The Little Hulton Project: A Pilot Child Clinical Psychology Service for Pre-School Children and their Families

Caroline White, Joanne Agnew & Chrissie Verduyn
Department of Clinical Psychology, Royal Manchester Children's Hospital, Hospital Road, Pendlebury, Manchester M27 4HA, UK

A community-based early intervention psychology service for pre-school children with emotional and behavioural problems is described. The intervention included parent training groups, a weekly open clinic, and multi-agency training, liaison and consultancy. The aims were to provide successful intervention to families, to maximise liaison with community staff and to provide a seamless service to and from the main hospital department. Evidence indicated improvements in parental coping and children’s behavioural difficulties using standardised measures and gains were maintained at 6- and 12-month follow-up. This article outlines a framework for service delivery in a small community with high socio-economic deprivation.

Keywords: Community service; early intervention; pre-school; parent groups

Introduction

The Little Hulton Project was funded by the Salford Children’s Project, set up by Salford Health Authority to target children in need, from November 1996 to October 1998. It aimed to provide a child clinical psychology service for pre-school children and their families in Little Hulton in Salford, an area with a high level of socio-economic deprivation (Townsend index = 5.85; Salford & Trafford Health Authority, 1998) with similar levels to Camden in London (Jarmen score = 40.4; London Regional Office, 1998). This area was targeted by the Health Authority due to its high level of need and isolated location. Little Hulton has a population of 11,635, of which 9.4% (1098) are children under the age of 5 years. The project implemented an assertive outreach approach, whereby the target was a ‘high risk’ population living in an area where clinical psychology services were difficult to reach. Services were prioritised to those parents who would benefit the most.

The value of early detection and identification of problems and consequent intervention with young children and their families has been recognised for many years. Studies suggest that children with early externalising problems are more likely than comparison children without such early symptoms to have difficulties in behavioural control in early school years to middle childhood (Richman, Stevenson, & Graham, 1982; Fisher et al., 1984; Campbell & Ewing, 1990). In line with these studies, intervention in the pre-school years can be seen as a primary preventative strategy (Goldstein, 1977; Blair, 1992). It is estimated that 80–90% of children with psychosocial difficulties never reach specialist child services (Cox, 1993). However, there is evidence that providing a service in community settings, which are more accessible, increases the likelihood of higher risk families using the service (Printz & Miller, 1994). It has also been shown that parents who attend parent training groups run in the community report greater generalisation of improvements to the home situation, and better maintenance of these improvements at follow-up (Cunningham, Bremer, & Boyle, 1995). Furthermore, this experience is normalising for parents. In line with these studies, the project aimed to provide an accessible community-based clinical psychology service in Little Hulton.

The specific role of clinical psychologists in working with behaviour problems of those under 5 years of age is well established. This role involves support and training of front line staff as well as face-to-face work with children and their families. The NHS Health Advisory Service Report (1995) on Child and Adolescent Mental Health Services (Together we stand) described the range of levels of service to children and families and emphasised the importance of effective liaison between specialist and community services. The current demand for help with early behaviour problems falls mainly with community health professionals, in particular health visitors. However, limited resources often mean that these demands cannot fully be met (Davies et al., 1997). As a consequence, the service aimed to provide face-to-face work with the children and their families together with training, supervision and consultation to increase the confidence and knowledge of these professionals to deal with the problems encountered. In addition, the service aimed to increase accessibility and create clear pathways for referral to the clinical psychology service at its main hospital base and/or referral on to other agencies (e.g., social services, psychiatry).
Method

The service
The Little Hulton Project provided a community-based clinical psychology service aimed at early detection of problems and identifying effective intervention. It was evaluated using a range of qualitative and quantitative methods. The aim was to provide a seamless service to and from the main clinical psychology service, with families being seen in a community-based clinic when appropriate and at the hospital base for more severe or complex problems and linking with child psychiatry services when necessary. The service aimed to increase successful management of families during intervention and maximise liaison and communication with community staff. In recognition of psychological skills of community-based professions, the service promoted and developed expertise through training and consultation, working in partnership through both multi-agency and multi-disciplinary work. The service involved one session from a consultant clinical psychologist (management, consultation and training), and five sessions from each of the following: clinical psychologist, assistant psychologist and nursery nurse. The service comprised:

- Parenting groups (Parent Survival Course).
- Community-based clinic session.
- Consultancy and supervision of community-based professionals.
- Training of community-based professionals.

Parenting groups (PSC)
The groups were accessed by self or professional referral and were aimed at parents experiencing moderate difficulties with their pre-school children’s behaviour. The groups took place at the social services community nursery in Little Hulton and involved an initial interview to assess suitability. Each group ran for 7 weeks with weekly sessions and used a cognitive-behavioural approach based on the Webster-Stratton Parent Training Program (Webster-Stratton, 1990). The courses were run by the clinical psychologist and an assistant/trainee psychologist, and child care was provided by the nursery nurses. The Little Hulton health visitors played an important role in introducing to parents the idea of attending the PSC and discussing the appropriateness of referrals through liaison with the psychologist. Wherever possible the appointment for initial assessment was arranged by the psychologist by telephone, and once invited to the course phone contact was maintained prior to sessions. If parents were unable to attend a session, a home visit was arranged and the session was carried out by the assistant psychologist.

Community clinic session
The service provided a weekly session at the Little Hulton Health Centre when the clinical psychologists’ time could be booked. This time was used to see cases where brief involvement was likely to be appropriate, to meet parents with a view to continuing sessions at the hospital base, and for initial assessments for the Parent Survival Course referrals. Although initially set up solely for pre-school children, the clinic session became more flexible to allow clinical cases, where attendance at appointments was previously poor, to be seen for assessment only, with a view to continued intervention being carried out at the hospital.

Consultation and supervision
A consultation service was provided to the local social services team, to monthly panel meetings at the community nursery and to the Homestart management committee. Further networking was established through an existing multi-agency liaison meeting attended by the community paediatricians, nursery manager, head of social services child team, health visitors, school health advisors and nursery nurses.

Training sessions
Training sessions were provided approximately monthly in two formats: workshops for smaller groups (health visitors, nursery nurses and family centre staff) and more formal lectures with discussion for larger groups including social services and education professionals. Workshop topics included: feeding problems, sleep disorders; toilet training; wetting and soiling; oppositional behaviour; behavioural management strategies; complex cases; and methods to improve parental motivation. Topics for talks included: hyperactivity; aggression; attachment; separation and loss.

Further service developments
A further pilot study was conducted towards the end of the initial 2-year period to assess the feasibility of expanding the service into other areas of the city. This was conducted in Lower Broughton, another area of high socio-economic deprivation (Townsend index = 5.84, Jarmen score = 38.03) and consisted of some consultation and training of tier one professionals and one Parent Survival Course.

Method of analysis

PSC parent ratings
Evaluation was carried out using standardised questionnaires to measure change and satisfaction ratings. Questionnaires used were: Beck Depression Inventory (BDI) (Beck et al., 1961) – measure of depression in adults; Self Esteem Inventory (SEI) (Rosenberg, 1965) – measure of self-esteem in adults; Achenbach Child Behaviour Checklist (CBCL) (Achenbach, 1991, 1992) – measure of a wide range of child behaviours; Eyberg Child Behaviour Inventory (ECBI) (Robinson, Eyberg, & Ross, 1980) – measure of problem behaviours; Preschool Behaviour Checklist – (PBCL) (Richman, 1977; Richman et al., 1982) a measure of child behaviour. These self-rating questionnaires were completed by course attenders, pre and post group, and at 6 and 12-month follow-up; and by a group of non-attenders at 6 month follow-up.

PSC satisfaction
Qualitative views of service users were obtained using satisfaction questionnaires that were administered following each group. Parents were asked to rate 17 items
on a 5-point scale on aspects of the course, including access, location, session content and child behaviour change in terms of satisfaction, convenience, helpfulness and improvements. The questionnaire also included some open-ended questions inviting comments.

**Clinic modes of contact**
An evaluation was carried out during the project of the impact on uptake of the various modes of contact (letter and phone contact) used to inform the referred parent of the first appointment.

**Consultation**
In order to obtain the views of service users, health visitors completed a satisfaction questionnaire on various aspects of the consultation service.

**Training**
Health visitors who received training were compared to a control group of health visitors based at a nearby clinic using questionnaires. They were comparable in terms of case load, level of social deprivation of population and frequency of dealing with behaviour problems. The questionnaires detailed knowledge of behavioural problems, attitudes to training, current practice, and changes in practice over the last 6 months.

**Impact on referrals to clinical psychology service**
In order to evaluate the impact of the project upon total referrals to the psychology service from the area, a comparison was carried out between the year prior to the start of the project and the following two years. Information prior to the project was obtained retrospectively by case note examination.

**Results**

**Parent survival course (PSC)**
There were seven courses held in Little Hulton during the project, which involved 56 parents (including 3 fathers). Sixty-three per cent of attendees were single parents and the rate of uptake from referral was 61%, with 79% attending four or more of the sessions. Those attending fewer sessions were drop-outs (reasons given for this included moving out of area, working commitments and life events) and these were not included in analysis. The children who were referred averaged 33 months and the majority were male (71%). Health visitors were the most frequent referrers to the service (96%).

The pre-group means for BDI, PBCL and ECBI problem score were 24.8, 18.3 and 16.9; and post-group means were 19.6, 12.4 and 8.0 respectively (see Figure 1) (with clinical cut-offs: BDI = 15, PBCL = 12 and ECBI = 11). Paired t-tests results indicated that post group means had significantly improved compared with pre-group means on all measures (BDI \( t = 5.76, 43 \text{ df}, p < .01 \); CBCL \( t = 7.15, 40 \text{ df}, p < .01 \)). The difference between pre-group means and both 6 and 12-month means were maintained at a statistically significant level (BDI \( t = 3.56, 30 \text{ df}, p < .01 \); CBCL \( t = 7.49, 24 \text{ df}, p < .01 \) at 12 months). Parents who attended the course were compared to a sample group of parents who were referred during the project but did not attend. There was no significant demographic difference between these two groups at referral. The ‘non-attender’ group was compared to 6 month follow-up data of parents who had attended the course and indicated that course attenders were having fewer child behaviour problems on all of the questionnaires administered, the difference reached a significant level on the ECBI (\( t = -3.32, 16 \text{ df}, p < .01 \)), PSBL (\( t = -2.49, 16 \text{ df}, p < .05 \)) and CBCL (\( t = -3.29, 55 \text{ df}, p < .01 \)).

**Satisfaction**
A high degree of satisfaction was obtained. All commented that they would recommend the course to other parents with young children, and indicated that their confidence in dealing with their children had increased.

Nursery management at the Little Hulton Community Nursery, where the PSC was held, reported that the accessibility of the nursery staff to parents had increased, and the perceived ‘stigma’ of parents attending the nursery with their children had reduced since the course had been running.

**Clinic**

**Attendance**
In total, 33 clients were referred to the clinic for routine out-patient assessment/treatment. The majority of those referred were male (67%) and the average age was 82 months. Reasons for referral included aggression

![Figure 1. Mean scores on the evaluation questionnaires administered to the parents who attended the Parent Survival Course](image-url)
The most frequent referrers to this service were health visitors (78%). Of those invited to initial appointment, 73% attended at least one session, and 75% of those who attended were seen at one appointment only at the clinic. The remaining 25% were seen for further sessions at the hospital base after initial appointment, 90% of whom attended the appointment given.

Modes of contact
The average waiting time from referral was less than four weeks. The most frequent mode of contact was letter from the psychologist (38%), followed phone call from the health visitor (31%) and phone call from the psychologist (25%). The most effective mode of contact was phone contact from the psychologist (71% attended), which was significantly ($p < .05$) more effective than either phone contact from the health visitor (59% attended), or letter from psychologist (35% attended).

Consultation supervision
Content
The amount of time spent on consultation by the clinical psychologist was 30% of the clinic sessions (see Figure 2). Case supervision was the most frequent reason for use of the consultation service (50%). Of the remainder, 30% were for discussion of appropriateness of referral, and 20% were for the purpose of sharing information only. The most common mode of consultation was drop-in at the clinic (62%) followed by telephone in (17%). Professionals involved included health visitors (54%), nursery nurses (18%), social workers (13%), teachers and EWOs (13%) and community paediatricians and GPs (2%).

Evaluation
These indicated that all health visitors found the service ‘very user friendly’, the majority found the service ‘extremely useful’ and ‘almost always’ acted on the advice given by the clinical psychologist.

Training
The results indicated that the health visitors who received training reported greater overall awareness and knowledge of behaviour problems and a significant increase in their awareness, understanding and implementation of behavioural management interventions compared to the control ($t = 7.98$, 10 df; $p < .01$). In qualitative analysis, the overriding observation was that the Little Hulton health visitors had increased in their confidence to deal with problems compared with the control group. Satisfaction questionnaires also indicated that service users were satisfied overall with the venue, the topics covered, and their presentation. Health visitors were given training after the questionnaires were administered.

Impact on referrals to clinical psychology service
Results indicated a significant increase in to the clinical psychology service for both pre-school referrals (an average 5.5 fold increase over 2 years) and school aged children (an average 1.5 fold increase over 2 years). There were also significant increases in referrals from health visitors and social services. The percentage of people who attended any appointments offered to them also increased since the start of the project from 50% to 75%, suggesting increased accessibility. One case was ongoing at the end of the pilot period. Two cases were referred on to other services, both to child psychiatry, and three clinic cases were open to social services at the time of referral.

Further service developments
The pilot study in Lower Broughton provided encouraging results for the transferability of the service across the city. In a pilot Parent Survival Course significant changes were observed in pre and post-group means using paired $t$-tests and 6-month follow-up data indicated that improvement was maintained on several child behaviour measures.

Discussion
The aim of the project was to provide a community clinical psychology service to pre-school children and their families in Little Hulton, an area of high socio-economic deprivation. It aimed to implement a secondary preventative strategy directed at early intervention. The project emphasised the importance of prioritisation of service delivery to ‘high risk’ populations and implemented an ‘assertive outreach’ approach that targeted an area of high socio-economic deprivation. A community approach to service delivery was applied in order to increase the accessibility of a previously ‘hard to reach’ population. In addition, the project highlighted the importance of working within a multi-agency framework and of effective liaison and collaboration with community based professionals. A central aspect of this was the emphasis on providing a service at various levels of delivery, recognising and building upon the psychological knowledge and skills of community based professionals, in addition to
providing a face-to-face clinical psychology service to the pre-school children and their families. Evaluation of the service emphasised the importance of effective and research based interventions, and placed importance on the views of service users.

In recent years a number of different approaches have been described. In particular, parent support schemes have offered good evidence that multi-agency, community-based services targeted at parents of young children are effective including Newpin (Pound, 1994), Home-start (Van der Eyken, 1990) and PIPPIN (Parr, 1995). More recently statutory services have also considered new ways of service delivery. The Parent Advisor Scheme (PAS) (Davis et al., 1997) is a community based child mental health service providing a home based intervention conducted by health visitors and other professionals trained in parent counselling and behaviour management. The service was shown to be beneficial to children and families. The Little Hulton Project differed from the PAS in that parent training groups were offered as the main intervention by child mental health professionals. However, the role of training to health visitors, nursery staff and other front line professionals were viewed as being essential components in the success of the project. Although the parent outcomes of the groups showed significant improvements post-group, these professionals were considered to have an important role in offering continued support to parents and contributed to the gains being maintained at 6- and 12-month follow-up. Furthermore, the community service was functionally integrated with the hospital based service and not separate.

**Early intervention**

The service provided early intervention through a number of routes. Evaluation of the Parent Survival Course indicated that the course was effective in reducing the parents’ ratings of their children’s problem behaviour and in improving parental levels of depression and self-esteem. These improvements were maintained up to 12 months after completion of the course. This evaluation provided some statistical evidence of the effectiveness of this early intervention strategy, and due to the maintenance of the improvements it supports the view that it can be seen as a secondary preventative strategy. Interpretation of these results should be viewed with caution as this was not a randomised control trial and the control group used (non-uptakers) may, by definition, be atypical. However, in light of current government initiatives such as Surestart, dedicated to investing resources into early intervention strategies for pre-school populations, this model provides some evidence that this is a realistic and useful approach. Evaluation of the teaching, training, supervision and consultancy service also indicated that it was effective in increasing knowledge and confidence of other professionals to deal with the problems that they encountered with the pre-school children.

**Community approach and assertive outreach**

Evaluation of the impact of the community approach was carried out for each aspect of the project and indicated promising results. Uptake and attendance rates for the Parent Survival Course indicated good levels of uptake and rates of attendance at the sessions following uptake. Qualitative service evaluations indicated that parents who attended the course felt that it was held at a convenient location and indicated high levels of satisfaction with the service provided. Professionals who utilised the training, supervision and consultancy service indicated that they were satisfied with the location of the sessions and accessibility of the service. The evaluation also indicated that the service in Little Hulton had increased accessibility for referrers to the clinical psychology service as a whole.

**Multi-agency framework**

The role of clinical psychologists in working with those under 5 years of age is generally accepted to involve the support and training of front-line professionals. This paper outlines a service that emphasised the importance of working in partnership with the professionals and voluntary agencies who were involved with pre-school children and their families. As such, a multi-agency approach was central to the project and essential to the co-ordination and amalgamation of the service provided. It is important to note that the structure of the psychology service was designed to be networked between the existing agencies and led by consultation with the professionals established within the community. The training, supervision and consultancy services enabled the development of ‘working partnerships’ with front-line professionals and the effective sharing of psychological expertise with an efficient use of time and resources.

Furthermore, the needs of the population and professionals changed over time and it was considered of great importance that the service was responsive to these changes. The overall structure of the service was flexible in order to accommodate these developments. For example, the demand for parent groups fluctuated over time and good communication and close liaison with referring agents was essential in maintaining successful uptake of groups. Social services were re-organised within the area and, consequently, the use of the consultation service by social workers was also variable. Although the family centre was offered opportunities for training and consultancy early in the project, it was approximately 18 months before they accessed the service. Once again, the importance of flexibility and working within the pre-existing frameworks of other agencies was essential in providing efficient and widespread access to the psychology service.

**Conclusion**

The Little Hulton Project has provided a framework for service delivery that has successfully been maintained beyond its initial pilot and is now part of mainstream funding, which has been extended to provide further services into another area of high socio-economic deprivation. It is anticipated that this model may be useful in outlining a method of service delivery specifically for areas of high need. The service has been highly valued by families and professionals. Further research would be helpful in identifying those individuals who
benefit the most from this approach and in developing alternatives for those whose needs remain unmet. Randomised control trials of particular aspects of the service, such as parent groups and professionals training, would also be useful in isolating key variables of effective interventions. The Little Hulton Project has, however, outlined an effective structure for delivering a community based early intervention service to pre-school children and their families.

References
Parr, M. (1995). Why PIPPIN was developed: Some research findings. Stevenage: PIPPIN.