The New Forest Parenting Programme

Review: Foundations for Life, July 2016

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

The New Forest Parenting Programme (NFPP) is for parents with a child between the ages of three and 11 with moderate to severe symptoms of ADHD.

NFPP takes place in the family's home through eight weekly visits. During these visits, parents are made aware of symptoms and signs of ADHD and the ways in which they may affect their child's behaviour and their relationship with their child. Parents also learn strategies for managing their child's behaviour and attention difficulties.

Evidence rating: **3+**

Cost rating: **3**

EIF Programme Assessment

The New Forest Parenting Programme has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence rating: **3+**

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

What does the plus mean?

The plus rating indicates that this programme has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

Cost rating

A rating of **3** indicates that a programme has a **medium cost** to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of **£500–£999**.

Cost rating: **3**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Preventing crime, violence and antisocial behaviour

Reduced conduct problems

Based on study 1

1.69-point improvement on the Parental Account of Childhood Symptoms Scale

Improvement index: **+10**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 60% and worse outcomes than 40% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 1

2.14-point improvement on the Parental Account of Childhood Symptoms Scale

Improvement index: **+13**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 63% and worse outcomes than 37% of their peers, if they had received the intervention.

23 weeks later

Reduced inattentive behaviour

Based on study 2

2.73-point improvement on the ADHD-Rating Scale-IV

Improvement index: **+43**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 93% and worse outcomes than 7% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 2

11.71-point improvement on the Conners Rating Scale-Revised (Inattentive Scale)

Improvement index: **+31**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 81% and worse outcomes than 19% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced hyperactive/impulsive behaviour

Based on study 2

9.83-point improvement on the Conners Rating Scale-Revised (Hyperactive/Impulsive Scale)

Improvement index: **+33**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 83% and worse outcomes than 17% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 2

1.84-point improvement on the ADHD-Rating Scale-IV

Improvement index: **+45**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 95% and worse outcomes than 5% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced hyperactivity

Based on study 1

5.55-point improvement on the Parental Account of Childhood Symptoms Scale

Improvement index: **+33**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 83% and worse outcomes than 17% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 1

1.51-point improvement on a measure of observed attention and engagement

Improvement index: **+4**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 54% and worse outcomes than 46% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 1

5.28-point improvement on the Parental Account of Childhood Symptoms Scale

Improvement index: **+31**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 81% and worse outcomes than 19% of their peers, if they had received the intervention.

23 weeks later

Based on study 1

11.91-point improvement on a measure of observed attention and engagement

Improvement index: **+26**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 76% and worse outcomes than 24% of their peers, if they had received the intervention.

23 weeks later

Reduced defiant behaviour

Based on study 2

0.26-point improvement on the New York Parent Rating Scale

Improvement index: **+22**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 72% and worse outcomes than 28% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced behaviour problems

Based on study 2

11.18-point improvement on the Conners Rating Scale-Revised

Improvement index: **+34**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 84% and worse outcomes than 16% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 2

4.57-point improvement on the ADHD-Rating Scale-IV

Improvement index: **+45**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 95% and worse outcomes than 5% of their peers, if they had received the intervention.

Immediately after the intervention

This programme also has evidence of supporting positive outcomes for couples, parents or families that may be relevant to a commissioning decision. Please see the 'About the evidence' section for more detail.

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Preschool

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Home

The programme may also be delivered in these settings:

- Home

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated

Where has it been implemented?

United Kingdom, United States, Ireland

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence includes evaluation conducted in the UK.

Spotlight sets

EIF includes this programme in the following Spotlight sets:

- parenting programmes with violence reduction outcomes
  programmes for children with recognised or possible special education needs

About the programme

What happens during delivery?

How is it delivered?

- The NFPP is delivered in eight sessions of between 1 and 1.5 hours duration each, by one senior family-support worker, psychologist, health visitor or nursery nurse to individual families.

What happens during the intervention?

- During the weekly visits, parents are made aware of symptoms and signs of ADHD and the ways in which they may affect their child's behaviour and their relationship with their child.
- Parents also learn strategies for managing their child's behaviour and attention difficulties. Some of these strategies are taught through games that engage children's attention, encourage their patience and increase their concentration.
- The practitioner observes the parent and child playing the game together and provides feedback on the quality of their interaction.

What are the implementation requirements?

Who can deliver it?

- The practitioner who delivers this programme is a senior family-support worker, psychologist, health visitor or nursery nurse with QCF-4/5 level qualifications.

What are the training requirements?

- The practitioner has 24 hours of programme training. Booster training of practitioners is recommended.

How are the practitioners supervised?

- It is recommended that practitioners supervised by one programme developer supervisor (qualified to QCF-7/8 level), and one host-agency supervisor (qualified to QCF-7/8 level).

What are the systems for maintaining fidelity?

- Training manual
- Other printed material
- Face-to-face training
- Supervision
- Accreditation or certification process
- Booster training
- Fidelity monitoring

Is there a licensing requirement?

Yes, there is a licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- NFPP assumes that effective parenting skills help children with ADHD manage their behaviour and attention difficulties.
- NFPP provides parents with strategies to help their children manage their attention, behaviours and impulses.
- In the short term, the parent/child relationship improves. Children are better able to regulate their own behaviour and parents experience less stress.
- In the longer term, children can concentrate for longer periods and their behaviour improves. Ultimately, children are expected to do better in school.

Intended outcomes

Supporting children's mental health and wellbeing

Contact details

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About the evidence

NFPP's most robust evidence comes from two RCTs. One was conducted in the UK and one was conducted in the USA.

These studies identified statistically significant positive impact on a number of child and parent outcomes.

This programme has evidence from at least one rigorously conducted RCT along with evidence from an additional comparison group study. Consequently, the programme receives a 3+ rating overall.

Study 1

Citation:	Sonuga-Burke et al (2001)
Design:	RCT
Country:	United Kingdom
Sample:	58 families with a child screened for symptoms of ADHD.
Timing:	Post-test; 23-week follow-up

Child outcomes:

- Reduced conduct problems
- Reduced conduct problems
- Reduced hyperactivity
- Reduced hyperactivity
- Reduced hyperactivity
- Reduced hyperactivity

Other outcomes:

- Increased parenting satisfaction Increased sense of well-being Increased parenting efficacy

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Study rating: 3

Sonuga-Barke, E.J.S., Daley, D., Thompson, M., Laver-Bradbury, C., & Weeks, A. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 402-408.

Available athttp://www.sciencedirect.com/science/article/pii/S0890856709603889

Study design and sample

The first study is a rigorously conducted RCT.
This study involved random assignment of children to an NFPP treatment group, parent counselling and support group, and a wait-list control group.
This study was conducted in the UK, with a sample of 58 families with a child screened for symptoms of ADHD.

Measures

Child ADHD symptoms were measured using Parental Account of Childhood Symptoms (PACS) (parent report) and coded observation developed for the study (expert observation of behaviour). Child conduct problems were measured using PACS (parent report).
Maternal wellbeing was measured using the General Health Questionnaire (parent report).
Parenting efficacy and satisfaction were measured using the Parental Sense of Competence Scale (parent report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes:

- Reduced hyperactivity
- Reduced conduct problems

Study 2

Citation: Abikoff et al (2015)

Design: RCT

Country: United States

Sample: 164 families with a preschool child with symptoms of ADHD living in New York.

Timing: Post-test

Child outcomes:

- Reduced inattentive behaviour
- Reduced hyperactive/impulsive behaviour
- Reduced hyperactive/impulsive behaviour
- Reduced defiant behaviour
- Reduced behaviour problems
- Reduced behaviour problems
- Reduced inattentive behaviour

Other outcomes:

- Increased parenting satisfaction Improved parenting

Study rating: 3

Abikoff, H.B., Thompson, M., Laver-Bradbury, C., Long, N., Forehand, R.L., Miller Brotman, L., Klein, R.G., Reiss, P., Huo, L., & Sonuga-Barke, E. (2015). Parent training for preschool ADHD: a randomized controlled trial of specialized and generic programs. *Journal of Child Psychology and Psychiatry,56*, 618-631.
Available athttp://onlinelibrary.wiley.com/doi/10.1111/jcpp.12346/full
Study design and sample

The second study is a rigorously conducted RCT.
This study involved random assignment of children to an NFPP treatment group, Helping the Non-compliant Child comparison group, and a waitlist control group.
This study was conducted in the US, with a sample of 164 families with a preschool child (aged three to five) with symptoms of ADHD.
Measures

Child ADHD symptoms were measured using the Conners Rating Scale – Revised Total Score for Parent Report (parent report), Conners Rating Scale – Revised Total Score for Teacher Report (teacher report), ADHD-Rating Scale-IV Total Score (diagnostic interview), and coded observation of ADHD tasks (total score) (expert observation of behaviour). Child delay of gratification was measured using the Delay of Gratification-Cookies Delay Task (expert observation of behaviour). Child level of sustained and focused attention were measured using the Play Park Observation – Time on Task (expert observation of behaviour), Play Park Observation – Number of switches (expert observation of behaviour), and the Play Park Observation – Engagement Index (expert observation of behaviour). Oppositional and defiant symptoms were measured using the New York Teacher and Parent Rating Scales (aggression and defiance scales) (parent report) (teacher report).
Parenting behaviour was measured using the Global Impressions of Parent-Child Interactions - – Revised (expert observation of behaviour). Positive parenting practices were measured using the Parenting Practice Interview (parent report).
Findings

This study identified statistically significant positive impact on a number of child and parent outcomes.
Child outcomes include:

- Reduced behaviour problems
- Reduced inattentive behaviour
- Reduced hyperactive/impulsive behaviour

Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

Sonuga-Barke, E.J.S., Thompson, M., Daley, D., & Laver-Bradbury, C. (2004). Parent training for attention deficit/hyperactivity disorder: Is it as effective when delivered as routine rather than as specialist care? British Journal of Clinical Psychology, 43, 449-457 - **This reference refers to an RCT, conducted in the UK.**
Thompson, M.J.J., Laver-Bradbury, C., Ayres, M., le Poidevin, E., Mead, S., Dodds, C., Psychogiou, L., Bitsakou, P., Daley, D., Weeks, A., Miller Brotman, L., Abikoff, H., Thompason, P., & Sonuga-Barke, E.J.S. (2009). A small-scale randomized controlled trial of the revised new forest parenting programme for preschoolers with attention deficit hyperactivity disorder. European Journal of Adolescent Psychiatry, 18, 605-616 - **This reference refers to an RCT, conducted in the UK.**

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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