolescent Mental Health Services (CAMHS) described below, the National Health Service (NHS) Health Advisory Service proposed in 1995 (NHS Health Advisory Service, 1995) that these services should take the form of a tiered system. Tier 2 is a service provided by behaviour therapists or other workers with some specialist training in the management of mental health/behavioural problems. It acts as a gatekeeper to more specialised multidisciplinary psychiatric services (Tiers 3 and 4). Tier 1 is a primary care unspecialised service.

There has been a significant increase in the rates of various psychiatric disorders in young people over the past fifty years (British Medical Association, 1999). Many of these disorders begin in early childhood and have significant implications for psychological problems later in life (Farrington, 1995; Caspi et al, 1996; Stattin and Magnusson, 1996). For such reasons it is felt that early intervention is important.

The majority of preschool children who have behaviour difficulties appear to present with predominantly externalizing problems as defined by Achenbach and Rescorla (Achenbach and Rescorla, 2000), that is, problems that involve conflicts with other people (for example, physical aggression, such as hitting and nipping). This may well be because problems with internalizing behaviour (problems mainly within the self, such as fearfulness and sad mood) are harder to detect at this age

(Campbell, 1995). The overall consensus from studies that look at behaviour problems in preschool children is that 10-15% of preschool children have mild to moderate behavioural problems (Campbell, 1995).

Various risk factors predispose to childhood behaviour problems. Those specific to the individual include the child's temperament (Hill, 2002). Family factors include parental criminality; parental psychiatric disorder; large family size; parental discord; critical, hostile or coercive parenting; family breakdown (Kolvin et al, 1988); Lyons-Ruth, 1993; Garmezy and Masten, 1994; Hill, 2002). Factors linked to the wider environment include housing and poverty (Richman et al, 1982) poor peer relationships (Hill, 2002) and social isolation (Wahler, 1980).

On the other hand, certain factors protect children from developing behavioural or other mental health problems. The British Medical Association (1999) describes the importance of social (environmental) factors such as friendly government policies (of which Sure Start is an example); good social support; a reasonable standard of living; and available child care of good quality. Protective factors within the family include affection, promotion of self-confidence and self-esteem, good mothering and good maternal health (Kolvin et al, 1988). Protective factors relevant to the child included healthy physical development, an easy temperament and high self-esteem.

## Interventions for Children with Emotional and Behavioural Difficulties

What interventions are available for children with behavioural and emotional problems? Most authors feel that behavioural and cognitive- behavioural methods have so far been shown to be the most effective in treating antisocial behaviour (Macdonald and Roberts, 1995; Kazdin, 2002). These interventions tend to have

been more rigorously evaluated and have stood up to the evaluation process, giving, on the whole, positive results. Such intervention may be child-focused or parent-focused.

Child-focused interventions include Social Skills Training and Cognitive Skills Training since it is felt that children who exhibit antisocial behaviour have deficient social skills and problem-solving skills (Dumas, 1989).

Parent-focused interventions include Parent Management Training, which is founded on several important ground rules or strategies. It emphasises the importance of developing rules or boundaries for acceptable behaviour within the family so that their children are able to develop a framework within which they can assess their own behaviour (Macdonald and Roberts, 1995). Parents are also enabled to recognise which behaviours can be reasonably expected from their children.

Parent Management Training involves teaching parents certain techniques such as how to give clear unambiguous instructions. Parents are also given training in contingency management skills so that they can learn to recognise and reinforce desired behaviour and reduce or extinguish undesired behaviour.

Many studies have demonstrated the effectiveness of Parent Management Training with a wide range of child behaviour problems (Brestan and Eyberg, 1998; Barlow and Stewart-Brown, 2000; Barlow and Parsons, 2002; Richardson and Joughin, 2002). It is not, however, successful in all cases. Parent Management Training is also unlikely to succeed in families in which many complex problems are present (Macdonald and Roberts, 1995; British Medical Association, 1999). Such problems include poor parental adjustment, in particular maternal depression; maternal stress and poor socioeconomic status; maternal social isolation; parental discord and poor

parental perception of the significance and severity of the emotional and behavioural problems of their children (Dumas, 1989; Macdonald and Roberts, 1995). These same problems appear to overlap with the risk factors for the development and maintenance of behavioural problems in children described above.

Solution Focused Brief Therapy is an approach to counselling and consultation that was developed by Steve de Shazer at the Brief Family Therapy Centre in Milwaukee in the 1980s (de Shazer, 1994). It evolved when de Shazer started questioning clients about exceptions to their problem behaviours, for example, behaviours such as depression. From this it was possible to start constructing solution behaviours with the exceptions forming the basis of the solutions (George et al, 1999a). Solution Focused Brief Therapy is very much client-directed and makes much use of positive reinforcement by the therapist of the client's problem-free, successful behaviour. Evaluations of Solution Focused Brief Therapy appear to be positive (George et al, 1999b).

In this study Solution Focused Brief Therapy was used in conjunction with Parent Management Training.

## Method

### Aims and Objectives.

This study took place within the context of a Sure Start Project based in a small town and serving a rural area. This project had identified a need for a Tier 2 behaviour support service, as described above, for preschool children and their families.

The central aims of the Behaviour Support Service as recognised by the Sure Start Project were:

1. A reduction in the number of children with behavioural problems attending mainstream primary school.
2. A reduction in the number of children requiring statutory assessment of special educational needs due to behavioural difficulties (Department of Education, Northern Ireland, 1998).

Unfortunately these are long-term objectives and cannot be measured within this short-term study.

The aims of the present study were:

1. To reduce identified undesired behaviours of children referred to the Behaviour Support Service.
2. To empower and support parents in the management of their child's behaviour.

The Sample

The participants in this study consisted of children referred to the Tier 2 Behaviour Support Service that formed part of the Sure Start Project. The referral criteria for this service were as follows:

Any child under 4 years of age that resided within the boundaries of the Sure Start Project and presented with behavioural difficulties.

Referrals were accepted from:

- health visitors and social workers – these professionals needed to provide evidence of previous Tier 1 behaviour management input (described above) with the family prior to referral to the Sure Start Behaviour Support Service.
- nursery school teachers and playgroup leaders.

- any family visitor or support worker who was a member of the Sure Start Team.
- any other primary care worker.

All referrals needed parental consent for the referral to Sure Start.

This study involved a single therapist who had one day a week in which to see Sure Start families. The therapist was also available for consultation with the referrer.

All referrals to the Behaviour Support Service who had assessments completed between October, 2001 and April, 2002 were included in the study. It was not possible to randomly select a control group for comparison, since families selected themselves for treatment or no treatment. However all referrals who did not engage in or complete treatment were asked to complete assessment forms. The sample consisted of thirteen children, A, B, C, D, E, F, G, H, I, J, K, L and M. There were eight boys and five girls from twelve families (two children, A and B, were siblings). Six referrals were by health visitors, four were made by the local Child Assessment Clinic, one by a social worker, one by a nursery school principal and one referral was made by the School Health Team.

Ten children lived with both biological parents although in one family the parents separated during intervention. One child lived with her biological mother and her mother's new partner. Two children lived with a lone parent. The number of children in each family ranged from one to six, with only one child having no siblings. Two of the mothers were pregnant. Eleven families lived in Housing Executive accommodation. Six of these lived in well-repaired homes and five in homes requiring renovation. The twelfth family lived in owner-occupied accommodation. Three mothers were employed and two more gained part-time employment during intervention. Six fathers were employed.

Two of the mothers were diagnosed prior to assessment as suffering from depression and were receiving treatment. One mother and one father suffered from epilepsy. One father had a diagnosed personality disorder and attempted suicide during intervention. Two fathers had criminal records with histories of violent crimes and imprisonment.

Four of the families had current social services involvement and one child's name was on the Child Protection Register under the category of Potential Physical Neglect. Seven children attended nursery school and two attended a playgroup on a regular basis. Two children went to a childminder on a regular basis. Seven children had delayed speech and language development. Four children had attended the Child Assessment Clinic with developmental delay and one child was awaiting assessment. One child had a statement of special educational needs because of a medical problem and a second child was being assessed for special educational needs because of developmental delay. One child suffered from severe asthma and another suffered from epilepsy. One child was diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and was taking medication. Two of the children received play therapy in their own homes provided by Sure Start and two other children attended the Sure Start Play and Development session once a week.

Intervention took place with ten of the children and did not take place with three of the children. The children for whom intervention did not take place are included here as a quasi-control group

## Assessment

Initial interviews took place with parents/persons with parental responsibility. Parents were asked to identify target "problem" or undesired behaviours, for example, physical aggression. They then had to specify what they meant by "physical aggression", for example, hitting, biting, nipping. Parents were asked to record the frequency of undesired behaviours over several days on a frequency chart. Likewise they were asked to identify desired behaviours, for example, helping to tidy away toys or doing what they are told, and then record the frequency of desired behaviours. They were also asked to record examples of antecedents and consequences of target behaviour.

Research instruments (described below) were chosen to reflect the areas identified by the Project objectives described above. These instruments were administered to parents, teachers and other carers before, during and after treatment and at a one-month follow-up. The instruments were again administered at a one-year follow-up; however, this fell outside the time frame of this study and will therefore not be reported here.

## Research Instruments

### Child Behaviour Checklist (CBCL/1½-5; Achenbach and Rescorla, 2000); Child Behaviour Checklist – Teacher Report Form (CBCL-TRF; Achenbach and Rescorla, 2000).

The Child Behaviour Checklist for Ages 1½-5 (CBCL/1½-5) was completed by parents or other carers within the family setting and includes 100 items, each rated

on a 0- to 2-point scale. For several items respondents are asked to give descriptions of a particular problem. Other items are open-ended in that the respondent is asked to describe any illnesses or disabilities which the child might have as well as what concerns them most about the child and the child's best features.

The Caregiver-Teacher Report Form for Ages 1½-5 (C-TRF) is a similar form which is completed by teachers, playgroup leaders, childminders or other such caregivers.

The CBCL/1½-5 and the C-TRF enable users to obtain standardised ratings of various aspects of behavioural, emotional and social functioning. This is done by displaying the score for each item on a profile. A set of items or problems that occur together is known as a syndrome. By looking at forms completed for large numbers of children, the authors (Achenbach and Rescorla, 2000) were able to construct syndrome scales comprising the problem items that tended to occur together. The seven syndrome scales developed in this way are emotionally reactive; anxious/depressed; somatic complaints; withdrawn; sleep problems; attention problems and aggressive behaviour. Other problems are also noted. The score for any one child is compared with scores obtained by normative samples of children when it is plotted on the profile, thus a profile can be constructed in which the child may have low, intermediate or high scores compared with a normative group of children. It is also possible on the reverse of the form to correlate problems with DSM-IV diagnoses such as affective problems; anxiety problems; pervasive developmental problems; ADHD and oppositional defiant problems.

Beck Depression Inventory – Second Edition (BDI-II; Beck et al, 1996).

The BDI-II is a 21-item self-report instrument for measuring the severity of depression in adults and adolescents aged 13 years and over.

The BDI-ll was developed as an indicator of the presence and degree of depressive symptoms consistent with the DSM-IV diagnostic criteria. It was developed as a screening instrument for major depression.

Each of the 21 items is rated on a 4-point scale ranging from 0 to 3. The items include sadness; pessimism; past failure; loss of pleasure; guilty feelings; self-dislike; self-criticalness; suicidal thoughts or wishes; crying; agitation; loss of interest; indecisiveness; worthlessness; loss of energy; changes in sleeping pattern; changes in appetite; concentration difficulty; tiredness or fatigue; loss of interest in sex. The BDI-ll is then scored by summing the ratings for the items. The score gives an indication of the extent of the depressive symptoms experienced by the respondent.

The authors suggest the following cut score guidelines for total scores of patients diagnosed with major depression:

| Total Scores | Range |
|---|---|
| 0 – 13 | Minimal |
| 14 – 19 | Mild |
| 20 –28 | Moderate |
| 29 - 63 | Severe |

The total score provides only an estimate of the overall severity of depression, it is important to be attentive to specific item content such as suicidal ideation.

Parenting Stress Index (PSI; Abidin, 1983).

The Parenting Stress Index is a 120 item scale that assesses sources of stress to the parent. Each item is rated on a 5-point scale to reflect the extent to which particular characteristics are true for the parent. Items may belong either to the Child Domain or the Parent Domain. The Child Domain includes 6 subscales (Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability) that reflect areas in which the child may be perceived as stressful. The Parent Domain relates to the parent's views of their own functioning and includes 7 subscales (Sense of Competence, Social Isolation, Attachment, Physical Health, Restriction of Role, Depression, and Relationship with Spouse). The PSI Total Stress score combines Child and Parent Domains. Although each score may be interpreted independently, scores are best interpreted in relation to each other. In addition, the measure includes a separate Stress Scale consisting of 19 items that measure life events in the environment, such as death of a relative or loss of a job.

A defensive responding score of 24 or less indicates that the individual is responding in a defensive manner and caution should be used in interpreting the rest of the scores.

The Total Stress score is of primary importance in guiding professional judgement as to whether professional intervention might be necessary or appropriate for a given parent-child system. Parents who get raw scores at or above 260 should be offered referral for professional consultation.

High scores in the Child Domain may be associated with children who display qualities that make it difficult for parents to fulfil their parenting roles. If the Child Domain is elevated in relation to the Parent Domain and Life Stress scale scores, the interpretation can be made that child characteristics are major factors contributing to the overall stress in the parent-child system therefore interventions may need to focus on the behaviour of the child as opposed to the other domains of the parent-child system.

If the Parent Domain is elevated this suggests that sources of stress may be related to the parent's functioning.

Social Provisions Scale (Cutrona and Russell, 1987).

Social support is thought to have several components and serves a variety of specific functions. These functions include emotional sustenance; self-esteem building; provision of information and feedback; and tangible assistance. The Social Provisions Scale assesses these specific components as well as the overall level of support available to the individual.

Cutrona and Russell (1987) found that social provisions had six different social functions that are either assistance-related or non-assistance-related.

Assistance-related provisions are thought to be most relevant to problem-solving in the context of stress and include "guidance", such as that provided by mentors, teachers or parent figures, and "reliable alliance" which is the type of support provided by family members and friends.

Non-assistance-related provisions are instrumental in enhancing self-efficacy and self-esteem. Non-assistance-related provisions include "reassurance of worth"; "opportunity for nurturance"; "attachment"; and "social integration".

The Social Provisions Scale consists of twenty-four statements, with two positively-worded and two negatively-worded statements assessing each of the social provisions described above. The respondent answers each statement using a four-point rating scale. Each social provision scale can have a total score between 4 and 16. A score of 4 would imply a deficit of support whereas a score of 16 would imply a lot of support.

Cutrona and Russell (1987) found that individuals who report higher levels of social support more frequently receive supportive behaviours from others in the context of stressful experiences. They also felt that several components of social support enhance health through their impact on self-efficacy beliefs and therefore effective coping behaviour.

Life Experiences Survey (Sarason et al, 1978).

Numerous studies (Rabkin and Struening, 1976; Vinokur and Selzer 1975) have found life stresses to be associated with physical and psychological problems. It would appear that psychological difficulties are related to undesirable as opposed to desirable events. A measure of life stress should therefore include not only a list of events experienced with some measure of frequency, but also ratings by the respondents themselves of the desirability or undesirability of the events as well as the personal impact of the events experienced.

Sarason et al (1978), who developed the Life Experiences Survey, found a significant relationship between negative change and scores on the Beck Depression Inventory (described above).

Up to fifty items are listed in the Life Experiences Survey, ranging from the death of a spouse to a major change in the living conditions of the family. Respondents

are asked to indicate those events that they have experienced during the past year (in the past 0-6 months or in the past 7 months – 1 year). They are also asked to indicate, firstly, whether they viewed a particular event as being positive or negative and, secondly, the perceived impact of the event on their life at the time of occurrence. Ratings are on a 7-point scale, ranging from extremely negative (- 3) to extremely positive (+ 3). Summing the impact ratings of those events designated as positive provides a positive change score. In the same way summing the impact ratings of the events perceived as negative gives rise to a negative change score. By adding both values together a total change score can be obtained that represents the total amount of rated change, desirable and undesirable, experienced by the respondent during the past year.

Procedure

Families referred to the Sure Start Behaviour Support Service were individually assessed at home by interview and by using the instruments outlined above. Families were asked to record examples of desired and undesired behaviours together with the antecedents and consequences of the behaviours. The therapist also took a detailed history and observed behaviours within the family home. Other caregivers such as nursery school teachers were involved in the assessment procedure and asked to complete the CBCL-TRF as appropriate. A CBCL-TRF was completed in eight of the thirteen cases.

Treatment administration occurred in the family home in weekly/fortnightly sessions lasting ½-1 hour. Telephone contact was also maintained between sessions. If a family cancelled or was not at home another appointment was arranged.

Treatment took the form of Parent Management Training. Parents were encouraged to use techniques such as ignoring unwanted behaviours or using "time-out". They were also encouraged to praise or otherwise reward desired behaviours and to make use of "special time", for example, spending ten minutes at bedtime reading a story with a child.

Solution Focused Brief Therapy was also used with the parents. For example, several of the mothers were depressed or otherwise disempowered and unable to see how well they were actually coping with their children. By using Solution Focused Brief Therapy, it was possible for them to see the exceptions, that is, occasions on which they managed their child's behaviour successfully, times when they felt good about their child and to build upon these exceptions until they reached a stage at which they could manage their child's behaviour and perhaps other aspects of their lives effectively.

If a family was unable to or decided not to avail of the service, the family was contacted if possible and asked to complete the research instruments as follow-up. Ten families availed of the intervention offered by the Sure Start Behaviour Support Service. All thirteen families consented to the data, which they supplied, being used in this study.

## Results

The results are summarised below. Intervention did not take place with Children F, H and K.

The Child Behaviour Checklist – Teacher Report Form was completed for eight children. Four children (A, F, J and M) exhibited significant problems with a carer/teacher.

The Beck Depression Inventory was completed by eleven of the twelve mothers. Seven exhibited minimal depression, two exhibited moderate depression (C and G) and two severe (A/B and H).

The Social Provisions Scale was completed by eleven of the twelve mothers. Lower levels of social provision were experienced by three of the parents: A/B, E and H. there appeared to be no great variation between assistance-related and non-assistance-related values. Of note is the fact that parents E and H appeared to achieve higher scores for nurturance, that is, they were reinforced socially by the nurturing of their children.

The Life Experiences Survey was completed by eleven of the twelve mothers. Five mothers had positive scores and six had negative. Three had negative scores greater than –10 (E, H and M), suggesting very significant negative life events.

The Parenting Stress Index was completed by eleven out of twelve parents. Six parents had significant levels of stress in all domains before intervention (A/B, C, E, G, H and M). Three parents had significant scores in the Child Domain and Total Value only (D, J and L). I and K had normal scores only.

A/B, C and E had significant but lower scores following intervention. Scores for M had, however, increased. D and J had significant but lower scores in the Child Domain following intervention, however L's Score had increased. Following intervention, G, I and K had normal scores.

The Child Behaviour Checklist was completed for all children. Five children showed definite improvement following intervention (C, D, E, G and I). Four

showed borderline improvement and tended to be those who had scored more significantly for problem behaviours (A, B, L and M). Of those with whom intervention did not take place, two showed improvement (H and K, however H had been taken into foster care and the CBCL was completed by the foster parent) and a second CBCL was not completed for F.

Of the four children that demonstrated minimal improvement in behaviour at one month after intervention, the mother of A and B scored highly for negative life experiences and parenting stress as well as scoring in the severe range for depression and the mother of M scored highly for negative life experiences and parenting stress prior to intervention. The mother of L, on the other hand, found that L generated more stress following intervention than before.

## Discussion

An assessment of the effectiveness of Parent Management Training and Solution Focused Brief Therapy within the context of a Sure Start programme was carried out for families of preschool children with behaviour problems. Results showed that by-and-large the intervention appeared to be successful in the short-term and produced behavioural improvements in most children. However, in multiproblem families in which parents were experiencing high levels of stress and low levels of support, the efficacy of these interventions appeared to be lower. Child behaviour problems also seemed to be more severe in multiproblem families. Six of the children required referral to other agencies for multidisciplinary assessment (Tier 3) for conditions such as ADHD, autistic spectrum disorder and for more severe emotional and behavioural problems. In a larger study it is likely that such children would have been excluded from the study.

It was not possible to complete a statistical analysis of this study because of the small numbers. Brestan and Eyberg (1998) in their literature review, stated that a study needed fifty participants for each condition in order to have the conventional eighty per cent power for a significance test of a medium difference between two treatment groups. This study had thirteen subjects, only ten of whom self-selected for intervention. There was also no control group as such.

The main outcome measures in this study were changes in child behaviour. Other outcome measures were changes in stress levels experienced by parents. Barlow and Coren (2001) found that parenting programmes brought about improvements in maternal psychosocial well-being, however limited follow-up data was available in the studies that they reviewed. Several aspects of maternal psychosocial well-being were assessed in this study and a full analysis would require further research and at least a one-year follow-up.

This study used a large number of instruments. While each instrument contributed in looking not just at the child's behaviour but at the various stresses and supports in the wider family environment, the battery of instruments was unwieldy with some duplication and taking an excessive amount of time to administer. For further follow-up it was decided to use the Child Behaviour Checklist and the Parenting Stress Index – Short Form.

Another shortcoming is the brief timespan over which the study was undertaken. This initial study was undertaken between October, 2001 and June, 2002. The families were reviewed one year after the completion of intervention, however this data is not yet available. Several workers have argued for the benefits of long-term follow-up (Schweinhart et al, 1993; Barlow and Parsons, 2002).

In this study intervention consisted primarily of Parent Management Training with Solution Focused Brief Therapy used as an adjunct. This combination allowed parents to some extent to evaluate their coping strategies for dealing with adversity.

Parent Management Training is regarded as an intervention of choice for young children with severe conduct problems and antisocial behaviour (Brestan and Eyberg, 1998; Barlow and Stewart-Brown, 2000; Barlow and Parsons, 2002). However, as has been described earlier, there may be a considerable variation in the effectiveness of Parent Management Training due to a high rate of attrition; poor parental adjustment and problems in the parental relationship; poor socioeconomic status and social isolation and the degree of therapist training and involvement.

Families who are suffering from considerable adversity are less likely to use or apply in a consistent manner effective child management skills (Miller and Prinz, 1990). The findings of this study agree with this in that children such as Child A and Child B, whose mother experienced significant stress and depression with poor social support, showed little improvement and no maintenance of improvement.

It should also be noted that this study evaluates the work of a single therapist and it should be queried whether outcomes would have been different if a different therapist or therapists had been involved. Other Sure Start services were involved with several of the families studied and there is a question as to whether any improvement was brought about by the Behaviour Support Service or through the input of other Sure Start services such as Home-Start, speech and language therapy or play therapy.

The behaviour therapist visited families in their homes The benefits of a home visiting service have been shown in other areas of research, for example in the prevention of child abuse (Olds et al, 1986).

Sure Start has been set up by the British Government to target children in need. Structures have been put in place to evaluate the work of Sure Start by the National Evaluation of Sure Start in England and the Family Policy Unit in Northern Ireland. The Family Policy Unit (Family Policy Unit, 2002) has decided upon eight key indicators that will gauge the effectiveness of Sure Start in Northern Ireland over a period of at least five to six years. These indicators do not include social adjustment and socioeconomic factors at present and they may therefore have to be adjusted with time.

This study has shown that:

- A Tier 2 Sure Start behaviour support service appears to bring about improvements in child behaviour and the amount of stress experienced by parents on a short-term basis, however this initial study is too small to support a statistical analysis.
- There is a question regarding the level of behaviour support available (one therapist on one day a week) given the intensity of input required by these families and the general level of need in an area suffering from socioeconomic deprivation.
- Since so many of the Sure Start families require multiagency input, it is queried whether there should be stronger links between Sure Start and core services.

**Acknowledgements**

We would like to acknowledge Mr C. Allen; Professor J. Belsky; Miss L. Crawford; Mrs C. O'Hagan; Professor D Russell; Mrs S. Slavin and Dr M. Stanfield.

**References**

Abidin, R.R. (1983). Parenting Stress Index – Professional Manual. Odessa, FL: Psychological Assessment Resources, Inc..

Achenbach, T.M. and Rescorla, L.A. (2000). Manual for the ASEBA Preschool Forms and Profiles. Burlington, VT: University of Vermont Department of Psychiatry.

Barlow, J. and Coren, E. (2002). Parent-training programmes for improving maternal psychosocial health (Cochrane Review). The Cochrane Review, Issue 2, 2002. Oxford: Update Software.

Barlow, J. and Parsons, J. (2002). Group based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children (Cochrane Review). The Cochrane Library. Issue 2, 2002. Oxford: Update Software.

Barlow, J. and Stewart-Brown, S. (2000). Behaviour problems and parent-training programs. Journal of Developmental and Behavioural Pediatrics. 21. 356-370.

Beck, A.T., Steer, R.A. and Brown, G.K. (1996). Beck Depression Inventory – Manual. San Antonio: The Psychological Corporation. Harcourt Brace and Company.

Brestan, E.V. and Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. Journal of Clinical Child Psychology. 27. 180-189.

British Medical Association (1999). Growing Up In Britain: Ensuring a Healthy Future for our Children._A Study of 0-5 Year Olds. London: BMJ Books.

Campbell, S.B. (1995). Behavior problems in preschool children: a review of recent research. Journal of Child Psychology and Psychiatry. 36. 115-149.

Caspi,A., Moffit, T.E., Newman, D.L. and Sylva, (1996). Behavioral observations at three years predict adult psychiatric disorders: longitudinal evidence from a birth cohort. Archives of General Psychiatry. 53. 1033-1039.

Cutrona, C.E. and Russell, D. (1987). The provisions of social relationships and adaptation to stress. In W.H. Jones and D. Perlman (Eds.), Advances in personal relationships, Volume 1. Greenwich, Conn.: JAI Press.

De Shazer, S. (1994). Words Were Originally Magic. New York: W.W. Norton and Company.

Department of Education, Northern Ireland (1998). Code of Practice on the Identification and Assessment of Special Educational Needs. Bangor: Department of Education, Northern Ireland.

Department for Education and Employment (2001). Sure Start: Making a Difference for Children and Families. London: DfEE.

Dumas, J.E. (1989). Treating antisocial behavior in children: child and family approaches. Clinical Psychology Review. 9. 197-222.

Eayrs C.B. and Jones, R.P. (1992). Methodological issues and future directions in the evaluation of early intervention programmes. Child: Care, Health and Development. 18. 15-28.

Eistenstadt, N. (2001). Sure Start in England: a community-based approach to child public health. BACCH News Winter 2001. 10.

Family Policy Unit (2002). Sure Start: Regional Evaluation Guidance. Belfast: Department of Health, Social Services and Public Safety.

Farrington, D. (1995). The Challenges of Teenage Antisocial Behaviour. In Rutter, M. (Ed) Psychological Disturbances in Young People: Challenges for Prevention. Cambridge: Cambridge University Press.

Garmezy, N. and Masten, A.S. (1994). Chronic Adversities. In Rutter, M., Taylor, E. and Hersov, L. (Eds). Child and Adolescent Psychiatry: Modern Approaches. Oxford: Blackwell Science Ltd..

George, E., Iveson, C. and Ratner, H. (1999a). Problem to Solution: Brief Therapy with Individuals and Families. London: Brief Therapy Press.

George, E., Iveson, C. and Ratner, H. (1999b). Solution Focused Brief Therapy: Course Notes. (Reprinted with corrections 2000). London: Brief Therapy Practice.

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

Kazdin, A.E. (2002). The state of child and adolescent psychotherapy research. Child and Adolescent Mental Health. 7. 53-59.

Kazdin, A.E. and Weisz, J.R. (1998). Identifying and developing empirically supported child and adolescent treatments. Journal of Consulting and Clinical Psychology. 66. 19-36.

Kolvin, I., Miller, F.J.W., Fleeting, M. and Kolvin, P.A. (1988). Social and parenting factors affecting criminal-offence rates: findings from the Newcastle Thousand Family Study (1947-1980). British Journal of Psychiatry. 152. 80-90.

Lyons-Ruth, K., Alpern, L. and Repacholi, B. (1993). Disorganised infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behaviour in the preschool classroom. Child Development. 64. 572-585.

Macdonald, G. and Roberts, H. (1995). What Works in the Early Years. Ilford: Barnardo's.

Miller, G.E. and Prinz, R.J. (1990). Enhancement of Social Learning interventions for childhood conduct disorder. Psychological Bulletin. 108. 291-307.

NHS Health Advisory Service (1995). Child and Adolescent Mental Health Services: Together We Stand. London: HMSO.

Olds, D.L., Henderson, C.R., Chamberlin, R. and Tatelbaum, R. (1986). Preventing child abuse and neglect: a randomised trial of nurse home visiting. Pediatrics. 78. 65-78.

Richardson, J. and Joughin, C. (2002). Parent-Training Programmes for the Management of Young Children with Conduct Disorders. London: the Royal College of Psychiatrists.

Roberts, H. (2000). What is Sure Start? Archives of Disease in Childhood. 82. 435-437.

Sarason, I.G., Johnson, J.H. and Siegel, J.M. (1978). Assessing the impact of life changes: development of the Life Experiences Survey. Journal of Consulting and Clinical Psychology. 46. 932-946.

Schweinhart, L.V., Barnes, H.V. and Weikart, D.P. (1993). Significant Benefits: The High/Scope Perry Preschool Study Through Age 27. Ypsilanti, Michigan: the High/Scope Press.

Schweinhart, L.J. and Weikart, D.P. (1997). Lasting Differences: The High/Scope Preschool Curriculum Comparison Study Through Age 23. Ypsilanti, Michigan: the High/Scope Press.

Stattin, H. and Magnusson, D. (1996). Antisocial development: a holistic approach. Development and Psychopathology. 8. 617-645.

Sylva, K. (1994). School influences on children's development. Journal of Child Psychology and Psychiatry. 35. 135-170.

Wahler, R.G. (1980). The insular mother: her problems in parent-child treatment. Journal of Applied Behaviour Analysis. 13. 207-219.

Webster-Stratton, C. (1994). Advancing videotape parent training: a comparison study. Journal of Consulting and Clinical Psychology. 62. 583-593.