

# The Children And Parents Service (CAPS): A Multi-Agency Early Intervention Initiative for Young Children and their Families

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Behaviour problems make up approximately 30–50% of all referrals to child and adolescent mental health services. Behavioural parent training is one of the most effective interventions for young children. However, those families most at risk of difficulties fail to access services. This paper outlines the Children And Parents Service (CAPS), a citywide multi-agency, early intervention service to young children and their families. The intervention includes parent training groups, multi-agency training and liaison in community settings. The model of service delivery is outlined and the obstacles to service implementation and the strategies used to overcome them are discussed. The service has adopted a well validated evidence-based model of parent training, monitoring of outcomes and user involvement, and is delivered in the wider context of multi-agency systems. A thorough evaluation of service delivery models, including CAPS, would be beneficial. Whilst research trials examine the efficacy of treatments, the effective delivery of treatments within clinical services requires clarity about the place of the intervention within wider systems. The CAPS model proposes a framework for delivering interventions within these systems.

**Keywords:** Early intervention; multi-agency; community service; parent training

## Introduction

Recent health and social care legislation has highlighted a number of principles that should inform the development and provision of child mental health services (DoH, 2003; 2004). These emphasise the need for evidence-based interventions, improved accessibility, increased user participation, the development of partnership including joint planning and delivery of services and a commitment to ongoing audit and evaluation (DoH, 2003). The purpose of these reforms is to ensure that services are well integrated and offer comprehensive and effective packages of care. The integration of these principles into everyday practice does, however, pose clinical services with a number of practical challenges. In terms of evidence-based interventions, there is now substantial evidence highlighting that, conduct disorders for example, are common and result in considerable personal social and economic costs (Meltzer et al., 2000; Scott et al., 2001a). However a large proportion of those in need, particularly those in high risk populations fail to reach specialist child mental health services (Cox, 1993; Rutter, Tizard & Whitmore, 1970). In terms of efficacy, working with parents of children with behavioural difficulties is recognised as one of the most effective approaches in preventing and reducing conduct problems (Brestan & Eyberg, 1998). Parent training based on group approaches can lead to significant reductions in antisocial behaviour (Scott et al., 2001b), hyperactive and distractible behaviour (Elliot et al., 2002), and childhood behaviour problems in three to eight year olds compared to waiting list controls

(Taylor et al., 1998). Group approaches have also been demonstrated to be more acceptable to parents (Taylor et al., 1998). Regardless of the potential efficacy of treatments for specific disorders, they will not be useful unless barriers to accessing services are overcome. Studies suggest that parents who are more socio-economically disadvantaged or isolated may be less likely to participate in or complete parent training groups (Kazdin 1990; Prinz & Miller, 1994; Strain, Young & Horowitz, 1981); therefore those most likely to be in need are less likely to utilise services. Finally, the evidence for the successful implementation of these standardised programmes in everyday practice with hard to reach populations is less convincing with a further challenge being the issue of ensuring the treatment fidelity of those who provide the service.

The importance of user consultation and participation in the development of services has been highlighted in major UK Government initiatives such as Sure Start (Glass, 1999). These services often incorporate forums to provide the ongoing collation of user views to further influence service delivery. One of the long-term objectives of Sure Start is to ensure community capacity building; that is, to establish sustainability of local services and provide employment opportunities. Therefore, the development of community approaches that involve user consultation are seen to be crucial in engaging families.

In addition to user participation there is an increased emphasis upon the audit and evaluation of services. However, service evaluation as part of routine service provision is a major issue nationally. Shepherd (1986)

identifies that evaluation methods need to be both sophisticated and flexible to address user needs in addition to wider service contexts. Perhaps the best research example of service evaluation in CAMHS is the Fort Bragg Experiment (Bickman et al., 1995). The study was based on an overarching programme theory model that evaluated proximal, intermediate and ultimate outcomes within a complex service delivery model. There were evaluation stages at intake, assessment and treatment stages. Outcomes for each stage were defined, measured and then compared between routine (control) and new service. The integrated approach to interventions using the service model was not shown to be more effective than the routine treatment pathway in terms of clinical outcomes; however, significant improvements in user access were demonstrated.

Studies evaluating the effectiveness of community based parenting initiatives are beginning to emerge: Davis et al. (1997) and Davis and Spurr (1998) describe a model for service delivery in very deprived areas where health visitors are trained in parent counselling, including behaviour management, and also receive supervision from a clinical psychologist. Findings suggest this approach is beneficial to families on a number of measures, including a decrease in child behaviour problems and parenting stress. In a recent article on the development of parenting initiatives, Day and Davis (1999) comment that a missing component in these approaches is the availability of social support to parents, which could be offered through a parenting group approach. White, Agnew and Verduyn (2002) describe an early intervention psychology service for preschool children with emotional and behavioural problems, which adopts this model of service delivery and provides parent training groups, open clinics and multi-agency support and training. Those attending parent training groups, based within the community in an area of high socio-economic deprivation in Salford, reported improvements in parental coping and children's behavioural difficulties that were maintained at 12-month follow-up. The success of this model was attributed to the multi-agency partnership, the use of an evidenced-based intervention (Webster-Stratton, 1984) and the active community outreach approach that was used to engage families. This more universal approach to offering behavioural intervention is outlined by Sanders (1999), as part of a five-level model of intervention (Triple P). The lower levels form part of a preventive and early intervention strategy targeted at whole populations aimed to engage families into evidence-based interventions through the use of the media and tier one professionals.

The focus of this report is to consider the issues described above as the Manchester Children and Parents Service was developed and implemented.

### **The Children And Parents Service (CAPS)**

The city of Manchester is the seventh most deprived district in England, with 30 of its 32 electoral wards in the 10% most deprived wards in the country. With a resident population of approximately 439,550, and 6.5% (28,500) under five years old (ONS, 2002), it is clear that there are a great many preschool children in Manchester living in poor and stressful environmental

conditions. The Manchester Children and Parents Service is resourced to offer a multi-agency, early intervention service to children aged between 2 and 8 years and their families.

#### *Model of service delivery*

CAPS is a multi-agency partnership involving Child and Adolescent Mental Health Services (CAMHS; clinical psychology and nursing), educational psychology and Manchester and Salford Family Service Unit, a voluntary sector family support agency. The principles of the CAPS model of service delivery include: (i) evidenced-based practice, using the Incredible Years Webster-Stratton (Webster-Stratton, 1990) model of parent training; (ii) to provide a conceptual model whereby professionals deliver services with an explicit agenda of user involvement; (iii) community capacity building to achieve the long term goals of sustainability both in terms of sustaining change for parents by a consistent approach from all workers, and in terms of extending the skill base available within communities; (iv) a flexible approach where need can be converted to demand and services are responsive to changes in service delivery in other agencies and settings. The service comprises the following five components.

#### *Parent training courses (Parent Survival Course)*

Parent training courses take place at each children's centre and other family community based resources, with child care support and supplementary individual work where needed. This includes direct input into some Sure Start programmes. The courses are accessed by professional and self-referral and are targeted at parents experiencing moderate difficulties with their young children's behaviour. Referral is by application form, signed by parents, in an attempt to reduce the stigma that can surround more traditional processes of accessing services. The majority of individuals attending the Parent Survival Course (PSC) are previously unknown to secondary services and typify a 'hard-to-reach' population. An active, parent centred approach is taken to recruitment. Courses are advertised 2 months before the initial session, using display boards and colourful leaflets. Parents are approached by team members (co-leaders of the course) and are actively encouraged to sign up to the course if they express any interest. Coffee mornings are arranged at the host centre to provide parents with the opportunity to speak with co-leaders on a more informal basis about the course. A link worker from the host centre plays a key role in introducing parents to the PSC. Parents are invited to attend an initial assessment interview with co-leaders to discuss the course and are then visited at home prior to the course to assess their engagement and to collect pre-group data.

Each course runs for 10–12 weeks and uses the cognitive-behavioural Incredible Years Programme (Webster-Stratton, 1990). The courses are run by two trained co-leaders and the model maximises the use of videotape modelling and role play. Individual sessions at home are provided by co-leaders when parents are unable to attend a session and telephone contact is maintained prior to every session. Courses are now run in languages other than English using interpreters and

bi-lingual workers who have been trained to deliver the programme.

*Parent Survival Course evaluation.* Parent Survival Courses are evaluated using standardised measures. Questionnaires used are: Beck Depression Inventory (BDI) (Beck et al., 1961), a measure of depression in adults; Eyberg Child Behaviour Questionnaire (Robinson, Eyberg, & Ross, 1980), a measure of a wide range of child problem behaviours; Parenting Stress Index Short Form (PSI) (Abidin, 1990), a measure of parenting stress. These self-rated questionnaires are completed by parents attending the course at pre-group, post-group and at 3-month follow-up. Course outcome statistics will not be reported in detail as this is not the main purpose of the paper. Analysis of the data collected occurs annually for audit purposes, to ensure that statistically significant changes occur pre- to post-group (at  $p < .001$  level) and that these gains are maintained at 3-month follow-up. This analysis is considered an important part of the quality control process to ensure effective interventions are being delivered. All outcomes are presented in an annual report that is distributed and discussed at the multi-agency steering group. In addition, uptake rates and completion rates for the parent courses are regularly monitored. Data for the last 12 months (involving 30 parent courses and 273 parents) show that 86% of parents recruited and assessed attend the first session of the course and that 92% of parents complete the course. Given that these parents are recruited from within the community and are not necessarily actively seeking help prior to being approached, the uptake and retention rates are favourable.

Family characteristics such as single parent status, number of children, and ethnicity are monitored to ensure that all communities are accessed. In terms of ethnicity, figures are representative of those for Manchester according to the 2001 Census (Office for National Statistics, 2002). Data show that socially and economically disadvantaged families attend and complete courses.

The user component of evaluation is addressed through satisfaction measures, uptake rates and outcome measures alongside audit standards. User views are obtained via a parent satisfaction questionnaire completed at the end of each course. These comments are summarised and reviewed every 6 months as part of the routine audit process. Wherever possible, parents' suggestions are acted upon, for example, changes made to leaflets to simplify language and facilitating parents' access to further educational courses and support. Any such service developments are implemented in partnership with the Parents' Forum.

#### *Training of community based professionals in running effective parent courses in their own agencies*

*Level One: Awareness raising.* Training sessions are provided for professionals from several agencies based within the community, including health, education and voluntary sectors. Professionals trained include medical and children centre staff, health visitors, nursery nurses, paediatricians, Sure Start staff and in addition

Home-Start (community parent) volunteers. Workshops are provided on management of common preschool behaviour problems and other related topics. In particular, behaviour management training based on the PSC is provided to all children's centre staff before the course is run in their centre.

*Level Two: Training professionals to run parent training courses in their own schools/agencies.* Schools and agencies are approached by a team member and meetings are arranged with head teachers and senior managers to discuss the interest and feasibility of them running their own courses. The model of course delivery is outlined along with the key benefits for the school/agency. These include the active community outreach approach that builds positive relationships with parents and increases their involvement. The level of commitment required from each contact is highlighted and the practical issues are discussed in detail. It is expected that managers will allow their staff enough time to complete all other tasks required in addition to the 2 hours per week to actually deliver the course. These tasks include time for preparation, phone calls, home visits and supervision. Therefore approximately one day per week in total is required. Other issues discussed include practical requirements such as rooms for both parents and crèche, television/video and tea/coffee making facilities. Finally, their ability to sustain courses independently of the CAPS service long term is discussed and planned. Once agreement is reached, the school/agency identifies two to three workers to be trained and plans are made for them to deliver their own courses.

Workers attend 3-day accredited training in the parent training model to be delivered. In addition, workers attend a further one-day training on the practicalities of setting up a successful parent course in their school/agency. The importance of parental engagement and working collaboratively with families are key elements highlighted, and home visiting and phone calls are encouraged to maintain attendance at courses. A senior group worker from the team (all of whom are accredited group leaders) then co-leads their first course, gives regular support and feedback, and encourages all group leaders to attend regular supervision.

#### *Training evaluation*

Training is evaluated by satisfaction ratings (Level one) and for those trained to run courses (Level two), by evidence of running a course post-training, a key outcome in capacity building. Approximately 100 professionals complete awareness (level one) training each year with 97% of professionals rating the quality of the training as good to excellent. In terms of level two, 250 professionals have completed the 3-day accredited training to date of whom approximately 75% have delivered at least one parent training course. Not all of those trained are expected to run courses, with some senior managers being trained with a view to them supporting their staff in delivering the courses. This is a successful strategy in engaging longer term commitment from schools/agencies, as having the support of managers is considered to be crucial in allowing staff realistic amounts of time and resources to deliver effective courses.

*Supervision of professionals running parent training courses*

All group leaders are expected and encouraged to attend video based supervision approximately every 6 weeks, and are actively encouraged to gain accreditation. Emphasis is placed on quality, including the use of standardised measures and maintaining treatment compliance. Approximately 70% of those actively running groups attend a minimum of one supervision session per course. Where close links exist with key partners it has been possible to work alongside senior managers and include the accreditation process within staff appraisal systems. The accreditation process requires the successful completion of a minimum of two courses, with a minimum retention rate of parents and videotape review to assess group leader skills. This can be a lengthy process depending on an individual's skill level, support systems and resources available. To date, seven group leaders have been accredited and over 15 others have submitted tapes for review.

In addition, an audit standard for courses has been developed within CAMHS that addresses group process standards. These include factors such as parent uptake and attendance, and group leader self-monitoring and videotape supervision attendance.

*Strategic links with Sure Start and multi-agency planning in early intervention for children via a steering group*

The service is managed jointly by partner agencies with a steering group that meets quarterly. In addition to key partners, membership includes representatives from users, Sure Start, local Primary Care Trusts and local regeneration projects. This group reports to the CAMHS multi-agency strategy group and has links with various groups within the local authority working on parenting strategy.

*User forum (Parents' Forum)*

It was intended from the outset of the service that user views would be represented in order to influence service delivery. Initially, parent satisfaction data formed the basis for collecting these views. Parents requested further involvement once courses were completed, and

with increased resource for the service, the team was able to support the co-ordination of parents from across the city to express their views. Initially, this took the form of citywide meetings with transport and crèche provision, which all parents who had completed a course were invited to attend. With increasing numbers of parents completing courses these meetings have increased in number and are organised in local community venues by recently appointed Parents' Forum Workers, recruited from the Parents' Forum. This provides ongoing feedback from parents regarding the service and related issues. CAPS has been responsive to parents' feedback by establishing follow-on parent support groups, making changes to advertising leaflets and providing parents with the opportunity to be involved with the service directly, by helping recruit other parents to courses. In addition, four parents have attended the 3-day accredited training, joined local community organisations and successfully delivered parent courses themselves.

**Multi-agency context**

Figure 1 demonstrates the management of CAPS within multi-agency frameworks within Manchester. CAPS has evolved together with other services into the strategic framework represented in the figure. The initial resource was from Health funding but all developments since have involved multi-agency commissioning. Having commenced as a project driven by perceived need 'on the ground', the service has become a key element of integrated services for parenting support.

*Barriers to service provision and implementation*

A key element of the service is its multi-agency ownership. The steering group, with its shared objectives and the inclusion of managers with authority to act within their own agencies, has been crucial. Staff line managers initially met in order to resolve any issues from building staff teams of workers managed within separate organisations. Initially, a further voluntary sector partner was uneasy about the approach, preferring a non-directive approach to parenting support. This led to the agency withdrawing as a staff employer in the

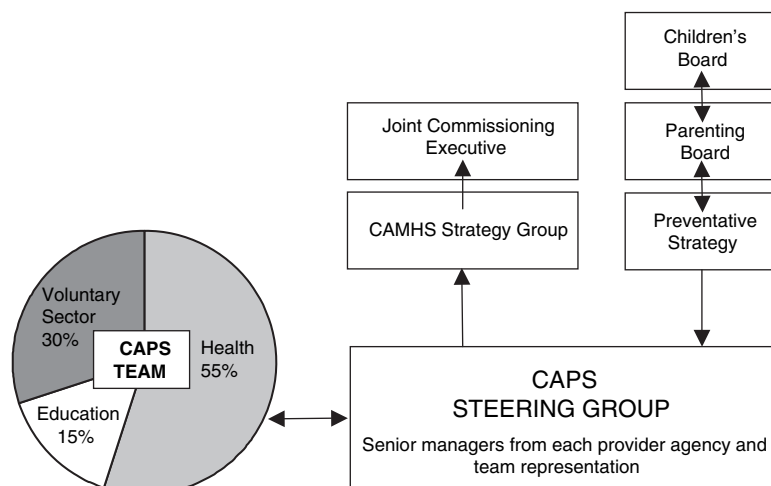


Figure 1. Multi-agency context

project, although relationships have remained positive. Active direct involvement at a senior management level of some agencies, particularly Social Services, has not been successful, although there are links at an operational level and at higher strategic levels.

At a multi-agency level there have been few barriers to implementation. Some competing models of service provision have arisen and at times generated confusion as to their similarity and differences from the CAPS approach, but the presence of an over-arching parenting strategy within the city has limited the potential profusion of well-intentioned smaller projects. The CAPS approach has also been to welcome and work with complementary approaches. Practical issues (e.g. staff bases, who pays telephone bills) have been resolved by recourse to steering group support. The main problems in relation to staffing have been in regarding clarity of roles within the team and the identification of generic versus specialist skills. One of the benefits of the approach has been the range of skills potentially available to families; but the focus on parenting courses has led to all staff wanting to lead groups, sometimes at the expense of the availability of other interventions. This has been a particular issue for education staff. These skill-mix issues have been resolved successfully using discussion and compromise, as is often required in multi-disciplinary working. The scope for different agency partners to lead in different elements of the service has aided this, particularly in relation to the challenges of multi-agency working within schools.

Staff retention, particularly for family support workers, is a major problem. Staff develop very useful skills in the service, which facilitates their career progression. This has to be seen as part of the capacity-building element of the service and where possible career progression within the service has been supported. Also, at times when short term funding was coming to an end and bidding for mainstreamed funding in progress, staff were concerned about their job security, which was at times threatening to the maintenance of the service. Fortunately, a high degree of job satisfaction and the ability to keep staff well informed has supported the retention of those workers.

Within CAMHS, the value of the approach has been recognised, with some CAMHS referrals being referred to community groups as well as receiving core specialist CAMH services. In terms of service delivery, barriers have been largely due to individual circumstances of host agencies. In some areas of the city potential bases are scarce and individual managers may have competing priorities. There is also the challenge of promoting a white American model within a multi-cultural context. These challenges have and continue to be addressed by demonstration of the value and effectiveness of the programme and flexibility and inclusiveness in staff's approach. The service has been highly successful in delivering to the diverse communities in Manchester as a result of investment in positive working relationships with community groups.

As the service continues to develop there are recurrent issues that potentially could cause difficulties. Despite financial resources being available to provide crèche support there are the inevitable problems of staff shortages, reliance on agencies, and the necessary implementation of statutory regulations regarding the

appropriateness of venues for crèche provision. The long standing good working relationships that exist between health, Early Years and education are crucial to overcoming these perennial obstacles.

As more community based multi-agency workers are trained to deliver groups independently, there are increasing demands placed upon the core team to support delivery of effective intervention and maintain quality control. The establishment of city-wide supervision sessions is regarded as an important element to maintaining high standards. This expansion of supervision has impacted on the role of senior members of the team, allowing them to develop new skills in a supervisory capacity and continue their own professional development. This in itself has helped with the retention of staff.

The CAPS service is well resourced and is viewed locally as a successful model of service delivery. As a consequence of this, sometimes demands are placed upon the team that fall outside of the service core aims and objectives. For example, pressure from external lead agencies is placed upon CAPS to deliver courses to parents of adolescents, parents of babies and to provide intensive individual work on parenting. It has therefore been important to maintain clear boundaries regarding the core elements of the service, whilst also allowing flexibility to pilot new developments, which may complement existing services. Any such developments are only implemented following consultation with and agreement from the steering group as any new developments risk a dilution of core services as resources are targeted elsewhere. Pilots are therefore time limited and the establishment of new services are dependent on additional resource.

## Conclusions

Monitoring of outcomes is a key element of the service in all aspects of delivery. Whilst only tentative conclusions can be drawn from the methodology described, evaluation data suggests that PSC has good uptake and attendance rates, with the rate of drop out much lower than the average of 28% (Forehand, Griest, & Wells, 1970) and the 41% reported by Scott and Stradling (1987). The active community outreach approach to service delivery is considered to be integral to the success of the service as it has increased accessibility for those families most in need. This has been achieved through joint working with front line professionals led by a multi-agency steering group involving key partners from health, education and the voluntary sector. Service delivery is informed by user involvement enabling collaborative working and overcoming the barriers detailed in the literature (Kazdin 1990; Prinz & Miller, 1994; Strain et al., 1981). Whilst the clinical nature of the service does not allow for data to be analysed under the conditions of a research trial, the importance of evaluating intervention outcomes has been crucial for maintaining high standards and securing funding for service expansion. This has been achieved through regular audit of service delivery and by monitoring professional standards through supervision and appraisal.

A prime objective of Government strategy in recent years has been to integrate successful delivery models

within the community, which shape existing services, and ensures sustainability. CAPS achieves this through a collaborative framework for service delivery. Joint working with users, front line staff, and senior managers from key partner agencies occurs within local communities to provide accessible, effective interventions on a needs led basis resulting in community capacity building.

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