EVALUATION OF THE PARENTAL GUIDANCE PROGRAMME BASED ON THE INTERNATIONAL CHILD DEVELOPMENT PROGRAMME

Report to the Ministry of Children, Equality, and Social Inclusion

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ICDP RESEARCH TEAM

Evaluation of the Parental guidance programme based on ICDP

Foreword

Parental guidance, aiming to strengthen the parental role and hence promote healthy child development, was initiated as a national commitment in Norway in 1995 as a cooperating project between the Ministry of Children and Family and the Ministry of Social Affairs and Health. The Ministry of Education, Research and Church Affairs was involved at a later stage. Today the Ministry of Children, Equality, and Social Inclusion is responsible for the Parental guidance programme, and the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) is responsible for the implementation of the programme. The Parental guidance programme that is being evaluated and described in this report is based upon the International Child Development Programme (ICDP).

ICDP was developed by Professor Karsten Hundeide and Professor Henning Rye and colleagues in 1985. It is a community based programme implemented as a preventive measure across different groups of caregivers with the objective of supporting and promoting psychosocial care competence in the persons responsible for children's care giving. The programme is based on established knowledge from research on early communication, attachment, mediation and regulation and is formulated within a humanitarian common sense genre in order to make it easily available and understood. The programme is intended to supplement existing professionalized services by training local resource persons who work with children and families. For further information about the ICDP and the Parental guidance programme, see www.icdp.info, www.icdp.no, or www.bufetat.no/foreldrerettleiing.

The Ministry of Children, Equality, and Social Inclusion initiated and financed the *Evaluation of the Parental guidance programme based on ICDP*. The evaluation was carried out in the period between 2007-2010, in cooperation between the University College London and the

University of Oslo. The present report summarizes the results of the evaluation study. The full reports will be published in peer reviewed international journals.

Academic Evaluation Team

Professor Lorraine Sherr, University College London: Principal Investigator.

PhD candidate Ane-Marthe Solheim Skar, Department of Psychology, University of Oslo: Responsible for data collection and day to day management, data preparation (transcription, coding, SPSS entering), qualitative data analysis, and the current report.

Dr. Claudine Clucas, University College London: Senior research assistant and data manager. Responsible for statistical preparation of the data.

Professor Stephen von Tetzchner, Department of Psychology, University of Oslo: PhD advisor and project advisor.

Professor Karsten Hundeide, International Child Development Programme: Project advisor.

ICDP Research Team

Trine Gerlyng was part time research assistant in the first part of the evaluation period. She was active in the planning of the study and in data collection.

Ylva Snekkvik was part time research assistant in the first part of the evaluation period. She was active in the planning of the study and in data collection.

Marit Reer was part time research assistant for a year with video coding and telephone interviews, data collection, and data preparation.

Hilde Breck was part time research assistant for half a year with video coding and data preparation.

Kristina Aas Fure worked for half a year for ICDP (parental leave period). She assisted with recruitment for the evaluation project.

Joakim Fink Graasvold worked part time for three months with SPSS entering.

Joanne Mueller, a part time research assistant at UCL, assisted when needed during the first six months of the study.

Joshe Bose worked part time for ICDP for nine months and assisted with SPSS entering.

Anja Kristin S. Skar assisted for two weeks with recruitment of facilitators.

Kanza Raza translated the Urdu qualitative questionnaire responses.

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Executive Summary

Aim: A multicenter research initiative has been operationalized to provide evaluation and monitoring feedback to the Norwegian Ministry of Children, Equality and Social Inclusion about the Parental guidance programme/ICDP as implemented by the Norwegian Directorate for Children, Youth and Family Affairs.

Methodology: The study uses a pre and post design with six months follow up with data contrasted against a comparison group. ICDP group participants were recruited from groups that ordinarily were held in the community, and compared to a group of parents that did not participate in parental guidance. As this was a field study of applied practice there was no random allocation to intervention groups and thus change scores are used in comparisons. A sub group of parents were interviewed in depth to provide qualitative feedback data about the ICDP course and another sub group participated in a video interaction study to observe parenting styles before and after ICDP intervention. A questionnaire was also sent out to facilitators and trainers, and semi-structured interviews were administrated to a subgroup of those attending. Log books from the ICDP groups were also collected.

Main findings: The current evaluation suggests that there are a consistent number of significant positive effects of the ICDP intervention for caregivers, parenting and children (independent of gender of the parent and ICDP version). The findings suggest positive effects on the following:

- positive discipline
- parenting strategy and emotional engagement to the child
- caregivers' attitudes towards child rearing and perceived ability to manage their child
- caregivers' self-efficacy, anxiety, anger and concentration
- household commotion
- children's overall distress and social impairment

Educational levels influenced the uptake of the programme: Self-efficacy increased only in caregivers without higher education, and commotion decreased only among caregivers with a higher education. Gender also influenced the uptake of the intervention: Fathers improved more than mothers in their relationship with the child and family as well as in parenting strategy, whereas mothers viewed their child as having fewer difficulties after intervention. The data also shows some variation in effects between the general group and the prison and ethnic minority groups. Ethnic minority mothers appeared to benefit in particular in relation to appreciating the need to talk, give explanations, and to direct their child, they had become calmer, and more positive. For incarcerated fathers, the programme had a positive effect in terms of emotional engagement, parenting strategy, the child's distress and social impairment and some aspects of child rearing. However, both incarcerated fathers and minority women scored worse on a variety of outcomes after intervention. This might be due to the expected effect of parents becoming more conscious and therefore more self-critical, or that incidences in some cases worsen because of changed parenting strategies before it improves. The trend that caregivers in the minority and prison version scored better at baseline as compared to the basic group on variables where parents worsened supports this hypothesis.

Overall satisfaction with the courses was high and the consumer demand was solid. Beyond the direct gains in terms of parenting skills, for some groups there were added mental health gains in terms of reduced isolation and ongoing group benefits. This was especially reported by parents attending the minority version of the ICDP program. In the prison implemented ICDP program, the focus on child/family related issues in a group situation were especially appreciated, both in regards to the individual incarcerated father, but also for the prison officer-prisoner relationships, and the prison social context.

Initial data from longer term follow up (six months follow up data available for a subsample of respondents) indicates that there are sustained positive effects for ICDP group attenders. Furthermore some parenting behaviors in the comparison group deteriorate over time, perhaps due to the strains and stresses of longer term parenting, whilst on some the ICDP exposed group showed an ability to sustain levels – despite initial lowered scores than the comparison group. Some initial gains directly after the ICDP training wane with time.

The programme is used nationally and in March 2011 there were registered a total of 1773 certified ICDP facilitators and 73 trainers. Facilitators and trainers report positive attitudes and great gain from working with the programme, and they use ICDP in their work across their various occupations. Generally the evaluation shows that the programme is implemented in line with the ICDP principles. However, many certified facilitators do not use the programme. Lack of funding and time available is reported to be great barriers for running caregiver groups. Only half of the facilitators report that the parents do their home tasks and that they use the checklist and log book regularly, and trainers have little experience of running caregiver groups. These limitations need to be taken into account as one would assume that a stricter implementation due to the ICDP manual would reveal stronger effects on parents and parenting.

Recommendations: ICDP guidance seems to have a positive impact on caregivers, children and families and should be offered to all caregivers. There are variations in effects across the different targeted groups, and this supports the need for targeted adjustments. A stronger emphasis should be put in quality assurance through more support and follow up of facilitators, and a greater focus and earmarked funds for commitments to lead groups after they are trained as facilitators should be considered. This strategy of follow up and quality assurance would be cost effective as compared to the common practice of educating new facilitators, many of them who never tend to use the program actively. However, many trained facilitators utilized the skills they had learned within their everyday work situation rather than (or in addition to) running groups, and this aspect should be catered for and assessed in more detail as an added benefit. The future development of input may need to address intensity and dose of provision to ensure that benefits are sustained. Follow up of caregivers should therefore be prioritized. A prison manual and additional sensitization material for the different adjusted ICDP versions should be developed. The evaluation has some limitations in terms of design (non random allocation) and attrition in follow up. The results should therefore be interpreted with caution and repeated evaluation may help to answer more specific questions.

1 Introduction

Research indicates that the quality of parenting is a critical factor in child development. This is especially true for young children who are entirely dependent on caregivers for their well being, their developmental environment and their social environment. Key parental factors are positive parent-child relationships and communication, parental supervision and monitoring, parental warmth and responsiveness, and positive discipline. Child development theories point out the importance of parenting style and the particular benefits of a more authoritative approach, which combines warmth (the demonstration of love and affection), the ability to be demanding (the setting and reinforcement with consistent discipline of high standards requiring mature behavior) and respect for the child's psychological autonomy. Authoritarian, permissive and neglectful parenting is on the contrary related to less positive outcomes in child development (Chandan & Richter, 2008).

Parenting can be a challenging task and it is well established that the stresses of caring can result in poor mental health and reduced vitality (Edwards & Higgins, 2009). It is furthermore documented that caregiver illness such as depression and anxiety affect parenting and negative or compromised child development outcomes (Glasheen, Richardson & Fabio, 2010; Davé et al., 2008; Downey & Coyne, 1990). However, parents and children influence each other, and factors such as difficult temperament are found to change in transaction with parental personality (Komsi et al., 2008). Interventions to ameliorate parental mood can benefit child outcomes (Gunlicks & Weissman, 2008). Indeed, the utilization of parent training with depressed parents has shown such effects (Cooper et al., 2009).

Early intervention programmes often operate through the caregivers of the child regardless of child and parent characteristics, with the aim of improving parental knowledge and strengthening parental confidence as well as parent-child relationships, and consequently to promote healthy child development. A number of training methodologies are used, ranging from information based, didactic teaching, skills based approaches, and theoretically driven programmes to complex models which use a mixture of approaches. Delivery mechanisms also vary, from individual, couple and group interventions and utilizing face to face, home- or

center-based programmes, or web based provision (Plantin & Daneback, 2009). When comparing the effects of parenting programmes on children's outcomes, Barlow and Parsons (2008) conclude that programmes delivered through group-based formats have stronger positive effects than individual-based formats. They are also more cost-effective, facilitate the sharing of experiences, reduce social isolation of parents and develop self-confidence among participating parents (Coren, Barlow & Stewart-Brown, 2003).

Parental programmes are important because any long-term effect on a child living within a family needs to be facilitated by the caring quality and practices of the parents (Fraiberg, 1980). Research has shown that various interventions are quite effective (Scott et al., 2010) and there is good evidence that parents do take in advice and modify their parenting behavior as a result (Smith, 2010). Long-term studies show that the rate of return for the money invested in intervention programmes is higher than in all other fields of educational investment when the intervention group is compared with non-intervention groups (Young, 2002). This research shows that the most effective programmes are intensive, broad-based and long-term, involving parents and local social services that include systematic monitoring of quality and outcomes (Young & Richardson, 2007).

Early intervention programmes have traditionally been directed toward special groups of parents, for example parents from low socio economical classes, or towards special groups of children, such as children with conduct disorders. The Sure Start programme in the United Kingdom is an example of a huge scale intervention targeting all children under the age of four in specific disadvantaged demographical areas. The Sure Start is bottom up by using local authorities who provide *"1) outreach and home visiting, 2) support for families and parents, 3) good quality play, earning and childcare, 4) primary and community health care and advice about child and family health, and 5) support for children and parents with special needs"* (Melhuish et al., 2007, p. 544). Several evaluations have been conducted of the Sure Start programme, suggesting all from adverse to significant improvements in child outcomes. For example, a quasi-experimental, cross sectional study in England of 12 575 children aged nine months and 3927 children aged 36 months showed limited effects and the data also showed that the most deprived recipients were negatively influenced by the

intervention (Belsky et al., 2007). Another study conducted in Wales indicated that children in a risk of conduct disorder benefit from the intervention (Hutchings et al., 2007).

Community based programmes in general populations has been less common. There is, however, increasing recognition that a preventive community based approach is necessary and that less complex targeted population-based parenting programmes that are widely accessible in the community are needed in order to empower and strengthen caregivers' roles (Sanders & Morawska, 2006). Support of parents offered at population level is thought to have a preventive function and is therefore aimed to enhance public health. In addition to support ordinary parents in their important caregiver role, Shapiro et al. argue that huge scale preventive interventions might de-stigmatize the barriers for seeking help when needed and also to approach the dark figures of dysfunctional families (Shapiro, Prinz & Sanders, 2008).

It is important that parenting interventions are evaluated in order to understand whether they actually promote positive outcomes by addressing "*significant risk factors associated with parent and child difficulties and to bolster key protective factors*" (Shapiro, Prinz & Sanders, 2007, p. 458). Studies have monitored the impact of parenting training on the psychological well-being of the caregivers themselves (review by Barlow & Coren, 2004). However, there is currently a paucity of evidence concerning whether these results are maintained over time (Barlow & Coren, 2004). Much evidence of the effects of parental intervention programmes come from clinical interventions which has prompted the idea of generalized community availability of such programmes (Fergusson, Horwood & Ridder, 2005). However, there are often reported hurdles in terms of engagement with programmes (Spoth, Redmond & Shin, 2000), gender of recipients, long term impact, and differential effects according to variables such as education and social class, with few studies reaching inclusion criteria's for quality of design and analysis (Woolfenden, Williams & Peat, 2001). This highlights the need for evaluation studies of such programmes in order to reach theoretical understanding of the components and processes in care that promotes children's development.

2 The ICDP intervention

The intervention was carried out according to the standardized components of the ICDP system which has been adopted by the Norwegian Ministry for national implementation. ICDP trainers have the competence to educated facilitators. The training of facilitators is usually split into one theory part and one with field exercises to be completed for certification as ICDP facilitator. The facilitators run a caregiver group under the supervision of a trainer (self training group). Participants in the facilitator training can be kindergarten staff, teachers, nurses, or staff from child welfare authorities, prison officers etc.

Facilitators trained in the ICDP have the competence to lead groups of caregivers (usually parents) through a sequence of eight to 12 meetings. The ICDP programme is formulated within three dialogues and eight guidelines for good interaction (see table 4) in addition to positive redefinition of the child (Hundeide, 2001; Hundeide, 2007). These key topics in the programme are discussed and put into practice through home exercises that are shared and discussed in the groups. The task of the facilitator is to facilitate discussions and encouraging everyone to speak, for then to stand back to listen. They give examples and hints, and make positive assessments. They demonstrate interaction settings with role play, stories, video clips etc. (www.icdp.info).

Table 4: *The three dialogues and eight guidelines of good interaction in the ICDP program*

Emotional dialogue:	1: Show your child you love him or her.
	2: Follow your child's lead.
	3: Talk to your child, with emotional expressions, gestures and sounds.
	4: Praise and appreciate what your child manages to do.
Comprehension dialogue:	5: Help your child to focus his/her attention and share experiences.
	6: Help your child to make sense of his/her world.
	7: Help your child to widen his/her experience.
Regulation dialogue:	8a: Help your child to learn rules, limits, and values.
	8b: Help your child to plan activities step by step to reach the set goal.

The basic version is targeting parents from the wider community mainly through kindergartens and child health centers, but also through other arenas where there are parents and children. All other versions of the ICDP programme are based on the same basic version but with some adjustments for the special target group as outlined in table 5. This evaluation included basic groups, prison groups, minority groups and groups for parents of children with special needs.

Table 5: *The ICDP versions*

ICDP Version	**Manual**	**Additional focus**	**Number of meetings**
ICDP basic version (main study)	X		8 meetings
ICDP prison version (prison study) *		Parenting from prison, feelings of loss	8 meetings (some prisons adjust for additional contact)
ICDP minority version (minority study)	X	Cultural issues, e.g. similarities and differences in parenting practices	12 meetings
ICDP special needs version (special needs study)		How to deal with the child's special need	10 meetings

*A recommendation for implementation is given based on a pilot study conducted in 2006.

3 Evaluation of the Parental guidance programme/ICDP

On the initiative of the Norwegian Ministry of Children, Equality and Social Inclusion (BLD), a neutral evaluation was carried out of the ICDP Programme as it has been used in the national Parental guidance programme. The evaluation was carried out by the University College London and the University of Oslo, Department of Psychology.

The main study is a pre/post questionnaire study with a comparison group and six months follow up. Several sub studies were conducted in order to look at variations in effects. The ICDP programme is adjusted for minority caregivers, incarcerated parents, and parents of children with special needs, and the current evaluation project also explores the effects of the intervention on these groups of parents. Trainers and facilitators received a questionnaire in order to explore the implementation of the programme. A sub sample of caregivers, facilitators and trainers were interviewed about their experiences with the programme. In addition, parents from both the intervention group and comparison group were filmed in interaction with their children in order to investigate whether the interaction between parents and children was affected by the parent guidance course.

The evaluation contains the following elements:

1. Setting up of evaluation team/methodology.
2. Facilitator and trainer feedback study – systematic insight into facilitator and trainer experiences.
3. Pre-post ICDP intervention study of caregivers, monitoring demographics, parenting, psychosocial variables and appraisal.
4. The pre-post ICDP intervention evaluation was extended from the main group to specialised groups (prisons, ethnic minorities, parents of children with special needs).
5. Video study – standardized caregiver/child interactions were video filmed before and after ICDP intervention.
6. Interview study – caregivers provided qualitative interview feedback.
7. Six months follow up to examine sustainability of ICDP intervention.

The focus for the evaluation is:

- What is the impact of the programme on caregivers?
- What is the impact of the programme on caregiver-child relationships?
- What is the impact of the programme on children's development?
- What is the sustainability of the effects obtained?
- How is the quality of implementation?

Participants

During the study period, 120 parental groups were planned to our knowledge; of these eight were cancelled due to withdrawal of caregivers. 38 of the groups were self-training groups. 414 caregivers from the intervention group and 157 comparison caregivers participated in the pre phase of the evaluation, and 204 and 79 respectively participated in the post phase. A sub group of caregivers participated in semi-structured interviews (N=63), while others participated in a video study with their child (N=22). Facilitators (N=172) and trainers (N=35) participated in a questionnaire study, and semi-structured interviews were administrated to a sub group of those attending (13 and 16 respectively). Also, all facilitators that participated in the evaluation were asked to hand in their log book as part of the evaluation. An overview of participants and log books collected is presented in table 1 and in table 2.

Table 1: *Participants: Facilitators and trainers*

Participants	**Questionnaire study N**	**Response rate questionnaire study**	**Interviews**
Facilitators	172	25 %	13
Trainers	35	48.6 %	16

Table 2: *Participants: Caregivers, and number of log books collected*

ICDP version (number of groups run 2008 Oct -2010 March)	**Participants**	**N Pre (baseline)**	**N Post ((%) of baseline sample)**	**Post intervention interviews**	**Video (pre and post)**	**Log books**
Basic (75 groups)	Caregivers from the basic version	269	141 (52.5 %)	12	11	13
	Females	202	105 (52 %)			
	Males	64	36 (56 %)			
Minority (18 groups)	Caregivers from the minority version (females)	75	31 (41.3 %)	24		2
Prison (21 groups)	Caregivers from the prison version (males only)	63	25 (39.68 %)	20		4
Children with special needs (6 groups)	Caregivers with children with special needs			7		1
Child protection (2 groups)	Caregivers within child protection					2
Comparison group	Drawn from the community	157	79 (50.3%)		11	

Instruments

Parental questionnaires were selected according to two criteria, namely that they were internationally validated and relevant in relation to the aims of the ICDP programme. The measurement tool contained a series of such validated questionnaires translated into relevant languages (Norwegian, Urdu and Arabic), together with study specific questions gleaned from ICDP input, aims and objectives and previous pilot evaluations. In addition basic demographic and satisfaction data was systematically gathered. All questionnaires contained scales on parents' perception of the child and her/himself as a caregiver, parent style, and interaction between parents and children. Table 3 gives an overview of the scales used before the intervention (T1), after the intervention (T2), and six months after T2 (T3).

Table 3: *Instruments*

Instruments	About
Demographics [3]	Asked to focus on the child closest to four years (focus child); number of children, education, work
Strengths and Difficulties Questionnaire (SDQ)	Emotional symptoms, hyperactivity, conduct problems, peer problems, prosocial behavior
The Hospital Anxiety and Depression Scale (HADS)	Self-report measure of anxiety and depression
Parent-Child Activity Scale[1]	Activities with one's child
Harsh Discipline+pos. discipline items	Violent and non-violent discipline
Household Chaos[2]	Home environment
SF-36 VAS Scale	Health/quality of life indicator measurement
Dyadic Adjustment Scale (Item 31)	Assessment of marriage/intimate dyads
The UCLA Loneliness scale	Personal characteristics of loneliness
Life Satisfaction	Measure of life satisfaction
Rosenberg Self Esteem Scale	Global self esteem
Generalised Self-Efficacy Scale	Ability to cope under stressful events
Basic Emotions Trait Test (BETT) [4]	Anger, explore, fear, pleasure and sadness
Social Support Questionnaire 6 [4]	Availability of people on whom we can rely
Time spent on TV/computer [4]	Time spent on TV and computer games
Time spent with the child [2, 4]	Time spent with the child mother and father
ICDP specific questions: Parenting strategy scale [3] (negative items reverse coded)	I expand my child's experiences by giving explanations and telling stories, I help my child to focus his/her attention so that we have a mutual experience, I set limits without explaining why, I adjust myself to my child's focus and interests, I take the initiative when playing with my child, I often have to scold my child (reverse coded), My child makes contact with other adults than mother and father, I take the initiative when my child is playing with other children, My child cannot play alone for more than 10 minutes, My child draws my attention when s/he is doing something, I provide a meaning for my child's experience of the outer world by describing things we are doing together and by showing feelings and enthusiasm and My child does not always listen when I ask him/her about something.
ICDP specific questions: Parenting engagement scale (strategic and emotional engagement)	Strategic engagement: Loving-unloving, engaged-unengaged, good-bad, talkative-non-talkative, sensitive-insensitive, adjust to child-directing. Emotional engagement: negotiating-commanding, kind-aggressive, rewarding-punitive, lenient-strict
ICDP specific questions: Child management scale/child rearing [3] (distant and facilitating child management) (negative items reverse coded)	Distant child management: I think it is difficult to have emotional conversations with the child, I dominate in games and interaction with my child, I tell my child to be tough and not to cry when s/he is sad, I am not certain of myself as a caregiver, I do not show much love to my child, I do not talk much to my child and only say what is necessary, when we are together, much of the time is spent on setting limits, my child plays better with other children than with me, there is no reason to talk to my child. Child management: I often join a game that my child has started, I give my child praise and recognition, I help my child to make plans and carry them afterwards in life, I set limits for my child when s/he behaves badly, I extend my child's initiative, the time around bedtime is pleasant on the whole, when I am together with my child, we often have to break off because I have so many other things to do, I handle it well when the child becomes unruly, even though I am angry I listen to my child, I regard myself as a good caregiver, when my child is hurt, I comfort and cuddle him/her, I explain to my child that s/he should be careful in dangerous situations, I trust my ability to take good care of my child
Questions about experiences with ICDP [3]	Including whether they notice any changes in them selves, the family, or child

[1]Some items excluded in prison study [2]Excluded in prison study [3]Some items excluded in T3, [4]Excluded in T3

Interview guides were created and pilot tested, and semi-structured interviews were administered to caregivers, ICDP facilitators, and ICDP trainers. Three main issues were covered in the parental interview guide, including experiences from the ICDP participation, effects on caregivers themselves, their children, and their families, as well as questions about the course content. The facilitator/trainer interview guide comprised questions regarding attitudes towards, and implementation of, the ICDP programme.

Recruitment and procedure

Facilitator evaluation

Facilitators received information about the study in the post at the end of 2007, and they received further information in 2008. They also received a letter from Bufdir were they were recommended to use eight group meetings when holding parental groups. A questionnaire was sent to all facilitators with known contact information in the post at the end of 2008. This initial survey of ICDP facilitators was used to map facilitator training and ICDP implementation, and all ICDP certified facilitators who were registered in the departmental training system were informed about the evaluation and asked to log future groups with the evaluation team. Facilitators rarely reported groups, and most of the recruitment happened through active inquiries from the research team.

ICDP Evaluation study

Groups were mapped continuously, and intervention participants were gathered from those recruited to all newly commencing ICDP programmes based on national availability. The pre and post data from parents were collected in the time period October 2008 to March 2010. [1] 34 % of the groups that participated in the evaluation were self-training groups as part of facilitator qualification steps – which needs to be taken into consideration when examining outcome results.

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[1] Self-training groups were initially thought to be excluded from the study because of their lack of experience in running ICDP groups; however it was decided at an early level to include them because of the limited number of groups run by certified and hence more experienced ICDP facilitators.

The current evaluation was confidential but not anonymous, as we were to contact the participants, with consent, with a follow up questionnaire in the post. The researcher (or in some instances the facilitators) gave the parents clear information about the study at the first (sometimes the second) group meeting. Those who consented to participate in the evaluation received questionnaire 1 on commencement of the ICDP course (during the first or before the second group meeting), and questionnaire 2 on or after the last day of the ICDP course. The follow up questionnaire 3 was sent in the post six months after the end of the ICDP course. The questionnaires were translated into Urdu as this is the largest language group of caregivers within the implementation of the ICDP programme. The questionnaires were also translated into Arabic as there were some groups run in this language prior the evaluation period. The Norwegian version of the parental questionnaires was published online and the link was given in the information letters. The data were transferred encrypted.

Comparison group participants were recruited by the researchers or trained staff at child health centres and kindergartens where ICDP was not offered. The parents took the questionnaire with them home and returned it in a sealed envelope. They received questionnaire 2 and 3 in the post after three and nine months respectively.

Interview component

A sub group of parents from the ICDP intervention group ticked yes for an interview in the questionnaire, or they were recruited during the last group meeting for an interview about their experiences with participation in the Parental guidance programme. All parent interviews were conducted face to face at the same place where the ICDP intervention took place. In the cases where participants could not write or read Norwegian, an interpreter was brought in order to assist in filling in the questionnaire or interviews.

Video component

A sub group of parents from the ICDP intervention group and the comparison group ticked yes for participating in a video study with their child. The parents who consented to

participate in this part of the study were contacted and video filmed before and after the ICDP intervention. The comparison participants were filmed with the same time interval.

Trainers' evaluation

Trainers received an information letter about the evaluation and a similar questionnaire as the facilitators via e-mail at the end of 2009.

Interview component: facilitators and trainers

Facilitators and trainers ticked yes for an interview in the questionnaire, and were contacted by the researcher over the telephone. Semi-structured interviews were administered over the telephone in 2010 to a sub group of facilitators and trainers in order to obtain more qualitative information about their experience with the programme.

Log books

In connection with facilitators' experience with the parental guidance groups, they were asked to hand in their log-books (these books are recommended as standard internal evaluation for the facilitators of the ICDP programme through the ICDP manual).

It is worth noticing that the data reflects the situation in 2008 (facilitator questionnaire data), 2009 (trainer questionnaires) and 2010 (facilitator and trainer interview data), and changed implementation practices after this period is therefore not included in this report.

Coding and analysis

The questionnaire data were analyzed in SPSS 16 and statistical methods were chosen based on the nature of the study and study sample. The main analysis was a 2 (group: intervention/ comparison) X 2 (education: higher education/not higher education) X 2 (time of measurement: pre/post) mixed ANOVA with repeated measures on time of measurement. It controlled for education because groups significantly differed on this variable.

All interviews were transcribed word for word with Hyper Transcribe, a transcription programme which has special features to make the transcription process easier and hence less prone to error (www.researchware.com). The transcriptions were imported into NVivo 8, an online qualitative analysis programme (www.qsrinternational.com). Parental interviews were coded and analyzed in an inductive way (from the data) in the first coding process. Codes were created based on the interview questions in the facilitator and trainer interviews. All data were coded for patterns and similarities in the second phase of the coding process. Responses to open questions for the intervention groups were typed into Excel. The responses on each question were grouped in themes, and then made into categories. The content of the log books were analyzed and compared to recommendations given by ICDP on how to use the log book.

Ethical considerations

Information sheets were provided to all study participants. Clear information about anonymity and confidentiality were given as well as information about follow-up. Participants were assured that their data would not be available to the individual facilitator or group members, and that refusal to participate would have no effect on their participation in the ICDP training. The study was approved by the Regional Ethical Committee and the Data Inspectorate. The project furthermore gained approval from the Norwegian Correctional Services to recruit prisoners and employees from prisons for the evaluation project.

The questionnaire contains questions about child, child rearing, child strengths and difficulties and parental psychological health, life quality, and number of social supports. These questions might lead to reflections and increased consciousness about sensitive issues. This can be especially difficult for incarcerated fathers. Piloting of the questionnaire in prison revealed that some of the questions concerning home related activities triggered adverse responses of frustration and discomfort for some incarcerated parents. For this reason, unsuitable questions were removed from the prison study questionnaires (see table 3). In cases where a parent would react in an unhealthy way to issues that might be facilitated by the evaluation, the participant would have the possibility of seeing a professional therapist. However, during the course of the study, this was not necessary and was not called upon at all.

The case of real voluntary consent became an issue in some groups of minority parents, as it became clear that some mothers thought of this more like compulsory “home work”. The voluntary nature of research was therefore explained even more profoundly in minority groups. Furthermore, this group of parents, many less educated than the general population, needed up to 2.5 hours to fill in the questionnaire. We considered it unethical that the parents should fill in the questionnaire during the group meeting, as this would influence other group members who did not want to participate, and potentially influence the voluntary nature of the study. Participants from ethnic minority groups therefore had the option to complete the questionnaire at home.

Preliminary list of papers under preparation for publication

- An evaluation of the International Child Development Programme in an general Norwegian parent sample
- The effect of parental guidance on a group of incarcerated fathers in Norway
- An evaluation of the International Child Development Programme with parents from minority groups in Norway
- A six month follow up study of parents receiving parental guidance based on the International Child Development Programme (only some preliminary results presented in this report as the data are not yet fully analyzed)
- The impact of gender on the effect of ICDP guidance
- A video observation study of the effect of parental guidance on parent-child interaction (not included in the current report as the data are not yet fully analyzed)

4 The main study: Evaluation of the ICDP intervention in the general population

The objective of study I is to provide insight into the impact of the ICDP intervention on parents who participated in the ordinary implementation of the programme (basic version). Parents participated in a pre/post questionnaire study, and quantitative data responses and open answer responses to questions in the post questionnaire about perceived effects of the intervention on the parent, the child and the family is presented in this chapter.

4.1 The effects of ICDP

Procedure

The study examines the characteristics of caregivers before and after entering the ICDP programme compared to a comparison group who were not in receipt of any intervention. Intervention parents were recruited via the evaluators (44.6 %) during the first group meeting, or via the facilitators (55.4 %) who had received information about the study and exact procedures for recruitment. Comparison group were recruited by the evaluators or trained staff at health centers and kindergartens. The parents in the comparison group took the questionnaire home and sent them to the project office in the post. They received the post questionnaire with the same time span as the intervention group, approximately 10 weeks after they filled in the pre questionnaire.

Description of the sample

Data is available from 269 participants who attended the ICDP intervention and 157 comparison participants who did not have the possibility of ICDP attendance and were thus not exposed to this intervention. At the post-assessment period, questionnaires were received from 220 participants' altogether. This comprised 141 caregivers from the ICDP intervention group (52.4 % post response rate) and 79 from the comparison group (50.3 % post response

rate). These 220 participants with pre-intervention and post-intervention data form the basis of the main analyses.

Findings

At baseline, 75.5% were female, 64.5% had completed higher education, 90.5% were born in Norway, 91.4% were married or with a partner, 60.9% were in full-time employment and 45.9% had 2 children. Caregivers were on average 34.5 years old (SD = 5.90, Median = 34, range = 23-60). The focus child was on average 3.8 years old and 45.9% of the focus children were female and 38.6% were male. Before the intervention, caregivers in the comparison group with pre and post data were significantly more likely to be married or with a partner (94.9 versus 89.4 %) and to be in higher education (74.7 versus 58.9 %) than caregivers in the intervention group with pre and post data. There were no significant group differences in any of the other demographic variables (gender, place of birth, age, employment, number of children, number of people in the home, age and gender of focus child, child having a television or computer in his/her room, number of televisions' in the home). Despite initial differences between the comparison group and the intervention group, change scores can be used to examine the effects of change over the intervention and controlling for the main differences in education and civil status. Due to differences between the intervention and comparison groups in terms of education, the study used 2 (group: intervention/comparison) X 2 (education: higher education/not higher education) X 2 (time of measurement: pre/post) mixed ANOVA with repeated measures on time of measurement.

Out of 33 outcomes, (without counting follow up analyses on individual items for positive discipline, child rearing and parenting strategy), caregivers that received ICDP guidance showed an improvement on 20 outcomes in terms of means, no change on eight outcomes, no deterioration on three outcomes and worsening on two outcomes. Caregivers showed a significant improvement on six outcomes in the whole sample and on five outcomes only on caregivers who were married/with a partner (see table 17).

More precisely, the findings suggest that there are a consistent number of positive and significant effects of the ICDP intervention on parents themselves, parenting strategies and children. These include:

- Increased activities with the child
- Improved parenting strategy
- Improved child management
- Increased emotional engagement
- Increased strategic engagement (interactive vs. rigid)
- Reduced commotion in the home
- Reduced impact of child difficulties on social impairment and distress
- Decrease in caregivers' loneliness (while increased in the comparison group)
- Caregiver's attitudes towards child rearing and perceived ability to actually manage their child were improved for ICDP intervention participants

Several trends also emerged, suggesting that the ICDP programme may also have a positive effect on:

- Caregivers' use of positive discipline
- Their degree of happiness with their partner
- Decrease in overall distress and social impairment
- Increase in caregivers' sense of self-efficacy
- Positive effect on children's overall difficulties
- Positive effect on caregivers' life quality
- Decrease in caregivers' negative emotions (anger, fear, and anxiety)
- Increased concentration

The ICDP programme decreased commotion in the home and caregivers' behaviour of dominating in games only in caregivers with a higher education, and the programme furthermore appears to have only increased self-efficacy in caregivers without a higher education. This may suggest that caregivers with higher education have less space for improvements.

ICDP specific effects

There appears to have been improvement for the basic community group related to the following ICDP guidelines for interactions (bold):

EMOTIONAL DIALOGUE - Guidelines 1, 2, 3, 4:

1. Show your child you love him or her

2. Follow your child's lead (improvement for caregivers with higher education only)

3. Talk to your child. Get a conversation going my means of emotional expressions, gestures and sounds.

4. Praise and appreciate what your child manages to do

COMPREHENSION DIALOGUE - Guidelines 5, 6, 7:

5. Help your child to focus his/her attention and share experiences

6. Help your child to make sense of his/her world

7. Help your child to widen is/her experiences

REGULATION DIALOGUE - Guidelines 8a, 8b:

8a. Help your child to learn rules, limits and values

8b. Help your child to plan activities step by step to reach the set goal

4.2 Perceived changes

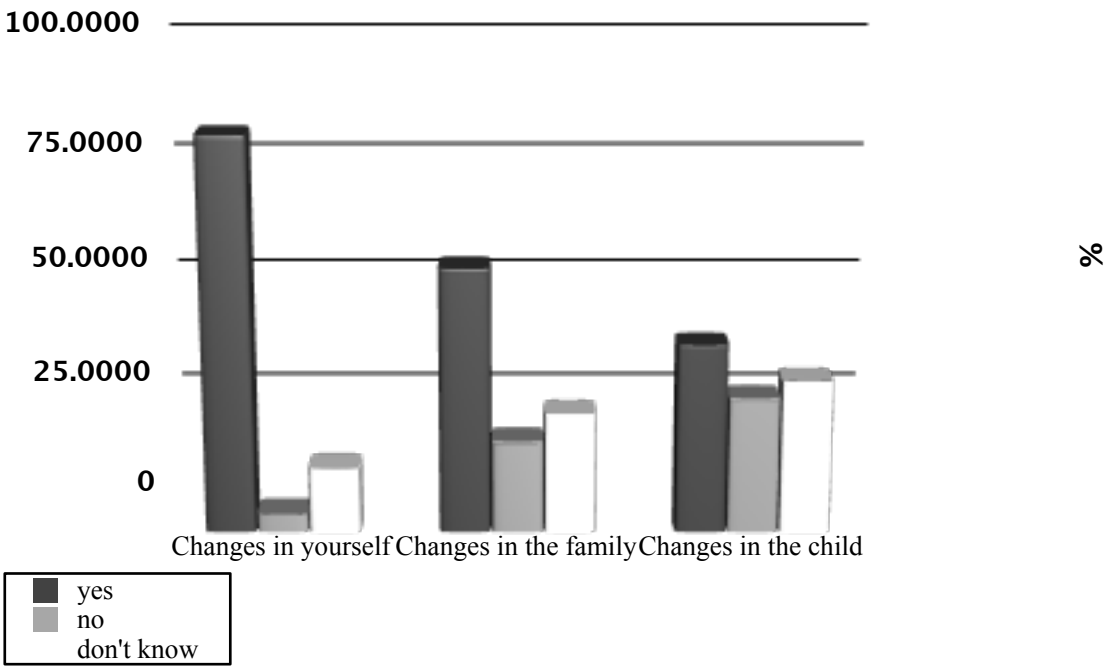
Open answer questions in the post questionnaire were asked to get more in depth information. The following responses are from the sample of 141 post responses from ICDP intervention participants within the basic version. One question asked whether some of the course content was difficult to understand. Most participants answered no to that question. Six yes responses were given, four concerned the programme content and/or that it is difficult to put the program into practice. Two responses were about confusing language in the home exercises. Parents were also asked whether they have noticed any changes in themselves, the family, or the child after the ICDP intervention. See table 6 for an overview of number of yes, no, and don't know responses on these questions, and figure 1 for a graphic presentation of these numbers.

Table 6: *Perceived changes in themselves, their child, and their family after the ICDP intervention as reported by the parents' themselves*

	Yes N (%)	**No N (%)**	**Don't know N (%)**	**Total**
Changes in yourself	109 (82.6)	5 (3.8)	18 (13.6)	132
Changes in the family	75 (55.6)	26 (19.3)	34 (25.2)	135
Changes in the child	53 (39.6)	38 (28.4)	43 (32.1)	134

Figure 1: Percent of parents who report noticeable changes

Figure 1: Percent of parents who report noticable changes



Changes in themselves as caregivers

116 parents gave qualitative feedback to this question. Parents agree that they have changed, as 112 parents reported noticeable changes in themselves as parents after their ICDP participation. 3 participants did not know whether they noticed changes in themselves, and one parent reported no changes in him or herself. The reported changes fall into the following categories: 1) More conscious; 2) Explain more, are calmer and more patient; and 3) More certain in their caregiver role.

More conscious:

First of all, they had become more conscious of their own role in interaction with their child (46 %), e.g.: "*As a father I choose to do things differently than before: Nag less, short messages, and choose sometimes not to comment as much as earlier*".

More explanatory, calm, and patient, and increased understanding about the child's needs:

Secondly, they explain more and experience themselves as calmer and more patient, and with a greater understanding about their child (26.7 %): "*Try to do more in a positive way, more concerned about the child's needs, try to be creative and solve things in other/positive ways*".

More certain in their caregiver role:

They furthermore feel that they manage their parental role better (13 %), e.g.: (*"more faith in myself as a caregiver. Greater focus on what I do which is good"*), and they give the child more praise and show more positive feelings towards the child: "*Better to give praise, the right kind of praise. Adjust more to the child"*; *"Calmer, more attentive, loving*".

Changes in the family

Extended information about changes in the family was given by 77 parents. 72 reported changes in their family after participating in parental guidance, three were not sure, whereas two did not notice any changes in the family. The reported changes fall into the following categories: 1) A friendlier atmosphere, and 2) More conscious their way of interacting. The important thing here seems to be rising of consciousness so that the parents become empowered to focus on the positive, which again influences family life to become more harmonious: "*We can handle stress better; have more fun togethe*r".

A friendlier atmosphere:

44 % reported less nagging and an overall friendlier atmosphere at home: "*It is a nicer atmosphere. We focus more on the positive about the children. Have helped us to become aware of positive regulation. The tone of voice has become lower*". The feedback generally suggests that ICDP made the parents more positive, resulting in a *"more connected family"*.

More conscious:

Following that parents report that they are more positive, 41.6 % reported increased harmony at home after the parental guidance as the parent(s) had become more conscious their way of interacting. As one parent put it: *"Reflect upon and are more conscious of having good interaction with the child. Have become more patient and including*", or as another parent put it: "*We are more in harmony – use the programme as a reference*".

Changes in the child

62 parents gave qualitative feedback to this question and most agreed that the child had changed. 58 parents reported changes in their child after participation in parental guidance, whereas four were not certain. The reported changes fall into the following categories: 1) Positive changes in child because parent changed; 2) Improved mood in child and improved atmosphere; 3) Child cooperates better/less conflicts; 4) Other/Don't know.

Positive changes in child because parent changed:

30.6 % of the responses were about changes in the child-parent relationship. These parents noticed changes in their child as a consequence of their own changed behaviour: "*Safer/ happier mom who influences my child more positively"*; *"Routines are easier because I am aware what kind of conflicts that might arise".*

Improved mood in child and improved atmosphere:

30.6 % reported that the child had become happier and less angry, and that there is a better atmosphere. The following quotes are examples of responses within this category: "*The child seems more patient and less angry/irritated"; "More harmonic, less angry".*

Child cooperates better/less conflicts:

16 % of the participants reported that the child cooperates better, and is involved in fewer conflicts, e.g. "*There is less arguing and conflicts between us"; "Calmer, both mother and child are less hot-tempered"; "Fewer conflicts*".

Other:

11 % noticed other changes, for example that the child took more initiative towards the parents ("*to get our attention to things she finds interesting"* and *"eager to tell things, want to show me"*). Another parent reported that "*yes, believe that the oldest boy is more externalizing towards me because I'm different; more consistent and not as indulgent*". This suggests that children and interaction might worsen before improving and that the children feel freer to express themselves, also negatively.

4.3 Summary and concluding remarks

The ICDP programme has significant positive effect on parents, parenting and parent-child relationships. Questionnaire data suggests that the ICPD intervention have a positive effect in the form of increased activities with the child, increased engagement, and improved parenting strategies. There is an improvement in caregiver's attitudes towards child rearing and perceived ability to actually manage their child. The intervention furthermore seems to reduce loneliness, as parents score lower on this after the ICDP intervention. Parents furthermore report less impact of their child's difficulties and less household commotion after the intervention. Parents report increased confidence in their parental role; less nagging, less conflicts, better emotional contact, increased positivity, better atmosphere and more harmony. The programme appears to reach caregivers in need since caregivers in the intervention group had lower scores than the comparison group on many of the baseline outcomes. An alternative explanation to the differences at baseline scores could be that those with higher education consent to participate in research that does not directly involve them to a larger degree than the less educated. This difference also raises the issue that greater changes in the intervention group could be a consequence of caregivers in the intervention group having more room for improvements.

There does not appear to have been an improvement in providing meaning for the child's experiences and showing loving feelings. This is important as it is an explicit aim of the programme. This may indicate that the message has not come through, or that the responders take for granted that she or he is already fulfilling these criteria for good care. Despite this

array of findings, some caution should be used in generalizing the data giving the particular research design and the response rate at follow up.

5 ICDP intervention for minority groups of caregivers

There is evidence of cultural variation in parenting styles in caregivers from western and non-western ethnic minority groups (Kagiticibaci, 1996). Hurley et al. (2008) found that African American mothers monitored less but showed more warmth, better communication, and more behavioral control, and higher self-efficacy than European American mothers. Some studies indicate that ethnic minorities from traditional societies tend to adopt a more authoritarian and controlled style of child rearing demanding respect, obedience and loyalty to the family collective from the children. This style clearly conflicts with the dominant liberal style of child rearing in Scandinavian countries (Sommers, Pramling & Hundeide, 2010).

Studies have shown the importance of disentangling ethnic and contextual factors when looking at interventions, parenting styles and child outcomes. In a recent UK study of 4,349 ethnic minority pupils, minority groups had lower care and higher control scores, but perceived quality of parenting was a correlate of psychological difficulties for all ethnic groups irrespective of reporting differences. The authors therefore conclude that programmes designed for supporting parenting will be effective regardless of ethnicity (Maynard & Harding, 2010). On the other hand, some studies suggest that parents with a minority background benefit less from parental interventions (e.g. Bailey, Nelson, Hebbeler & Spiker, 2007).

The groups of caregivers selected for parent targeted intervention varies (Prinz, 2009) and it is important to understand whether subgroups of the population have special adaptation needs in order for them to be maximally effected. The literature on parenting and family understanding is disproportionately based on western samples (Abdou et al., 2010) and there is a growing need for understanding ethnic minority interventions and their efficacy [2]. Furthermore there is a specific need to understand tailored interventions as the literature shows that general programme implementations may suffer from lower uptake and completion from ethnic minority groups (Lavigne et al., 2010) with fewer programmes and evaluations tailored specifically to the needs of ethnic minorities residing in the general population.

Much of the literature emerges from the US (Pinderhughes, Nix, Foster & Jones, 2007) where factors associated with ethnic minorities may differ from Europe and Norway. Within the latter contexts there are often issues associated with new arrivals, previous experiences of social unrest and language/cultural hurdles faced by ethnic minority groups. Parents may lose respect when the children become more knowledgeable about the Norwegian society and language than themselves (see the ICDP minority manual (Hundeide, 2009) for a discussion about this). Indeed there may well be a number of additional factors which contribute to parenting style, caregivers' insight, abilities and competence.

The ethnic minority study

The programme was delivered to ethnic minority groups and basic Norwegian groups. In the minority intervention the facilitators leading the groups are selected from the same ethnic group that they are going to lead and the discussions are all held in their local ethnic language. In in 2004, a pilot study was accomplished within the minority version of the programme (Hundeide & Hannestad, 2004), and the minority manual was made based on the findings from the pilot study. The minority implementation is suggested to be carried out in accordance with the minority manual. As recommended by ICDP and the Directorate, most minority

[2] Ethnic minority is not necessarily a unified group. One has to distinguish between ethnic minority groups coming from traditional non-industrialized societies compared with modern ethnic groups (see LeVine & White, 1985).

groups had 12 meetings as compared to eight meetings in the basic programme. Part one (4.1) will present findings from a quantitative pre and post investigation, whereas part two (4.2) will present qualitative interview data from minority caregivers attending ICDP groups.

5.1 The effects of ICDP

Procedure

Facilitators convening groups were recruited via phone calls by the evaluators, and all minority caregivers were asked whether they would participate in the study. The researcher took part in the first group meeting in all but two groups where trained facilitators gave oral information about the study and administered the questionnaires. Pilots showed that minority groups of caregivers needed 1.5-2.5 hours to fill in the questionnaire. The parents were therefore asked to fill in the questionnaire at home before the second meeting in order not to take too much of the group time for the evaluation study. The facilitators collected the questionnaires in sealed envelopes and sent them to the project office. The post questionnaire was either handed out at the second to last meeting and collected by the researcher or the facilitators at the last meeting, or distributed at the last meeting for the parents to complete and send to the research team themselves.

Description of the sample

Of the 21 minority groups included in the study, 15 were in Urdu, one was in Kurdish, two were in Tamil, and one was in Arabic. Two groups in Kurdish were cancelled due to low participation at the first meeting. One of the groups in Tamil did not answer the questionnaire due to poor Norwegian skills, and the other Tamil group was cancelled half way into the

course due to external reasons, which resulted in pre data only from this group. Of the six participants from the Arabic group who participated at the pre phase of the questionnaire study, only one participated in the post phase. The minority sample in this report therefore mainly includes immigrant women from Pakistan, of which the majority are first generation immigrants with poor Norwegian skills.

75 participants from the minority version answered the pre questionnaire, while only 31 (41.3 %) answered the post questionnaire. This is slightly lower than the basic group who had a 54.8 % post rate. The fact that all post questionnaires were filled in at home for the minority groups may explain some of the variance in post rate between the minority groups and the basic groups. Male caregivers were also asked to participate. However in the ethnic minority groups only three males attended, which was insufficient for any gender comparisons to be made. Thus the data from these three males was excluded. The comparison group comprises 105 female caregivers attending the basic version of the ICDP to ensure that they were matched on gender.

Findings

The data shows that at baseline, before the intervention, caregivers from the ethnic minority group were significantly less likely to have a higher education than caregivers from the basic group (14.3% vs. 55.2%). They were also more likely to work at home (74.1% vs. 4.9%) and less likely to be employed full time (3.7% vs. 65%) than caregivers in the basic group. They had more children (59.1% vs. 23.5% had three or more children), and more people in the home (68.8% had five or six people in the home vs. 20.8% in the basic group and 31.3% had four or less people in the home vs. 79.2% in the basic group). This indicates a traditional pattern regarding roles in the minority sample. There were no other significant differences in terms of demographic variables (civil status, gender of focus child, child having a television/ computer in room, number of televisions).

The findings also indicated that at baseline caregivers in the ethnic minority group on the one hand generally appeared to be more involved, more likely to score high on positive discipline

and to interact more with their children compared to the basic group. The ethnic minority group furthermore scored higher on life satisfaction and happiness with their partner and scored lower on anger (also tending to score higher on positive emotions). On the other hand, the minority mothers were less emotionally engaged and they scored higher on distant child rearing than mothers attending the basic ICDP group by being more likely to agree on the parenting strategy items: "I set limits without explaining why" and "my child does not always listen when I ask him/her about something" and less likely to agree in the items "I help my child make plans and carry them out", "I handle it well when my child becomes unruly" and "even when angry, I listen to my child". Minority caregivers also scored higher on anxiety and depression and had a lower number of social supports, and they reported that their children had greater difficulties than the basic group.

The effects of the intervention

This evaluation shows that there are several significant effects from pre to post measure which suggest that the ICDP parenting programme had a positive effect on both minority caregivers and caregivers attending the basic version on the following indicators:

- Positive discipline
- Parenting strategy (including: "I help my child to focus his/her attention so that we have a mutual experience", "I provide a meaning for my child's experience of the outer world" and "I set limits without explaining why" (reverse coded))
- Child management (including: "I help my child make plans and carry them out", "I extend my child's initiative", "I handle it well when my child becomes unruly", "even when angry, I listen to my child"
- Less anger and anxiety for caregivers

Interactions between group and pre/post measurement indicated an improvement from pre to post intervention for the ethnic minority group only. This applied to the child rearing items:

- "I regard myself as a good caregiver"

- "There is no reason to talk to my child" (reverse coded)

The first effect is important as this is a specific aim of the ICDP programme, and the last effect is particularly positive given that caregivers in the minority group were more likely than the basic group to agree that there is no reason to talk to their child at baseline.

The groups of caregivers attending the basic version and the minority version of the ICDP implementation differed not only in their baseline characteristics but also in the impact of the ICDP intervention on their post intervention outcomes. The results are not straightforward. Both groups showed an effect of ICDP in changing outcome measures such as the above findings and guidelines for interaction. However, ICDP had a different impact on the minority caregivers compared to the basic Norwegian caregivers on some specific variables where there was little change or a slight increase in scores for the basic group, while scores worsened for the ethnic minority group. For instance, the minority group scored higher at baseline on life satisfaction and happiness with their partner but this difference narrowed after the intervention as their scores decreased and scores from the basic group slightly increased. The minority group was less likely than the basic group to agree that they set limits when their child behaves badly at baseline and they were even more likely to disagree with this after the intervention. Furthermore, an increase in children's difficulties and decrease in child prosocial behaviour for minority caregivers following the intervention was reported, and this is a concern.

ICDP specific effects

There appears to have been improvement for the minority group related to the following ICDP guidelines for interactions (bold):

EMOTIONAL DIALOGUE - Guidelines 1, 2, 3, 4:

1. Show your child you love him or her

2. Follow your child's lead

3. Talk to your child. Get a conversation going my means of emotional expressions, gestures and sounds.

4. Praise and appreciate what your child manages to do

COMPREHENSION DIALOGUE - Guidelines 5, 6, 7:

5. Help your child to focus his/her attention and share experiences

6. Help your child to make sense of his/her world

7. Help your child to widen is/her experiences

REGULATION DIALOGUE - Guidelines 8a, 8b:

8a. Help your child to learn rules, limits and values

8b. Help your child to plan activities step by step to reach the set goal

5.2 Interviews

Participants and procedures

Parents attending the minority version were recruited for interviews during the last group meeting. The interviews were conducted within a week after the last meeting. All interviews were conducted by the same interviewer at the same place as the ICDP intervention took place.

A total of 24 participants attending the minority version of the ICDP programme were interviewed. 12 (11 mothers and one grandmother) were Pakistani which had attended an Urdu group, and this mirrors the high number of ICDP interventions directed at the Pakistani minority in Norway, usually in Oslo. Interviews were also conducted within three other groups of languages, namely Arabic (3), Burmese (4), and Tamil (5). A translator was used in 16 of the interviews (see table 7). The average length of an interview was 25.44 minutes.

Table 7: *Number of interviews and the use of translators in the different languages*

Translator	Urdu	Tamil	Burmese	Arabic
Yes	5	4	4	3
No	7	1	-	-

Findings

Multicultural families face challenges due to different cultural practices and expectations, and daily stressors regarding parenting might be difficult. This was expressed by the mothers during the interviews: "*I was a bit distraught at the beginning about whether I should give them our culture and parenting, Pakistani culture, or whether I should give them the Norwegian culture"* (interviewee 15). All but one interviewee were first generation immigrants, and even though most of them had lived in Norway for many years, the majority needed an interpreter, indicating their limited acquaintance of Norwegian culture in general and ethnic Norwegian people in particular. By having an ethnic Norwegian facilitator in addition to the facilitator speaking the mother tongue, the parents were allowed to discuss cultural issues, similarities and differences, which was expressed to be positive experienced. However, parents would welcome more focus on Norwegian practice: *"It would be nice if we had examples or explanations of the Norwegian way of doing it. It was too little focus on that, when it comes to Norwegian parenting and stuff"* (interviewee 16).

Log book data supports this finding. In one of the groups which handed in their log book for evaluation purposes, more involvement of the ethnic minority facilitators was an expressed wish throughout the group implementation.

> "*The bilingual facilitator asked for more activity from the two ethnic Norwegian facilitators. She said that the women are interested in learning more about how we do things in Norway. The two ethnic Norwegian facilitators felt that it was difficult to interrupt conversations were the participants were eager (...)*" (log book, group ID 55).

In this group, the claim for more involvement from the ethnic Norwegian facilitators was partly solved by communicating in Norwegian when appropriate. This might be a possible pathway of including the ethnic Norwegian facilitator to a larger degree; however it is

important to keep the main discussions in their mother tongue in order to include also non-Norwegian speakers, and in order not to hamper the group process.

Psychological effects

The intervention had a positive psychological effect on the participants and their quality of life. Almost all of the mothers claimed to be less stressed now as compared to earlier:

> "*Sometimes, before I had the course, when I was busy and it was a lot of stress and stuff, I didn't listen to what the children said, or if they said anything, I was very stressed. But now I don't do that (laughs). Now I am very clever and I listen carefully at the children and what they say. And if I tell them anything, I do it slowly, or gradually, what we are to do during the day (...)"* (interviewee 19).

This not only influenced their relationship with their children and in some cases their spouses, it also influenced their concept of self and quality of life, as this woman expressed when asked if she had changed because of the intervention:

> "*As a person .. You know as a mom it is much about the children, but I do have changed as a person. Before I had this course I thought sometimes that there is nothing, it's nothing, and it's only stress. And now, now I'm trying, all the time. More positive. I think that all humans should have this course. You see, I have no family here"* (interviewee 2).

The interviewees generally recommended that all parents should go through ICDP, and many would like to participate in an ICDP group again if possible. The ICDP programme engages and appeals, and this can be exemplified by a funny incident which took place during an interview when the interpreter said: *"This actually sounds very exciting. I have three children myself (...). Do you know if there is such a course in /name of city/district?"*

The citation above (interviewee 2) points to an important aspect, namely the importance of meeting others. Most of the interviewees stayed at home and some of them had little contact with the outside community and had few or no friends before attending the ICDP group.

"*I don't have a large network, but after I attended the course and after my son started in kindergarten, I have got to know people"* (interviewee 14). In many instances the women would keep in touch with one another after finishing the course: "*I've gotten to know everyone and everybody is very kind and it's nice to keep in touch with them"* (this woman's' face lights up while she mentions the names of all the women in the group) (interviewee 4). For some, the social component of the intervention made an important difference in their lives. At the end of the interview, when asked if she had any additional experiences she wanted to share, one woman said:

> "*It's been so useful. I was pretty antisocial before. I had no friends. My husband was at work. The only activity we do together is on Saturdays. Then we go out together me and my husband. I had no friends, knew no one before I entered the course. Here it was a lot of meetings and agreements and I could feel as a social type. My life changed after the course. So it's not just that I've had benefits for the children, but also for myself and my life"* (interviewee 5).

Increased parental investment

Interview data shows that the mothers spend more time with the children after ICDP guidance. Some mothers talked about the social expectations of frequently having visitors, serving food and giving visitors their full attention and how this might go on the expense of the children. When asked *"Have you changed yourself in any way as a result of the course?"* one mother talked about this issue:

> *"Yes, I feel so actually. When it comes to children. I have noticed that I've begun to think more. Although my kids are small, I have started to think more about how it should be at home. That we should have rules and stuff. To spend more time with the children. Thus, for us it's the kids first. And at Pakistanis there is a lot of visits and one make a lot of food when you are together and stuff. And then you don't know where the children are, right. When the children come to us we push them away, and "no, I have to make ready supper." As we talked about on the course we use*

one day to clean, one day to cook, and one day to tidy up after the guests have gone. (...)" (interviewee 13).

When asked if her child had noticed this change in any way, she gives an example to illustrate this:

> *"Yes, when I, before the ICDP-course, I had bought a puzzle. But he was just throwing all the pieces. But after* (the ICDP) *I sat down with him and we played and puzzled together. And then he was so clever. He could do it so quickly. All of them* (the puzzle pieces). *And then I felt that it was because I gave him time and that we sat together"* (interviewee 13).

Hence, more time and more attention given to the son had already made noticeable changes. Changes in the child were reported by others as well, for example by a mother that prioritize her son more after intervention by spending more time with him and by being more talkative and more open towards him: *"Yes, he's more happy, cheerful and satisfied than he was before. When he sees that "I am seen, I am prioritized and I am being heard." So I see changes in him as well* (as in myself)*"* (interviewee 14).

Redefinition

Redefinition of the caregiver's conception of the child was reported in line with the programme aim, as a more positive conception of the child and by seeing the child more as a person. This was expressed through quotes like

> *"I learned a lot on how to talk to my child and to meet the needs of children. And (...) understanding that he is a human with own needs. You shouldn't just treat the child as a chair in the house, like "no, they have no feelings, they don't have any meanings", but rather be a part of the children, to see them, and cooperate with them*" (interviewee 5).

This is important as the way the caregiver perceives the child is connected to what kind of care the caregiver gives to the child, and this is a specific aim and a central part of the ICDP

programme. Hence, a positive change in the conception of the child will influence changes within the emotional, comprehensive, and regulative dialogue. A redefinition of the child can in some instances result in giving the child more freedom to follow own wishes, as experiences by the daughter of a mother that had undergone ICDP training:

> "*One of the participants told that she had never decided anything on her own; neither during her childhood, or in her marriage. (...) Her adolescent daughter, aged 16 years, asked who she should be marrying. The daughter became very surprised when the mother answered that she could decide herself. (...) The mother told that she would not have given this answer if she hadn't been through ICDP guidance"* (log book, group ID 49).

The emotional, comprehension, and regulative dialogue

Following a changed focus on the child and parenting, the mothers reported improved relationships with their children. They now feel closer to the child, and one mother expressed her love to her son more often and vice versa: "*(...) It's hug, hug, and "I love you", and like "I love you too". And he has begun to say that quite often! But perhaps that's because I have begun to say it too. That he has noticed it (...)"* (interviewee 17). As the quantitative data also suggests, minority women particularly improved in their communicative dialogue with their children. The interview data shows that the mothers generally communicate more and more positively and openly with their husband and with their children after the ICDP intervention, also about emotional issues. For one mother, this had made important changes in her son's life: "*My oldest son easily became nervous, failed to cope with situations, but after I have taken this course I have talked with him, and it has become much better. He dares and he is coping"* (interviewee 18). By being more open and talkative towards the children, children become more secure and also more open towards their mothers: *"So when I've been more open with the children then the children are more..., easier for him* (son) *to come to me and say "mom I'm sad" and stuff like that"* (interviewee 5).

Several mothers expressed earlier communication as being characterized by scolding, and that they now were more able to gain greater control over their own negative emotions. Corporal

punishment was only directly expressed by one caregiver, however minority facilitators reported that many minority caregivers stop using corporal punishment such as hitting after the ICDP guidance, but they do not dare to report it, neither in questionnaire format or in interviews because of its illegal nature. The parents reported that they had become calmer, which had the effect of less screaming and scolding, and this was reported by almost all of the interviewees. One mother expressed this in the following way:

> "*Yes, there have been improvements with everything. Home related work,* (child's) *homework, cooperation. I use the method for everything, so they* (children) *are happy. Also, I use this method on my husband* (laughs). *Before I complained about him, really, and screamed at him. Now I use the method and try to talk to him calmly, as I have learned at this course. It's very good. It becomes calmer and less screaming between the two of us* (interviewee 1).

Some mothers had introduced more routines, for example to take the children to bed at ba certain time, and by explaining why it is time to sleep. The bed time was now valued as quality time between the mother and the child, as this was the time for exchange of experiences through the day as well as time for story-telling and reading:

> *"It is much easier with the new routines. Before it was a bit like a problem to put him to sleep. He remembered in the last minute that he would like to watch TV and stuff like that. But now I promise him that I'll read a little book for him, and then he's happy and doesn't complain for having to go to bed (...)"* (interviewee 5).

5.3 Summary and concluding remarks

The ICDP intervention performed well in the strengthening of minority mothers' parental role as well as improving their self perception. The data shows that the mothers felt more confident, secure and positive after the intervention, and this contributed to a calmer frame of mind. The intervention made the participants more reflective resulting in improved parental investment exemplified by giving more attention to the child and by being more talkative and explain more. The improved relationship resulted in changes in the children as well, and it was reported that children had become calmer, happier, more open, and more cooperative. In addition, the distal effects of meeting others and speaking openly about child and family related issues and getting support from others were of huge importance, and several mothers

said that they are happier, have higher life quality, are less depressed, are less angry, and more positive. Some of the women participated in the ICDP group without their husbands knowing as they would not have been allowed to participate. One should strive to offer ICDP guidance to males with a minority background, and this was also suggested by several of the mothers.

The decrease on some measures from before to after intervention in the minority sample study may be explained by a higher sensitivity toward the child and child rearing which allowed caregivers to be more self critical and also to see child behaviour in a more critical way. This possible made the mothers more realistic about their life situation. Such effects can also be explained from the responders being more sincere after the intervention. It is also possible that some elements in the demanding caring environment deteriorate, despite the ICDP intervention. It is important to note that ICDP has benefits as well as limitations and future development of the ICDP intervention may concentrate on these elements.

However, it is not only a question of adapting the programme to the specific nature of the ethnic minority group, but also a question of the appropriateness of indicators and diagnostic tools from an Euro-American background. Moreover, the length of the questionnaires could also potentially influence the results due to responder's fatigue. The sample size for caregivers in the ethnic minority group was small, mainly from one ethnic group, and males were not included. One should therefore be cautious in generalizing the findings to all minority caregivers attending ICDP.

6 ICDP intervention for incarcerated fathers

Imprisonment has a multitude of effects on family members, and children of incarcerated parents have an increased risk of criminal behavior (Gabel & Johnston, 1995), behavior problems, substance abuse, and school failure (Murray, Farrington, Sekol & Olsen, 2009 for a review). Most studies of incarcerated parents are from the United States and one cannot generalize findings from American prisons into a Norwegian context, as different legislation as well as physical conditions and prison culture vary. The role of the father and the expectations of fathers may differ. There are generally few studies on the prison situation in

Norway and no studies have been reported looking at parenting programmes within Norwegian prisons.

There were approximately 3,387 persons in prison in Norway in 2009 (Statistics Norway, 2009), and about 2,000 of these are parents. They have an average of two children each, implying that about 4,000 children in Norway have one parent in prison, most often a father, as only a small number of the incarcerated are women (for example 150 in 2004) (Talseth, 2004). In line with findings from other countries, Norwegian inmates generally score lower on educational level, and higher on psychological and physiological problems, troublesome childhoods, substance abuse, and economical and residential problems. Two of three experienced at least one serious difficulty during childhood, for example 30 % have been in contact with the child protection system during childhood and another 30 % have experienced the imprisonment of another family member (Friestad & Hansen, 2004). Furthermore, half of young inmates with non-western backgrounds in Norwegian prisons are at risk of deportation (Hjellnes & Torunn, 2007).

Literature suggests that parenting after release is challenging, and many parents have a strong desire to "get it right" (Frye & Dawe, 2008). This proposes that there is a need for parenting interventions during prison stay. By empowering incarcerated parents as well as opening up for new learning's, such programmes could buffer some of the risks that children of incarcerated parents often meet during their childhood. Eddy et al. (2008) reviewed prison based parenting programmes and noted that most programmes provide information about communication skills, parenting techniques and child development. Visitation opportunities were often included and a focus on parenting in prison was a part of most programmes. Prison programmes have recorded significant improvements in interactions, adaptation and parenting skills (Thompson & Harm, 2000).

The prison study

Part one (5.1) will give a presentation of a quantitative study with questionnaires administered to incarcerated fathers before and after ICDP guidance and to a comparison group of males from the community sample that received the basic ICDP program. In order to put the ICDP enrollment for this group of parents into context, part two (5.2) will present the implementation as well as reception and perceived effects of parental guidance on parents based on data from semi-structured interviews.

The start up of parental guidance based on the ICDP programme in Norwegian prisons was decided at a political level in 2004, with a start up in 2005. A report from the Ministry of Children and Equality on children's rights states that "*all prisons should be able to offer this* (parental guidance)" (BLD & UD, 2008, p. 52). During the study period, six prisons out of 67 (Kristoffersen, 2010) were working with parental guidance/ICDP on a regular basis. The ICDP groups in prisons are run according to the basic version of the programme with a focus on the specific issues raised in the prison facilitator education, which is based on the results from a pilot study run in prisons in 2006 (Egebjerg & Flakk, 2006). The facilitator training is presented through group lectures about the families of the incarcerated, and the purpose of parental guidance in prisons; contact with children when incarcerated, and a short introduction to child development with particular focus on psychological reactions to separation, longing and loss. Furthermore, practical components of running groups for parents in prison and special challenges of working with inmates with ethnic minority backgrounds are discussed as part of the ICDP prison facilitator education (Egebjerg & Flakk, 2006).

However, there are no manuals specifically designed for prison facilitators. Most prisons make smaller or bigger adjustments. As one facilitator said: *"We went on with the parental guidance and tried a group which we ran by the book with the eight guidelines, and we were not left with a good experience. (...) I think it was very limited. Because the boys* (inmates) *don't have the daily contact* (with the children) *and then it becomes difficult"* (interviewee 79). This makes it difficult to know the exact effect of the ICDP implementation in prison, as the sample is too small to look at variations in effects based on the implementation quality. Caution is therefore needed when interpreting the results.

6.1 The effects of ICDP

Procedure

ICDP training was provided to two groups of fathers, one drawn from males from the community according to general availability within the basic variant of the ICDP programme, and the other drawn from male prisoners who voluntarily signed up for the ICDP course offered by the prison. The parents were either recruited into the evaluation project by the researchers during the first meeting (77.8 %), or by the facilitator who was trained in the administration of the questionnaire. The incarcerated fathers were given oral as well as written information, and those who consented to participate in the evaluation filled in the questionnaire before or during the first group meeting, and then again after the course or during the last group meeting. The questionnaires that were administered to the prison groups were not specifically designed for a prison context, hence some of the questions were not appropriate due to the imprisonment situation. Questions and scales that were obviously not appropriate in this context were removed after piloting the questionnaire in prison.

Description of the sample

At baseline, 64 from the basic intervention group and 63 from the prison intervention group participated. At the post-assessment period, 61 (48 %) participated; 36 from the basic group and 25 from the prison group. These 61 participants with pre-intervention and post-intervention data form the basis of the main analyses. Given the fact that no mothers completed the post questionnaire, this report only set out the results for incarcerated fathers.

Findings

Baseline characteristics

To our knowledge, a total of 87 incarcerated fathers and 11 incarcerated mothers went through ICDP intervention during the data collection period. Four groups were composed of both mothers and fathers, whereas 14 groups were fathers only. At baseline, male caregivers in the prison group with pre and post data were significantly less likely to be married or with a partner (56 % versus 80.6 %), or to be in higher education (16 % versus 69.4 %), or to be employed full-time (48 % versus 86.5 %) than males from the comparison group. Caregivers in the prison group were also significantly more likely to have three or more televisions' in the home (50% vs. 16.1%), and the children were significantly more likely to have a television in his or her room (24 % versus 5.6 %).

At baseline, caregivers in the prison group reported more positive attitudes towards child rearing and better child rearing skills, they were more likely to engage in positive discipline, and were more engaged with the child than caregivers in the basic group. They also reported their children to be more prosocial. However, they suffered from lower self-reported health, quality of life, life satisfaction and self-esteem, and felt worse emotionally as well as more anxious and more depressed. Between-subjects effects that were found as part of the main pre-post analysis also support these conclusions, with the exception of the significant finding that incarcerated fathers were less likely to set limits when their child behaved badly than male caregivers from the community sample.

General effects of the intervention

The intervention appears to have had a positive effect on all caregivers in terms of

- Emotional engagement
- Parenting strategy ("expand my child's experiences", "help my child focus his/her attention so that we can have a mutual experience" and "my child cannot play alone for more than ten minutes")
- The child's distress and social impairment resulting from child difficulties (SDQ impact score)

- Some aspects of child rearing (the items “I dominate in games/interaction with the child” and “not certain of myself as a caregiver”, and “when with my child, we often have to break off because I have other things to do”)
- A borderline effect was also found for “provide meaning for my child’s experience of the outer world”

Yet, incarcerated fathers also showed a decline in health, quality of life, life satisfaction and greater agreement with the child rearing item “my child cannot start a game by him/herself” from before to after the intervention, while caregivers in the basic group showed only a slight decline (or slight increase for the child rearing item), or no change in these outcomes. Additional interactions between group and time of measurement for the positive discipline item “congratulated them for finishing a difficult task”, negative emotions, anger, anxiety and the child rearing items “often join a game my child started”, “help my child make plans and carry them out”, “handle it well when my child becomes unruly”, “even when angry, listen to my child”, indicate that while caregivers in the basic group improved on the outcomes, caregivers in the prison group worsened. Interestingly, caregivers in the prison group initially scored higher on these child rearing items than caregivers in the basic group, which was no longer the case after the intervention, with the difference narrowing or changing direction.

ICDP specific effects

There appears to have been improvement for the prison group related to the following ICDP guidelines for interactions (bold):

EMOTIONAL DIALOGUE - Guidelines 1, 2, 3, 4:

1. Show your child you love him or her

2. Follow your child's lead

3. Talk to your child. Get a conversation going my means of emotional expressions, gestures and sounds.

4. Praise and appreciate what your child manages to do

COMPREHENSION DIALOGUE - Guidelines 5, 6, 7:

5. Help your child to focus his/her attention and share experiences

6. Help your child to make sense of his/her world (not significant trend)

7. Help your child to widen his/her experiences

REGULATION DIALOGUE - Guidelines 8a, 8b:

8a. Help your child to learn rules, limits and values

8b. Help your child to plan activities step by step to reach the set goal

6.2 Interviews

Participants and procedures

20 interviews were administered to incarcerated participants who volunteered to take part in the study by ticking "yes" in the post questionnaire for interview about parental roles and the ICDP participation. Alternatively they were recruited by the researcher who had participated at the last group meeting. An interview time was agreed upon, no longer than one week after the course was due to end. All interviews were conducted by the same researcher at the same place as the ICDP meetings were held, or in the prisons' visiting room. The interviews were conducted one to one with one exception where a prison guard needed to be present because of prison rules. Each interview lasted an average of 30.38 minutes. The findings are presented

together with the facilitator data in order to get an understanding about the implementation and reception of ICDP training in prisons.

Facilitators from the six prisons included in the study were contacted and asked to participate in an interview study about the programme implementation. Seven interviews were conducted over the phone by a research assistant who knows the ICDP programme well. The interview guide comprised questions about the programme implementation in prisons, and how they like working with the programme. The average length of an interview was 41.5 minutes.

Findings

Contextual factors influencing programme implementation and impact on parents

Prison facilitators and incarcerated parents reported several factors influencing the susceptibility for programme implementation and hence the potential for impact on the parents. These factors can be divided into four main themes, namely 1) possibilities of seeing the children regularly, 2) visiting contexts and regulations, 3) harshness of the prison regime, and 4) financial constraints.

Two out of the six prisons in the current study adjusted for parent-child contact during the course period by offering additional contact, for example with trips to a cabin or a swimming pool. In such cases the incarcerated parents would have the possibility to do home tasks and discuss these experiences at the next meeting as recommended by the ICDP programme. This is also the standard practice in the basic ICDP implementation. Facilitators and parents report great benefit for the children and parents who participate in trips outside of prison with the ICDP group. For the child, the father becomes more apparent; for the father, his parental role is being confirmed; and for the mother on the outside this often means some hours or a weekend off:

> "*She* (the mother) *has been very grateful for the dad group, and she has said that she notice on* /name of child/ *that he is happy when he arrives home, so. And tired*

and sort of, yes.. And we relieve her actually, that Saturday. She is free to do whatever she wants, and that's good. The fact that dad also has one day, and in a way can be a (real) *dad*" (interviewee 34).

In father-child relationships where contact is absent, changes in parental self-esteem, knowledge, attitudes and/or behavior are less likely to manifest and probably more difficult to measure. Inmates from the four prisons which did not offer additional contact met their children in the prison visiting room. § 31 in the prison law (The Execution of Sentences Act, 2004) states the prisons responsibility for having visiting rooms designed for children. However, the visiting conditions in the prisons included in this study were generally of poor quality with small rooms with few toys and this was highlighted by several of the interviewees. This concern is also raised by the Norwegian Church Aid: "*Children of inmates suffer because the government haven't adapted better for visitation with parents in prison*" (Bakker, 2010, p. 10).

Furthermore, a harsh prison environment makes the implementation more difficult as the focus easily switches over to critique and confusion about the prison, and this was evident in one prison in particular. One father explained it like this: "*It's no fun to be in jail when you have children, it's not. But you got to make the best out of it. And the prison is to adjust for that, something they do to a limited extent. (...) Here it is safety before everything. So they don't give a shit about children. And that's not right. (...)*" (interviewee 10). Finally, the lack of economic resources and earmarked funds for programme implementation might influence the implementation quality and facilitator's motivation as well as the security level of the prison, as raised as a concern in one of the collected log books. The lack of earmarked funds also makes the implementation too person dependent. A co facilitator is "*alpha and omega"* (interviewee 72) in order to work with the ICDP programme in prisons. Most of the prisons in the present study have two educated facilitators only. This is highly vulnerable situation and the data shows that the ICDP guidance easily falls apart as is specifically evident in one prison where the implementation falls short when the key person is absent.

The implementation

Facilitators talk about the ICDP work as something they do with pleasure. As one facilitator eagerly said: "*This is not something we need to do. This is something we want to do as we are deeply passionate about this. It's that simple. Doesn't it sound wonderful*?" (facilitator interviewee 66). Parental guidance differs from the other work they do in prisons. They see noticeable effects on the incarcerated parents, and this is described as rewarding and motivating: "(…) *it's rewarding in the sense that we see immediately results, unlike a lot of other groups or programme activities"* (facilitator interviewee 79). Recruitment of participants to ICDP groups happens through direct contact or through advertising. Unlike many facilitators working in the community, facilitators in prison do not have difficulties in recruiting according to facilitators interviewed for this study. Rather there are waiting lists, and the fathers often want to take the course several times, of which some of them do. This might partly be explained by the extended visiting benefits.

The motivation that is expressed above is important in order to work with this program in prison. In addition to the importance of a co facilitator, the facilitators find the network meetings motivating and it gives them a new enthusiasm to continue the ICDP work. One prison follow up the facilitators by giving them a kind of "debriefing" throughout the parental guidance course. This debriefing is thought to give the facilitator an opportunity to talk about difficult things that might have come up during group discussions as well as reflect upon their own role in the group. This is positively evaluated by the facilitators and in line with requests from facilitators from other prisons of more frequent follow up of them as facilitators.

Two prisons represented in the evaluation study gave the parents an extended opportunity to meet their children until they got released, also after the group meetings. However, none of the prisons gave any follow up in the ICDP program neither during the prison stay or after release. The need for follow up was highlighted as important by facilitators, and this is also

where the implementation has an improvement potential, according to parental interview data. One father explained the lack of follow up for him and his children:

> "*What I miss in this situation is that it's no way, it's not any continuity throughout the sentence. You maybe go from a closed prison to an open prison and then to a Correctional Services halfway house. But the children are sort of not taken into account along the way. So now I have a residence here on* /prison name/*, and I have this offer with dads' group* (ICDP)*, but it's nothing either before or after that in a way. (…) So I lose a little of that contact and I feel that it's a little silly that this isn't taken into account, because then he* (youngest son) *loses me somehow again. And I lose my children again. Because now we have very good contact. So it would have been nice to follow up on that contact in a way"* (interviewee 33).

This sudden stop after the eight meeting might be difficult to handle, both for the parent and the child, and may even be a possible a step backwards for the rehabilitation process.

Sensitive content

Parenting from prison raises several challenges and concerns for the interviewed fathers. The fathers were generally afraid to be forgotten: "*I'm scared to death to be forgotten*" (interviewee 31), they felt guilty for being away from the child, they suffered from an external locus of control as what they know and are being told only are a fragment of the reality: "(…) *I don't know what is going on. What they tell me is just what they choose to tell me, right*" (interviewee 26). Furthermore, they feel guilt towards the mother who suddenly became a "single mother": "*I am married to a single mom, really. That's the way I feel. She has to do everything*" (interviewee 34). One father also worried about deportation, and this is in line with the high number of non-western migrants in Norwegian prisons in danger for deportation: "(…) *Suddenly they might decide that I will be deported for example. Then I won't see him* (the son) *at all, right. So I need to use the time I have. Nooo… This is extra hard. I don't know anything about what the future will bring*" (interviewee 26). They worry about their children, and how their incarceration influences them. One example of this is given in a log book: "*X had something that burdened him a lot that he needed to tell. His son*

had been called "drug kid" at school. He (the incarcerated father) *clearly expressed that this bothered him a lot, and this was also evident in his body language*" (log book, group ID 17).

The topics that ICDP raises, and the discussions, reflections and thoughts they facilitate are therefore very sensitive for most of these parents. The prison facilitators' seem to be careful and attentive towards these emotions as well as able to resign from their prison staff role and take on the role as a fellow human being. When the focus is on the children, and when the facilitator uses him/herself and experiences with their own children, the parent role becomes more prominent than the prison officer role. This can be explained through a feeling of sameness to a larger degree when the incarcerated and the prison officer have that one important thing in common.

The impact of the intervention

All of the interviewees wanted to make an effort to be a good parent to their child, and the support from the group and the facilitators of the fathers as important persons in their child's lives, empowered and motivated them to make an even bigger effort to parenting. Many would like to take the course again, and some fathers argued that it should be obligatory: "*I think it should be like obligatory. For everyone who have children. Particularly in prison (...)"* (interviewee 27).

The data show that the effect of the intervention on incarcerated fathers was:

1) <u>The psychological importance of an arena to talk about the child:</u> The fathers put emphasis on the importance of getting the opportunity to talk about their children:

> "*In beginning it was maybe, not embarrassing, but like "should I really speak openly for people I don't know". But when the others started to talk about their issues, it because much easier to talk about everything you worry about. And it helps to have a group that listens. And we had that*" (interviewee 36).

2) To be supported as important persons in their children's lives: Some of the fathers expressed that they are afraid to be forgotten:

"*Sometimes, my girl abandoned me, she was doing something else and didn't want to play with me, or she didn't want to talk with me in the phone. It was terrible. (..). But I have, during the* (group) *conversations, they have told me, that kids are like that*" (interviewee 31).

3) To gain new knowledge: Some fathers reported that they have learned something new during the guidance course, for example this father of a five years old boy:

"*(...) He's spoiled. Whatever he wants, he gets it. Whatever he says and they* (mother and grandparents) *listen to him, right. But now I have been in the group and learned how to set limits. Because I have given him everything, if he asked for a* (computer)*game for example, not really designed for children in a way, then I have said "yes, you will have it". Because I didn't want to see him cry. He gets everything he wants, right. So he is really spoiled indeed. But after the course I have learned that you should have some limits, in a way. Because it's not for me, it's in his best interest as well"* (interviewee 11).

4) To become more self-reflective and self-critical: The fathers reported increased consciousness in the way they relate to the child and the mother of the child. Incarcerated parents depend upon good cooperation with the co-family in order to arrange visits, and the interviewees described the mothers of the children as gatekeepers for father-child contact during imprisonment. One father expressed that he had become more aware of how he talks and relates to the mother. This interviewee, in a process to leave his criminal life due to the birth of his first child, tearfully said that "*I will need to work up more confidence before I get approval for her in a way"* (to meet the child) *and I just need to think of it as positive that the mother is skeptical. Then I know at least that the kid is doing fine*" (interviewee 51). Not only does this imply that the father had become more self-reflective, it also suggests that things might worsen before it improves, in this case the psychological health of the incarcerated father, through increased awareness about his relationship with his sons' mother.

5) To pay more attention to the child: Some of the fathers reported that they are more conscious how they related to their child and the attention they give to their child:

"*To spend quality time with the children, to put other things beside. This was something we didn't think about earlier. But during leave, after the dads groups, we suddenly have started to think this way*" (interviewee 34).

6) Noticeable changes: Noticeable changes were reported in themselves as caregivers, and some fathers also reported that their children have noticed positive changes in them:

"(…) *When I participated at the course, I learned a lot, very much. My children appreciate it as well (...) and my oldest daughter said to me "daddy, you have changed a lot". And it was nice to hear that from her*" (interviewee 12).

7) Impact on prison environment: An important distal effect of the ICDP intervention was reported by the fathers as well as the prison facilitators, namely that the opportunity to talk about their children impacted the prison environment:

"*When talking with inmates about what the outcome from the course was they said (...) that they actually sat in the living room or in their rooms and talked about their kids. And this was something new. They had never done that before. Then it was legal. Then it was all right to talk about the kids instead of fighting and violence and, yes" (facilitator interviewee 76).*

8) Strengthening of the relationship between the prison guard and incarcerated father: Finally, this way of working together (facilitator and inmates) is appreciated, as both parts learn to see the human side of the other:

"It was really fantastic (the ICDP). *Yes. And they do a really wonderful job the ones who run the programme. They give so much of themselves and that is why it became as it did, and I liked it (...)"* (interviewee 52).

6.3 Summary and concluding remarks

ICDP have a positive effect on incarcerated fathers by making them more conscious about their father role and the way they relate to their children, as well as positive effects on the prison environment. The intervention had positive effects on incarcerated fathers both in terms of emotional engagement, parenting strategy, the child's distress and social impairment resulting from child difficulties and some aspects of child management. The interview data suggests increased consciousness related to the relationship with the co parent. Cooperation and a low degree of co parent conflicts are associated with healthy child development, whereas a high degree of conflicts are associated with several risks. More focus should therefore be put in cooperation and communication with the co parent and other close family in ICDP prison groups. This would be in line with the facilitator's manual which states that the programme "*can also be used to raise awareness about interaction between adults, spouses, boss-subordinate etc.(...)*" (Hundeide, 2007, p. 4).

The incarcerated fathers scored better than non-incarcerated fathers on a variety of measures on child rearing and strategy at baseline. First of all, this has to be understood in the context of their life situation and the role their children may play in their life as hope and compensations for their absence and prior caregiver practices. Probably for that reason, they report more positively than the non-incarcerated comparison group at the start. Prisoners scoring themselves better than they are ("fake good") also appear in other studies (e.g. Haapasalo & Aaltonen, 1999). Secondly, as the ICDP uses a sensitization methodology, it might be that the incarcerated fathers' through the group process got a new frame of reference, and that their reports therefore became more realistic following the intervention. This explanation would be consistent with the observed improvements in parenting attitudes and behaviors'. An increased sensitivity towards the child's needs might explain the decline in outcomes relating to physical, emotional and mental well-being in caregivers in the prison group and the decrease in how they rate their own competence as parents. Results from an earlier evaluation of the ICDP (Bergen study) reported similar effects; the most vulnerable caregivers reported initially very positively but after the intervention their reporting became more realistic and less positive (Hundeide, 1994).

A programme does not work in a vacuum, and contextual factors and preconditions are therefore of importance. ICDP suggests the following cycle as a recommendation for improving interaction: 1) group discussions under the guidance of a facilitator, 2) caregiver try out the guidelines in interaction with the child, and 3) report and share these experiences. If only the first step is carried out, this will consequently influence the effect of the intervention as a whole. Prisons should hence strive for meeting these needs.

The sample size was small for each group, and females were not studied. One should thus be cautious in generalizing the findings to all caregivers attending the prison adjusted ICDP program.

7 ICDP intervention for parents of children with special needs

Parents of children who have special needs face challenges on top of ordinary parental challenges, and research suggests high degrees of psychological distress for parents of children with different types of disabilities (Sloper & Turner, 1993, Rye 2008; Tetzchner, Hesselberg, & Schiørbeck, 2008; Holten & Karlsen, 2008). The quality of parenting and parent-child interaction has been shown to influence the development of children with special needs. For example, parental characteristics are associated with neurobehavioral development, cognitive development, and social-emotional competence of preterm children (Treyvaud et al., 2009). The literature generally shows positive outcomes for intervention targeting parents of children with special needs (e.g. Whitton et al., 2008), for example in the presence of challenging birth outcomes such as pre-term infants (Kaaresen et al., 2007).

This is a qualitative study aiming to examine the ICDP intervention directed towards parents of children with special needs. The parental guidance follows the same procedure as the basic ICDP intervention; but usually uses 10 group meetings.

The special needs study

Parents participated at a semi-structured face to face interview after the last group meeting. Interviews were guided by an interview guide with key questions concerning how the ICDP intervention was received and if it had any effect on the participants or their children. One log book was handed in.

Participants and procedures

Semi-structured interviews were administered to seven parents; five mothers and two fathers. Four of the mothers were single parents, whereas the fathers were married, one of whom both parents participated in the ICDP group. The focus children had different disorders, including developmental delays, learning disabilities, intellectual impairment, autism, ADHD and cerebral palsy. The groups were broadly composed, and the interviewees differed not only in the age and the special needs of the children, but also regarding their educational background.

All interviews were conducted one to one by the same researcher in the same room as the ICDP groups were held, except for one interview when the interviewee brought in a preschool child. The average length of an interview was 51 minutes.

Findings

Qualitative analysis of the interviews showed that the effects of ICDP guidance on parents of children with special needs can be divided into four main themes:

- The consoling effect of confirmation from similar others

- Increased self confidence and positive attitude
- Release of sorrow
- Practical advice

The parents in the present study were at different stages regarding their child's needs and their own way of coping with this, as well as the different diagnoses, disorders and ages of their children. Still, the parents had faced many of the same challenges:

> *"The course has helped me because I have always blamed myself. It has helped me realizing that I was not alone: That there are several parents who are desperate. There are several parents who have been pulling their hair. There are several others that have cried of helplessness, without knowing what to do with the kid. There are several others who have though; many parents have realized that there is something wrong with the child, but you don't know what it is. (...).*" (interviewee 37).

Most of the parents had been through different kinds of courses due to their child's needs, but the ICDP group is experienced as different:

> "*One parent has another course through* /name of place/*, and is excited about ICDP, as she thinks the program maintain the parents' thoughts and feelings in a positive way. Several of the parents think that most of the forums and courses generally only maintain the children's needs*" (log book, group ID 120).

The fact that the intervention was non instructive was important for all the parents, and all described a group characterized by empathy, warmth, support, and understanding. When talking about the group and the facilitator's role in the group, one mother put it like this:

> *"(...) It wasn't many of us who didn't go through a process of tears during the meetings. Because it is something that happens to us when we are to put these things into words. And that in itself is a form of therapy that you maybe thought was not necessary, because all of us have talked about it so many times, right. But when you come into a room where you can <u>see</u> on the others that "ahh, we understand what you*

mean" and they share it in a way. Ahh, then it becomes ten times stronger, right" (interviewee 38).

Support of them as parents with special challenges from similar others was hence important, and they got relief from sorrow. This was especially mentioned by the mother of an adolescent boy with special needs: She had already been through many of the challenges that the others with younger children faced, and for this women the greatest effect of the intervention was to face the grief (interviewee 55).

Support from, and comparison with similar others in a group process created a feeling of understanding, support and empowerment, and with that came the following:

- Participants felt more comfortable with themselves, the child, and the challenges
- In line with the ICDP aim, the parents enhanced their feeling of competence and ability to be good parents necessary for the growth and development of their children
- The increased confidence activated an internal sense of control as well as increased hope and optimism about the future

These psychological effects are in line with other studies who find that supportive care is rated as more important than practical information (e.g. Whitton et al., 2008). More practical learning span out from group discussions as well as through increased evaluations and consciousness about own practices, with a greater focus on trying new methods and being more patient. The practical learning was often related to the psychological issues, e.g. by being more confident and therefore less embarrassed, one mother was now able to be consistent and hence able to regulate her child in public places.

The parents agreed that everybody should get the opportunity to participate in a parental guidance group. When asked "Do you have any further experiences from the course that you would like to share?" one father shared his reflections about this:

"(...) Without using to big words, it is something about how family life, how typical family life unfold today that, that creates an enormous need for people for forums like this (...). People are in a way alone; there were single mothers here and told that they nearly had no help with two children for example, two children with special needs (...).

And, you know, two adults in work which takes both time and attention, so, I think that many families, that applies for my family anyhow, that you lack such a supportive network. And this filled some kind of emptiness (…)" (interviewee 56).

7.1 Summary and concluding remarks

ICDP guidance for parents of children with special needs seems to have psychological effects on the attenders. The parents put huge importance into the need for, as well as the impact of, ICDP participation. To meet and share experiences and reflections with similar others served as supporting and consoling and they gained relief from sorrow. The data suggests that the parents gained increased confidence in themselves as they became better at self praise, and were less embarrassed and more secure in their caregiving role. This conclusion echoes similar results from groups with trauma experiences: When victims were afterwards asked what helped most in the process of recovery, they said that sharing experiences with others who had gone through the same experience helped more than professional psychotherapy (Ayalon & Soskin, 1986). Further efforts should therefore be put into educating facilitators for parents of children with special needs and more evaluations should be carried out.

8 The effects of gender for attenders at ICDP interventions

The background for the present analysis

Studies comparing male and female caregivers have noted similarities but also some gender specific variations (Hudson, Elek & Fleck, 2001). A systematic review of 142 well controlled parenting intervention trials noted the importance of gender on experiences of caring responsibilities (Nyström & Ohrling, 2004). Many programmes have traditionally been specifically aimed at mothers; however the importance of fathers in child development highlights the need for parental interventions targeting both mothers and fathers. The challenges of care giving on males (Williams, 2009) and the growing awareness that mental health problems such as post partum depression affects both mothers and fathers (Davé, Petersen, Sherr & Nazareth, 2010), with subsequent impact on children (Davé, Sherr, Senior,

& Nazareth, 2008) and child development outcomes (Ramchandani et al., 2008) supports this. A recent Finnish study utilized an internet based provision and found that there were general benefits of the programme reported, more so for mothers, but significant impact on fathers (Salonen et al., 2010). Yet few have examined gender differences and how males and females differ in their availability, impact and efficacy of such programmes.

The current analysis

This study was set up to evaluate the impact of the basic version of the ICDP training according to gender of the recipients. The ICDP intervention targets both mothers and fathers, and whereas some groups allow for both genders in one group, other groups target only mothers or only fathers. The study design allows for comparisons between male and female caregivers at both baseline and follow up. Data analysis also examines differences between responders at post measurement and non-responders on the baseline data characteristics, to examine the extent to which the data can be generalized.

Description of the sample

269 participated in the evaluation and 266 indicated their gender. 64 were males and 202 females. Three did not indicate their gender and were therefore excluded. 141 caregivers (52%) completed the post-assessment; 36 males and 105 females. All participants attended the basic version of the ICDP programme. These 141 participants with pre-intervention and post-intervention data form the basis of the main analyses.

Results

Baseline characteristics

The findings indicated that at baseline, female caregivers generally did better than male caregivers on the outcomes measured. They scored significantly higher on activities, positive discipline, parenting strategy, and emotional engagement. They also reported a higher number

of social support and lower on loneliness. Trends were also found for female caregivers scoring higher on strategic engagement, life satisfaction and pleasure. However, they suffered from lower self-esteem and there were also trends indicating lower self-reported health and more negative emotions compared to male caregivers.

Between-subjects effects that were found as part of the main pre-post analysis generally supported the above findings, although female caregivers after ICDP intervention no longer had lower self-esteem, self-reported health, or more negative emotions compared to males. In addition, these pre-post analyses showed that female caregivers scored significantly higher on strategic engagement, life quality, life satisfaction, and satisfaction with social supports and lower on reports of children's total difficulties, own depression, and child rearing.

Gender specific findings

With the exception of reported health, it appears that the ICDP programme had a beneficial effect for both male and female caregivers (as reported in chapter 2). However, there were some gender specific findings. These findings indicate that male caregivers improved from pre to post intervention but female caregivers did not in their:

- Parenting strategy
- Self-efficacy
- Anxiety
- Furthermore, female caregivers reported an improvement in their children's difficulties from pre to post intervention while male caregivers reported a slight worsening of their children's difficulties from pre to post intervention.
- Borderline interactions suggested that male caregivers reported a greater number of hours spent by the father with the child following the intervention, while female caregivers reported a slight decline in the number of hours spent by the father with the child from pre to post intervention.

- Male caregivers more frequently experienced explore emotions following the intervention but female caregivers did not, and general health declined for male caregivers but slightly improved for female caregivers from pre to post intervention.

8.1 Summary and concluding remarks

It appears that the ICDP programme has a significant impact on caregiver outcome for both males and females and the data clearly suggests that the intervention is appropriate for both female and male caregivers. There appears to be some gender differences in the effect of ICDP guidance. Male caregivers benefited especially in terms of relationships with the child and family, whereas mothers viewed their child as having less difficulties post intervention.

However, the sample size for male caregivers in the basic group was small; one should thus be cautious in generalizing the findings to all male caregivers in the basic group. One should also be cautious in generalizing the findings to caregivers who are not married or with a partner and caregivers with higher levels of depression, since caregivers who did not complete the post-intervention questionnaire were more likely to possess these attributes.

9 Evaluation of the ICDP implementation

When evaluating the effects of a given programme it will also be important to explore the implementation, as the quality of the implementation will directly impact the effects. The first part of this chapter (8.1) will present facilitator data, while the second part (8.2) will present data from ICDP trainers in order to provide systematic insight data into the implementation of the ICDP programme, and attitudes towards and experiences with the programme. Questionnaires were handed out to facilitators and trainers, and semi-structured interviews were administrated to a sub group in order to get more depth information about the above issues.

9.1 Facilitator feedback

In this study we explored the implementation of the ICDP programme and the facilitator role as seen within the ICDP theoretical framework. Quantitative questionnaire data, open answer responses, and semi-structured interview data form the empirical foundation for the following.

Procedure

A database of trained facilitators was made, revised and updated throughout the project period. A questionnaire was sent out via the post at the end of 2008 to all facilitators with known contact information, and questionnaires that came in return were sent out once more after controlling the name and address. Telephone contact with non responders provided minimal data. At the time of the evaluation, 700 facilitators were approached, and 172 facilitators answered the questionnaire. The four pages long questionnaire included fixed questions as well as qualitative open questions. Furthermore, facilitators were invited to participate in an interview through the facilitator questionnaire. One inclusion criteria was that they had run at least one parental group the year before. The facilitators who ticked yes for interview were telephoned and an agreement was made about the time of the interview. The interview duration was from 20 to 44 minutes, with an average of 31.6 minutes. The interviews were conducted over the phone by a research assistant well known with the ICDP

programme. All quotes are in italics, and quotes from telephone interviews are put in brackets with the facilitator ID.

Description of the sample

Written responses were received from 172 facilitators. 13 facilitator interviews were conducted; nine of facilitators certified in the basic version, and four with facilitators educated in the minority version of the programme.

Findings

Only 172 out of 700 successfully sent questionnaires were received. Caution in interpreting the data is needed as they represent only 25 % of those contacted and 9.7 % of all facilitators in 2010. Clearly the future training of facilitators needs to emphasize the importance of accountability and commitment, and focusing on monitoring and evaluation as an integral part of the programme. Despite the limited response rate, the facilitator data reveals a number of issues and this information can be utilized both in evaluation as well as future planning.

Facilitator demographics

In March 2011 the facilitator database contained 1,773 facilitators, 379 of them in the minority version. The data shows that facilitators were for the most part highly educated (87.2% had university level education), female (83.1%) and certified (92.4%). 10 responders (5.8 %) were not certified which is a requirement to work as a facilitator. It might be that these 10 responders were under education while answering the questionnaire. They ranged from 27 to 66 years old, the mean age was 44.4. A bit less than half had received extra follow-up (41.9%) and slightly more than half used the basic rather than the minority version (54.7% versus 34.3%). Most of them were certified recently; the mean year was mid-2006, the median year 2007 and the certification year ranged from 2000 to 2008. The majority had participated in or done supervision linked with the programme; respectively 75.6% and 64%.

Attitudes towards the programme

ICDP facilitators describe the ICDP work in a highly positive way when asked "how do you like running parental groups?" The interview responses comprise the following: rewarding (interviewee 67), meaningful (interviewee 69), interesting, fun, and educational (interviewee 71), exciting (interviewee 73), inspiring and educational (interviewee 74), important work (interviewee 78). Interviewee 73 put it this way:

> "*It is certainly very fun to be allowed to work with this. Although full-time jobs, and after being at work all day, it's fun to be allowed to go to work again in the evening and meet parents in these groups. Get it out to the people!"*

Facilitators generally consider the programme as an important and good tool. Open question data shows that facilitator's highlights that the programme is easily understood and recognizable when asked what they think is the strengths of the ICDP programme. Other responses fell in the following categories: The programme focuses primarily on the positive qualities of the caregiver and the child; the programme raises consciousness and sharing of experiences, the structure of the programme as well as the combination of experience sharing and theory; the programme is effective as facilitators see actual changes; and the programme applies to everybody. Social factors are also valued, and the themes are well known and relevant, and it is experienced as positive that the programme includes emotional issues.

The facilitators use different material to sensitize the parents as recommended in the ICDP programme. For example, they use own experiences as parents, films, poems, pictures, and music as reported in interviews. However, when asked about the programme weaknesses and if and how the programme could be improved, the main feedback was that the video material is old fashioned, and that there should be more examples of the guidelines that could be used in the implementation. Some facilitators suggested a think tank, as this would make the preparation easier and the programme implementation more cost effective and at the same

time *"ensure the quality of the parental groups*" (interviewee 67). Other feedback on programme weaknesses was regarding difficulties in recruiting parents; that there is too little focus on adolescents in the manual; that the content is (too) close to common sense and hence difficult to "sell"; and that there is not enough knowledge about the programme amongst people. Others reported to have too little experience with the programme, and that it takes time to learn by heart how to use the programme. Some facilitators do not see any programme weaknesses, but point to the difficulty of lack of time and resources allocated for programme implementation.

The implementation of the ICDP programme

Facilitators on average had not run many caregiver groups since they received their ICDP certification (the mean was 2.46, and the median was 1) but the standard deviation was quite large (4.55) and the numbers of groups held ranged from 0 to 50. Moreover, only 11.6% were currently holding groups while 84.9% were not. Training facilitator models do not appear cost effective in terms of running groups, but there is a high integration of ICDP principles into everyday work. Most facilitators were in touch with parents and children daily in their work, and the majority of facilitators reported using the programme frequently in their work when dealing with children and parents (58.2% and 55.2% respectively). Using the training in everyday work is an important additional pathway to distil the training.

The implementation was conducted according to the recommendations in terms of number of meetings held with the groups, as 44.2 % used six or eight meetings (eight meetings are recommended in the basic version), 34.9 % used 10 or 12 meetings. The facilitators who used more meetings for their groups tended to belong to the minority version of ICDP (12 meetings are recommended in the minority version). Only 4.7% of facilitators reported using a different number of meetings than six, eight, or twelve. Questionnaire data shows that more than half of facilitators reported having learned to communicate the programme in such a way as to be able to give the caregivers a simple, short and concise explanation of each theme, and that the parents understand and give feedback well on them (see table 8).

Table 8: *Description of proficiency in the program's components (N, %)*

	1-3 (1= not well)		**4-5 (5= very well)**		**Missing**	
Able to communicate:	*N*	*%*	*N*	*%*	*N*	*%*
Positive defining	26	15.1	134	77.9	12	7
Emotional dialogue	27	15.7	132	76.7	13	7.6
Meaningful dialogue	23	13.4	137	79.7	12	7
Regulating dialogue	34	19.8	123	71.5	15	8.7
Feel participants understand these 4 components	44	25.6	114	66.3	14	8.1
Think parents give feedback on these 4 components	44	25.6	107	62.3	21	12.2

More than half of the facilitators reported having used examples from interaction between adults to exemplify the content of the guidelines and having followed the plan in the Parental guidance programme carefully. Moreover, 41.3 % reported that the care persons follow the program's request of doing home exercises by observing and exemplifying the eight guidelines. Whether the parents understand and are able to separate the guidelines are influenced by the introduction given from each theme as well as the examples used:

> "*We got some feedback that some of the topics were similar and could have been merged. While some thought it was okay. And I think that when we had gone through the theoretical part and explained it using lots of examples it became very clear to them"* (interviewee 74).

The ICDP facilitators reported that they found the certification course very useful, and that it was important that it was based on self-training exercises, as this made them feel more confident about the programme content.

Only half of the facilitators reported that the caregivers followed the programme's principle of home exercises with observation and exemplification of the eight guidelines. This is a concern

since this is a recommended criterion of ICDP. Slightly less than half reported having planned the content of each meeting with new exercises every time; having met other facilitators to share experiences; and having prepared the strategy for new group meetings with other facilitators, as recommended in the programme. Nevertheless, the second major proportion of facilitators reported partly following the principles of implementation rather than not, except for preparing the strategy for new group meetings together with other facilitators (see table 9).

Table 9: *Details regarding implementation of the program (N, %)*

	Yes		No		Partly		Missing	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Able to give a simple explanation of each guidelines	90	52.3	3	1.7	72	41.9	7	4.1
Use examples from interactions between adults to exemplify guidelines	115	66.9	11	6.4	38	22.1	8	4.7
Planned meetings with exercises	80	46.5	21	12.2	54	31.4	17	9.9
Having meet other facilitators to share experiences	71	41.3	34	19.8	55	32	12	7
Prepared strategy for new meetings	74	43	50	29.1	35	20.3	13	7.6
Caregivers do their homework	71	41.3	4	2.3	81	47.1	16	9.3
Follow plan	117	68	3	1.7	34	19.8	18	10.5

The use of log books and check lists

Facilitators are recommended through the ICDP manual and the introduction book for the ICDP facilitator education to fill in a log book after each meeting, containing the following (Hundeide, 2007, p. 75):

1. To what extent was the meeting conducted according to the agenda?
2. How did the participants react to the different themes in the agenda?
3. What engaged them most?
4. What engaged them less?
5. Were some points not understood or disliked?
6. How was the homework received? Did everybody do all the homework?
7. How was the group's activity and engagement? (Who was active – who was passive?)
8. Was this a successful, average, or an unsuccessful session? Why?
9. Was everybody present or some did not show up?
10. When did the meeting start – when did it end?

11. How do you evaluate your role as a facilitator? (checklist)

12. Attach stories and examples from the meetings.

Only 23% of facilitators in the questionnaire study reported using the log book completely (see table 10). The data suggested that the more experienced facilitators were less likely to use the log book completely. One explanation for this may be that much experience leads facilitators to abandon the log book as they become more proficient in the use of the programme. In order to reflect upon question 11 ("How do you evaluate your role as a facilitator?"), facilitators are recommended to use a check list designed for regular use as a way of self-monitoring the quality of facilitators' own work (Hundeide, 2007). Only half of the facilitators reported having used the check list regularly. 11 % report that they do not use the check list, while 30.2 % reported that they are partly using the check list (see table 11).

Table 10: *Use of the log book (N, %)*

Use log book	N	%
Completely	40	23.3
Partly	44	25.6
Sporadically	16	9.3
Rarely	51	29.7

Table 11: *Use of the check list (N, %)*

Only 22 (18.3 %) out of the 120 participating groups sent us a copy of their log book. This number is comparable with the percent that report that they use they log book completely (23.3%). The points that are to be included in the log books are covered in most of the collected log books. However, the amount of work put into it varies. Some choose to only put key words to each of the question, whereas most log books contain more lengthy descriptions. Most log books also include an appendix with recruitment material, sensitization material, and some also includes the evaluation schemes used by the facilitators during the last group meeting as a self evaluation practice.

An overview of the different points that are covered in each of the collected log book are presented in table 12. The numbers in the first row represent the 12 points above. The

guidelines on how to use the log books were revised mid-2009, however most log books were collected before this.

Table 12: *An overview of the points covered in the log books*

Group	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***	***12***	***Comments***
1							x	X	X		X	X	This was a report
2	X	X	X	X	X	X	X	X	X	X	X	X	
3							x				X	X	
4	X	X	X	X		X	X	X	X	X	X	X	
5	X	X	X	X		X	X	X	X	X	X	X	
6	X	X	X	X		X	X	X	X	X		X	
7								X	X				One page summary + day to day agenda
8	X					X	X		X	X	x		
9	X	X	X	X			X	X	X		X		
10	X	X	X	X		X	X	X	X	X	x	X	
11	X	X	X	X		X	X	X	X	X	X	X	
12						X	x				X		One page summary + day to day agenda
13												X	Day to day agenda only
14	X	X	X	X	X	X	X	X	X	X	X	X	
15	X	X	X	X	X	X	X	X	X	X	X	X	
16	X	X	X	X	X	X	X	X	X	X	X	X	
17	X	X	X			X	X	X	X	X	X	X	
18	X	X	X			X	X	X	X	X	X	x	
19	X	X	X	X	X	X	X	X	X	X	X		
20	X	x	X				X				X	x	
21	X	X	X			X	x		X	X	X	X	
22	X	X	X	X	X	X	X	X	X	X	X	X	

X: this was described in the log book, x:this point was partly described in the log book

The low number of facilitators who use the log book and check list regularly suggests that more work should be put into encouraging ICDP facilitators to do so, as this probably will strengthen the quality of the ICDP implementation.

Implementation barriers

The major predictors of planning to hold a group in 2008 for a facilitator were the number of groups in 2007, and the number of fathers in the group – perhaps indicating the tenacity of the facilitator or the need. Furthermore, this might be explained by the large amount of male facilitators working with father groups in prison, where the recruitment might be easier, both because participating in ICDP guidance sometimes is obligatory in order to receive visiting rights, and because incarcerated parents have more time available (see chapter 6 for a detailed report on the ICDP programme in prisons).

There was also a trend that facilitators who report difficulties in recruiting participants are less likely to run group in the future. This represents a practical barrier for holding groups. Most facilitators found it difficult to recruit participants, and when asked why they faced difficulties in recruiting parents, the facilitators reported parents' time demands; difficulties in presenting the programme, and because the programme is little known. Sometimes parents lack baby sitters which also made it difficult to recruit caregivers.

The finding suggesting that barriers to running groups appear to have more to do with practicalities than with facilitators' attitudes is supported by open ended answer responses. When facilitators were asked for the main reason not to run groups, they reported that the programme is not prioritized in a way that makes groups possible. The next frequent category of responses was that facilitators went straight onto trainer education. Others had groups with professional caregivers, or they had just finished their certification. Furthermore, lack of time and capacity and new work tasks were also factors that explained why some facilitators didn't run parental groups and others had never run a group after they were certified as facilitator.

The majority of facilitators reported that they needed more practical knowledge to use the programme more (68.6%), more sharing of experiences with other facilitators (54.7%), more support from colleagues (76.2%) and more leadership support (62.2%). However, the majority of facilitators also reported that they were satisfied and did not need anything (77.9%). In an open ended question asking what they need in order to use the programme more, the

facilitators reported that they needed more municipal support, more time, more training in the programme, and support nearer to their work place. Some also reported that they would need a facilitator to collaborate with. This is in line with the finding that the majority of facilitators seldom met other facilitators (55.8%), and only 20.3% regularly met other facilitators. This suggests that more support is needed. Facilitators in the minority version of ICDP experienced more difficulties than facilitators using the basic version. Minority facilitators were more likely to find it difficult to recruit parents, to find the programme incomplete and to think the programme needs better follow-up, but they were more likely to believe that the facilitator training is good and they were more proficient in the use of the programme (see table 13).

Table 13: *Version and associated categorical factors*

	N	***Basic** (%)*	***Minority** (%)*
Need more practical knowledge			
Yes	106	68.9	31.1
No	40	40	60
Need more colleague support			
Yes	117	66.7	33.3
No	29	37.9	62.1
Need more leadership support			
Yes	96	67.7	32.3
No	50	48	52
Having done supervision			
Yes	99	55.6	44.4
No	49	71.4	28.6
Use to prepare strategy before groups			
Yes	66	68.2	31.8
No	47	57.4	42.6
Partly	31	45.2	54.8
Able to give simple explanations			
Yes	83	54.2	45.8
No/partly	66	69.7	30.3
Use checklist regularly			
Yes	76	53.9	46.1
No	66	68.2	31.8
Follow plan			
Yes	108	55.6	44.4
No/partly	32	75	25
Give follow-up			
Yes	66	75.8	24.2
No	77	54.5	45.5
The groups are active			

Yes	19	36.8	63.2
No	130	63.8	36.2
Have children contact at work			
All day	27	59.3	40.7
Daily	49	49	51
Weekly	32	65.6	34.4
More seldom	37	75.7	24.3

The interview data supports the results from the questionnaire study that there should be a higher priority of the programme on the municipal level, as facilitators report difficulties in finding time and funding to run ICDP groups. Interview data suggests that employers generally adapt to ICDP implementation, and facilitators would like to continue to run groups, however financial constrain and a lack of time often pose challenges*:*

> *"It's about economy. This is something one need to take in own budgets and here in* /city/ *at least there is no funding. It's very tight. So it's a pity if the economy should hinder us from using it (...)"* (interviewee 74).

Facilitators most often hold evening groups, which is an obstacle because it is in their spare time. One minority facilitator puts it this way:

> "*This is basically something at evenings mostly. So it's really a bit up to us. That's what I see as the biggest obstacle here. I have the coordinator responsibility of others who have ICDP competence, and the biggest hurdle for the ones not using it is that it actually is run in the evenings (...). So that's for sure, that it's time and economy that stops us"* (facilitator interviewee 64).

It is important to note that the facilitators interviewed had one or more groups the year before, i.e. they were active facilitators, and volunteered for the interview. They may therefore have incorporated ICDP more into their work than others. The challenges mentioned here are therefore most likely even more evident in the total sample of facilitators who did not, for various reasons, wish to participate in the current evaluation.

Characteristics of ICDP groups of caregivers

The groups of caregivers held by the facilitators that answered the questionnaire had on average 6.17 participants, with a minimum of 2 and a maximum of 20 participants. The groups had a larger number of mothers than fathers; the means were respectively 5.03 (*SD* = 3.09) and 1.96 (*SD* = 2.69) and the median values 5 and 1.

The parents generally reacted positively to the programme content according to the facilitators. Some parents might have felt that the content was slightly too common sense for them beforehand, however, this changed during the course period. Parents were reported to be most interested in advices on how to regulate their child but this also changes along the sensitization process:

> "*It's really fun when you experience on the last meeting that parents in a way draws the conclusions that if you only get things to work from guideline one to guideline seven, then guideline eight becomes redundant in a way – when you get the parents to see that there is a connection with everything they do in interaction with the child (...)"* (interviewee 78).

When asked if parents mention other subjects, or bring up subjects they would like to discuss more, this is reported to be about cultural differences and cultural issues, limit setting, relationships with family members, practical issues (for example contact with school and other authorities), substance abuse and violence, the parents own past, stress and time pressure in modern life, and adolescents.

77.3% of the facilitators reported that they had held a group that went really well, and 10.5% reported that they had never held a group that went really well. Conversely, 11% reported that they had held a group that went really badly and 69.2 % reported that they never held a group that went really badly. An open question about what went well in groups that were implemented successfully, revealed that the group members were engaged, they shared, and that the parents gave positive feedback to the facilitators. There were clear changes in parent-child relationships, and there was good communication within the group. Factors that contributed to poorer group implementation were reported to be too small groups, or group

members being too different, e.g. on an educational level; too many socially deprived people in one group taking too much space, or a mixture of men and women, resulting in greater silence from the women (reported by minority facilitators).

Picture 1 and 2: *Facilitators in the minority version of the ICDP teaching and role playing*

9.2 ICDP trainers' feedback

ICDP trainers are important in the programme implementation, as trainers are responsible for educating and following up on facilitators, as well as cooperating across the country. In March 2011 the trainer list consisted of 73 trainers, 53 in the basic version and 20 in the minority version. 25 of these are certified by the Regional Offices for Children, Youth and Family Affairs (Bufetat). ICDP trainers answered a questionnaire about demographical questions, and a sub group was interviewed about their experiences with the implementation of the ICDP programme nationally.

Procedure

A questionnaire was administered in 2009 to all trainers with a registered e-mail address with 11 error messages and 72 correct sent mails. All mail addresses were reread and sent a second time. A reminder was sent out six weeks after the first email. Semi-structured interviews were administered over the telephone to trainers who agreed to participate through the trainer questionnaires.

Description of the sample

The questionnaire was filled in by 18 trainers, and additional 17 responses were received after the reminder. This corresponds to a total response rate of 48.6 %. Qualitative open answer responses to questions about the programme and the implementation were filled in by the 35 trainers on questionnaire format. In addition, interviews were administered to 16 trainers. All quotes from questionnaires are in italics, and quotes from telephone interviews are put in brackets with the facilitator ID.

Findings

Trainer demographics

35 trainers answered the questionnaire, 30 females and 5 males. The trainers were from 16 different municipalities, with 10 out of 32 working in Oslo. Four of the trainers were bilingual. 26 were certified in the basic version, 9 in the minority version, one trainer answered "other" and one did not answer this question. They were certified between 1996 and 2010, the majority between 2005 and 2008. The trainers were from medium to very satisfied with the facilitator education they participated in to become a facilitator (see table 14). 87.9 % or 31 out of 35 report that they had received follow up after certification, whereas four facilitators had not received any follow up. All trainers who answered the questionnaire reported that they find the ICDP programme as an useful interaction tool. 88.2 % trainers agreed that it is a very useful program, and 11.8 % answered that they find the programme useful.

Table 14: *Trainers' expereience of the facilitator education they participated in (responses were given on a Likert scale from 1 very satisfied to 5 very satisfied))*

Satisfied	**Percent**	**Number**
1 Not at all satisfied	0 %	0
2	2.9 %	1
3	20.6 %	7
4	41.2 %	14
5 Very satisfied	35.3 %	12

The majority of the trainers had little experience of running caregiver groups before they were certified as trainers. 53 % had run zero or one group. "One group" might actually refer to the self-training group required as part of their certification (see table 15). This may be considered a concern since it is important that trainers are experienced facilitators in order to be able to run facilitator training. This is nicely expressed in one of the collected log books: "*To read and prepare is one thing; to put it into practice is a huge part of learning to become a facilitator*" (log book, group ID 49).

Table 15: *How many caregiver groups did you run before you became a trainer?*

Number of groups	**N**	**%**
0	4	11.8 %
1	14	41.2 %
2	6	17.6 %
3	5	14.7 %
6	2	5.9 %
7	1	2.9 %
11	1	2.9 %
<50	1	2.9 %

*It is a criterion to run a parent group as part of the facilitator education, and it is possible that some included while others excluded the self-training group while answering this question.

Only one out of 35 trainers who answered the trainer questionnaire run a parental group at the time of answering the questionnaire, and only one would run a parental group the following year. 13 did not know yet, whereas 15 trainers reported that they would not run parental groups the following year. The main reasons they gave was that they have other work tasks or they are due to have facilitator training. They had educated on average 3.2 groups of facilitators, with a minimum of zero to a maximum of 15 groups. In addition to the direct provision of the programme through educating facilitators, 81.25 % use their trainer competence in other parts of their work, while 18.75 do not. If they hadn't (recently) held facilitator training, this was reported to be because of lack of time and resources; they have other work tasks, or there are enough/too many facilitators in (part of) their municipality.

Trainers' experiences with the programme

Trainers described their ICDP experiences in a similar way as facilitators: "*Exciting, funny, engaging, meaningful – repeatedly surprised over the enthusiasm the programme creates and the impact it has on the participants in the groups".* They use the programme in their work with parents and children, as well as privately. Trainers are enthusiastic about the programme and find it rewarding to have facilitator training sessions. As one trainer puts it:"*It's actually*

something I do that I like the most" (trainer interviewee 91). The interview data shows that this engagement is evident when trainers' are communicating the programme to facilitators. This is important, as trainers are going to both motivate, educate, and sensitize facilitators in order to prepare them to run their own groups. Trainers use themselves and their own experiences in the training. They emphasize sensitization and argue that this should be more in focus at the beginning of the facilitator training, as this is essential for caregiver groups to be successful.

When communicating cultural issues, trainers focus on similarities and that "*the intentions are very much the same, but that there are different expressions*" (trainer interviewee 91). One of the minority trainers expressed that the distinction between individualistic versus collective cultures in the minority manual put too much focus on differences rather than similarities. Another trainer expressed concern about how one talk about and brings in the issues of forced marriages and genital mutilation. These issues are a part of the facilitator training within the minority version, and this trainer has the impression that parents can easily talk about this, however that the facilitators do not have enough competence in order to initiate real discussions on these topics. It's important to have knowledge about these issues and to use it to start discussions and reflections on its consequences when this is natural, however one will need to be cautious, culturally sensitive, and take in historical considerations in order not to hamper group processes. Some basic groups have ethnic Norwegians as well as parents with minority backgrounds, and these groups often have 10 meetings. One of the trainers argued that the programme should have some guidelines on how to organize the ICDP course to stretch over 10 meetings.

Questionnaire data suggests that trainers need more support to be able to use the program more (see table 16). Open answer data on what trainers need more of in order to use the program more show that trainers experience that the programme is not prioritized enough and that "*the programme is poorly controlled by the authorities*". All the responses to this question were concerned with issues connected to implementation criteria's: Trainers do not have time ("*fewer other work obligations*"), facilitators do not get paid for it ("*financial*

support for facilitators who run the groups"), and they need more back up from their work place ("*support and inspiration from the work place*"). All these factors refer back to governmental guidelines and municipal priorities and should be considered in the future.

Table 16: *Additional needs for trainers to use the program more*

Need more:	**%**	**N**
Don't need anything	32.4 %	11
Leadership support	32.4 %	11
Sharing of experiences with other trainers	20.6 %	7
Colleague support	5.9 %	2
Practical knowledge	5.9 %	2
Other	44.1 %	15

Programme strengths and weaknesses

Programme strengths as experiences by ICDP trainers can be categorized into the following categories, namely:

1) The programme is resource oriented and facilitating

   "(that it is) *individual, group-based makes it less expert-based, and home assignments make the parents feel that they can cope with their caring role and are "forced" to act – in contrast to "just talk*"".

2) That the programme is "*so easy that it is genius*".

3) The involved attenders are being sensitized through the combination of theory, practice and reflection ("*The strength is that parents and facilitators become more aware of their own way to communicate, and can make important changes*").

4) Moreover, different special fields, such as kindergartens, child care, health centers, child protection etc. are cooperating and sharing a common language.

The weaknesses of the programme are perceived to be:

1) That the programme is close to common sense:

   "*The weakness is also that it's easy. This makes some thinking that it's easy and that they're already doing what you're talking about. This applies to parents, facilitators and trainers. It needs to be worked with in order to get it under the skin*".

2) That the programme is common sense based and little known makes it difficult to present the programme and furthermore contributes to the difficulty of recruiting parents ("*parents feel stigmatized when they are recruited*").

3) Other factors explaining this difficulty is that the programme is not evidence based, which also makes it difficult to compete with other programmes.

4) Some trainers think there should be more focus on group processes and how to lead effective group discussions and promote reflections.

5) The last major part is about the material, which some trainers think is too complicated; ("*materials are linguistically challenging for bilinguals*") and that they are generally lacking material and information on adolescents.

Implementation weaknesses

For many of the respondents, programme weaknesses were linked to the implementation, (about 45 % of the responses). These responses are included in the following broad categories describing implementation weaknesses as experienced and reported by trainers:

1) First of all, the trainers report that the implementation receives too little Ministry support and that the foundation and lines of responsibilities is difficult: "*A much higher priority from the Ministry and Directorate is needed*". Another trainer reports:

   "*Too few resource persons in Bufdir to follow up the ambitious initiative to spread the program to all of the countries' municipals. It is for this reason difficult to obtain local support and hence time and support for training and guidance. The central guidelines*

are not strong enough. A lot of the responsibility lies on local resource persons. Little boost from Bufdir and ICDP Norway").

Trainers furthermore points at the lack of guidelines on how and if facilitators should use their competence after certified in the program:

> *"The municipalities don't commit to anything and the management or the ones who received it* (the program) *probably didn't think about this when we were offered this here in /municipality/"*.

This results in lack of time and funding for ICDP work:

> "*We are imposed to do this, but without any extra time or money. So, yes, we should do it during our working hours, or the hours we have at disposal, and that is expected from us without giving us anything extra for it*" (trainer interviewee).

The health centers stand out, as ICDP is an integrated part of their work and their way of approaching caregivers'.

Use check list	N	%
Yes	86	50
No	19	11
Partly	52	30.2
Missing	15	8.7

The next category of implementation weakness reported by trainers is that (2) the programme has to compete with other programmes which have more status, and this is difficult because "*the programme is not as profiled as other programmes"*. This is in line with what trainers see as a programme weakness, namely that it has not been EBP (evidence based practice). The trainers therefore feel that they have fewer arguments in favor of the programme. Despite the limited time trainers have for ICDP work they often need to recruit facilitators themselves, and explaining and convincing about the benefits of the programme is reported to be time consuming. The programme is thus little known considering that it is implemented nationally.

Trainers furthermore report that (3) quantity goes at the expense of quality when implementing the programme. Learning to be an ICDP facilitator is a process. One needs to withdraw from the professional role and give more responsibility to the parents, and this might be a challenge for some. Follow up of facilitators is therefore important in order to

ensure the quality of the programme implementation. This suggests that a higher focus should be directed to quality (quality assurance and follow up) rather than quantity (educating even more facilitators and trainers), and this is in line with the questionnaire study. One trainer put it this way:

> "*I am sometimes unsure whether facilitators receive adequate training, or whether we should be more careful when we choose who will run groups for parents. Not everyone fits this work, but it's difficult to weed out*".

Another trainer simply suggests "*more focus on quality assurance of facilitators work rather than training".* Facilitators are educated continuously, however without any national guidance on quality control or guidelines on how to use the competence:

> "*One of my facilitators once asked "when I'm done, can I hold private ICDP-courses?" (...) No, one cannot do that, I thought. But neither ICDP Norway or anyone else have made anything that we should sign*" (trainer interviewee 89).

Furthermore, the trainers report that there are little or no follow ups of parents (4) ("*There should be some form of follow-up after groups. Changes take time, and I think parents quickly fall back into old patterns*").

9.3 Summary of main findings from the implementation studies

- In March 2011 the database contained 1773 facilitators, 379 of them certified in the minority version, and 73 trainers, 20 of them certified in the minority version. The programme is implemented nationally and offered to parents, mainly by kindergartens and child health centers, but also by prisons, family centers, the child protection system, and schools. ICDP was also used within the refugee services and the introduction program for newly arrived immigrants at an earlier stage.

- The data shows that there are positive attitudes towards the programme. ICDP providers were enthusiastic about the ICDP programme and find it inspiring, important, meaningful, and educational. They had an overall positive attitude towards the training, endorsed the experience, welcomed the provision, and utilized it both in their everyday work as well as in ICDP specific groups. Programme strengths are reported to be that it is resource oriented and presented in a simple way, and that the programme sensitizes caregivers and makes real changes. They like the structure and the positive focus of the programme, and report that the programme applies to everybody. However, they highlight the need for more material and more concrete exemplifications of the eight guidelines.

- The data furthermore suggests that there is generally good implementation of the programme. More than half of the facilitators reported that they have learned to discuss the guidelines in such a way that they could talk about them in a simple and concise way. 77.3% reported that they had held a group that went really well and 10.5% reported that they never held a group that went really well. 11% reported that they held a group that went really badly and 69.2 % never held a group that went really badly.

- Only half use the check list regularly and only 23% of facilitators reported using the log book completely. This is an important objective in the ICDP programme, and further emphasis should be put on following these recommendations.

- Facilitators using the minority version were more likely to find it difficult to recruit parents and to find the programme incomplete and challenging, but they were more proficient when working with the programme.

- The low response rate in the facilitator study (25 %), the low number of parental groups held (an average of 2.46 groups), and the low number of facilitators currently holding groups (11.6%) suggests that future training should focus on commitment, and follow up

of facilitators. Following this, the majority of facilitators reported that they needed more practical knowledge to use the programme more; more sharing of experiences with other facilitators, more support from colleagues, and more leadership support. 34 % of the participating groups were self-training projects in the facilitator education, supporting the finding that most certified facilitators are not actively in holding groups. Notwithstanding, many utilize the skills and learning from the training within their everyday work.

- Barriers for not running groups are practical in nature, e.g. facilitators have not released time for ICDP work or there is a lack of funding and there is therefore a clear need for earmarked funds. Trainers furthermore report that they need leadership support and more sharing of experiences with other trainers.

- Trainers are little experienced in running parental groups when they move on from being a facilitator to be trained as a trainer. This is a concern, as experience is important in order to ensure the quality of the training, as the data suggests that it takes time to become safe in the facilitator role.

10 Evaluation conclusion

The current research project evaluated the impact and implementation of the parent targeted early intervention programme of ICDP, taken up and implemented by the Norwegian Ministry of Children, Equality, and Social Inclusion, to strengthen the care and upbringing of children and young people. This study included groups that ordinarily were held in the community and hence evaluates real outcomes in contrast to evaluations of efficacy in more controlled trials (Moscicki, 1993). The study can therefore be viewed within the context of the need to employ a pragmatic research design (Kirkwood, Cousens, Victora & de Zoysa, 1997; Victora, Habicht & Bryce, 2004). We conclude by returning to the questions outlined in chapter 2 followed by recommendations for practice and research in the next chapter.

The first question reads **"What is the impact of the programme on caregivers and caregiver-child relationships"?** The ICDP programme appears to have a positive impact on both. 82.6 % reported that they noticed that they had changed as a result of the ICDP guidance, and 55.6 % noticed changes in the family. The findings suggest that the ICDP programme has a positive effect on positive discipline, household commotion, emotional and strategic engagement, parenting strategy, caregivers' attitudes towards child rearing and perceived ability to manage their child as well as caregivers' self-efficacy, anxiety, anger and concentration. Several trends also emerged, suggesting that the ICDP programme may also have a positive effect on hours spent by father with the child, caregivers' life quality and caregivers' negative emotions. Benefits in terms of outcomes relating to caregivers' relationships with the child and the family and caregivers' well-being were more pronounced for male caregivers and, benefits in terms of outcomes relating to the child were more pronounced for female caregivers.

Interview data gives additional support and extends the above findings by suggesting that caregivers become more secure and generally improve their relationships with their children and sometimes also with their spouses, and this might be seen in relation to the improvement

in household commotion found in the questionnaire study. Caregivers generally report that their everyday life has become easier, with less conflict and a more positive atmosphere. Interview data suggests that female caregivers with an ethnic minority background report a great improvement in the communicative and emotional relationship with their children, and an additional important distal effect of the intervention for these women is the social nature of the programme as many of the informants reported that they before the intervention had limited social networks.

The next question is: **"What is the impact of the programme on children's development"?** This evaluation was not set up to directly address child development. The only direct measure of children occurred within the video sub study still under analysis. However, parental report was included utilizing a well validated inventory and the findings from this element suggest that the programme has a positive effect on children's overall distress and social impairment, and trends in the statistical data also suggest that the intervention has a positive effect on children's difficulties as measured through the Strengths and Difficulties Questionnaire (including emotional problems, conduct problems, hyperactivity, and peer problems). Interview data and open answer responses in the post questionnaires indicate that parents report that the programme benefits children in several ways. 39.6 % noticed changes in their children immediate after ICDP guidance meetings. Parents report that their children are happier, calmer, and more cooperative.

The programme aim is to strengthen child outcomes by improving the quality of care from the main caregivers and the main focus in the current study was therefore on the parents. It is important to note that the evaluation was not specifically set out to monitor child development and the main aim related to caregivers impact. Thus child developmental outcomes gathered within this data set are those reported by the caregivers and not directly observed. The next phase of the study and any evaluation would need to examine child outcomes with greater rigor. More research is therefore needed as outlined in the next chapter.

Given the impact as described above it is relevant to ask **"What is the sustainability of the effects obtained"?** The current evaluation includes a follow up time of measurement, six

months after the intervention ends. This data is currently being analyzed, and may shed some light on the long term efficacy of the immediate intervention effects given in this report. Preliminary data suggest that there is much long term gain, but some benefits wane with time. Consideration should be given to strategies to maintain effects and sustain improvement in terms of longer courses, sustained input, refresher opportunities or other developments.

The last aim of the evaluation reads **"What is the quality of implementation"?** This is important in any programme evaluation as the impact of the given programme will be influenced by the quality of the implementation. The results suggest that there is generally good implementation of the ICDP programme in terms of proficiency and engagement. Trainers and facilitators generally report very positive attitudes to the programme, and they tend to use the ICDP method in their everyday work, meaning that different specialist fields working with children and families gain a common language. This is positive and might have a wider effect in preventive family work.

However, only half of facilitators report that they use the check list regularly, and even less report using the log book completely. Furthermore, only half report that the caregivers do self practice exercises. Facilitators do not run groups frequently and many facilitators are inactive. It seems like there is a lack of responsibility and commitment. Furthermore, the data shows that facilitators face some challenges while implementing the programme, such as difficulties in recruiting parents, and lack of time and funding, and facilitators generally receive too little follow up.

Table 17: *Overview of some of the most important findings from the quantitative studies*

	Community sample (basic)	**Males (community sample)**	**Females (community sample)**	**Ethnic minority mothers**	**Incarcerated fathers**
1. Show love to your child	no change	no change	no change	no change	no change
2. Follow your child's lead	**X**	**X**	**X**	**X**	no change
3. Talk to the child/personal dialogue	no change	no change	no change	**X**	no change
4. Praise and appreciate what the child manage	**X**	**X**	**X**	**X**	no change
5. Help to focus child's attention and share experience	**X**	**X**	**X**	**X**	**X**
6. Help child to make sense of the world/provide meaning	**X**	x	**X**	**X**	x
7. Help child to widen his/her experience	**X**	**X**	**X**	no change	**X**
8. Positive regulating the child's actions	**X**	**X**	**X**	no change	no change
Commotion	**X** (only in high educated)	**X**	**X**	no change	(not measured)
Health	no change	x neg	x	no change	**X neg**
Life quality	x	no change	x	**X**	**X neg**
Life satisfaction	x	x	x	**X neg**	**X neg**
Child total difficulties (SDQ)	x	x neg	x	x neg	no change
Impact of difficulties (SDQ)	**X**	**X**	**X**	x	**X**
Child prosocial behavior (SDQ)	**X**	no change	x	x neg	no change
Self-efficacy	**X** (only in low educated)	x	**X** (only in low educated)	no change	x
Trust own ability to take care of child	**X**	**X**	no change	no change	**X**
Anxiety	**X**	**X**	**X**	**X**	**X neg**

Parental strategy	**X**	**X**	no change	**X**	**X**
Child management	**X**	**X**	x	**X**	**X** (some neg. items)
Emotional engagement	**X**	**X**	**X**	**X**	**X**
More time with child	x	x	no change		no change
Happiness with partner	x	x	x	**X neg**	no change
Regard themselves as a good caregiver	no change	no change	no change	**X**	no change
Negative emotions	**X**	no change	no change	**X**	**X neg**
Consentration	**X**	**X**	**X**	x	x

X: significant positive change, x: non-significant positive change, **X neg**: significant negative change, x neg: non-significant negative change

11 Recommendations

Recommendations for policy and practice will be given based on the findings of the current evaluation, and recommendations for further research beyond the scope of the current study are suggested.

11.1 Recommendations for the implementation of the programme

The data derived from the current evaluation and the recommendations that follows all refers to lack of sensitization and implementation control. Given that the Parental guidance programme is a national priority, the implementation appears to be too person dependent, leader dependent, municipality dependent, and work load dependent. Local authorities and workplaces are offered the ICDP education without extra funding and without taking into account the costs of running groups; for example, the need to bring in temporary workers or overtime payments, and this makes the implementation depended upon good will and a great deal of motivation and enthusiasm. It is important to monitor the accountability of the implementation for the usage of the programme to be maximized. A set series of quality standards, recording of facilitators, agreements for groups and a regular monitoring and evaluation system may assist in this.

The following recommendations should be taken into account in any future implementation of the Parental guidance programme/ICDP:

1. Guidelines for implementation and follow up of facilitators and trainers:

A greater focus should be put on quality assurance before educating even more facilitators and trainers. This is also a question of cost-efficiency. Educating a high number of facilitators without any commitment of usage of the programme will pay back in the long run. It should therefore be some guidelines on how to work with the programme after finishing the certification. Facilitators should be supported and recommended to commit themselves and their organization to carry out caregivers groups. Some form of training accreditation and validation may help facilitators actively enhance their skills, utilize them to a greater degree and be motivated for follow up provision. The network meetings organized by the Bufdir have a crucial role in keeping up the enthusiasm and motivation of the facilitators and trainers, and these should therefore continue. Smaller local network meetings should also be offered, as is already common practice in some cities.

2. Earmarked funds for commitments to lead groups:

Employers (including municipalities and prisons) should approve and be aware of the work that the employee needs to put in for the ICDP programme when starting at a certification course. (See implementation principles in the ICDP programme.) Cooperation with Bufdir will be important as they are responsible for the programme implementation.

3. Follow up of caregivers:

Even if the ICDP approach is promoting self sufficiency by withdrawing after the guidance is given, follow up of parents is recommended in order to maintain and strengthen the implementation and the effects on the participants. Six months follow up data from parents show that while some intervention effects are maintained over time, others vain with time. This suggests that even challenging parenting skills are possible to address but that sustained improvements may need refresher courses, follow up or more intense input.

4. An emphasis on commitment to the implementation recommendations:

The sensitization and implementation principles should be carefully monitored and controlled that they are implemented. One should strive for and highly recommend facilitators to use the check list and the log book for monitoring as this would serve as a quality assurance.

Furthermore, the ICDP programme has a clear practical component and clearly recommends home tasks as a method to sensitize parents. It is therefore important to strive for this.

5. Revision of national guidelines:

It should be considered to set out a national requirement of a minimum of experience before facilitators can take the trainer education.

6. Groups for parents of children with special needs:

Of the specialized groups that were included in the current evaluation, only some few groups were run for parents of children with special needs. More facilitators should therefore receive training in order to run ICDP-groups for this group of parents as the current study suggests great benefits for the parents attending. An evaluation would need to be conducted as this study relied on post interviews only.

7. Groups for minority fathers:

Also, one should strive for recruiting ethnic minority fathers as only some few fathers with an ethnic minority background received ICDP guidance during the data collection period. Evaluations would need to be conducted.

8. Recording of facilitators:

Before the current evaluation there were no statistics or information on certified facilitators and trainers. Such an overview is now made. It is recommended that this list is updated.

9. Implementation of the ICDP in prisons should strive for:

- Child adjusted visiting rooms as stated in The Execution of Sentences Act (2004)
- Additional parent-child contact, outside the prison if possible
- A sensitive rather than harsh programme implementation context
- Follow up

10. Web based meeting place for ICDP attenders:

A web page with all information about the programme; where and by whom it is offered; registration opportunities, and with an overview of all activities of relevance should be considered. A closed password protected page for facilitators and trainers for information sharing and cooperation should be considered as well as a web based discussion and meeting place for ICDP attenders.

11. Marketing strategies:

The programme is unknown by most parents and more efforts should be put into making the programme more visible. Marketing strategies could be used to a larger degree to make the programme better recognized and hence simplify the recruitment process. The name "Parental guidance programme" might be misleading as the program also is used to sensitize professional caregivers, or as stated by Hundeide (2007, p. 4) *"ICDP is not only a parental guidance programme, it is just as much a programme of human care in general*".

11.2 Recommendations for development of the ICDP programme

The results indicate that there should be more material developed for the facilitators when implementing the programme. This would serve as a quality assurance and at the same time empower facilitators in the early phase of familiarizing and working with the programme, as well as making the implementation easier and more time effective. Material should be developed for the following purposes:

1. Manuals should be developed for each specialized group, with detailed descriptions of groups agendas (there is a manual for minorities). The data suggests that a prison manual should be made, and literature should be included about parenting from prisons; children of incarcerated parents; how to talk about the imprisonment to the child; and how to relate to the child during visitation. Also, a focus should be put on communication and cooperation between the inmate and co parent/rest of the family, and the post release situation. This would be in line with the impact of parental interventions in prisons on co parent cooperation as suggested in this and other studies.

2. More sensitization material within all versions of the ICDP programme should be developed, for example video clips and a booklet of examples to each of the guidelines. A DVD was made in 2010, after the data collection period, in cooperation between ICDP Norway and the Norwegian Directorate for Children, Youth and Family Affairs, covering the age 1-14 years. Video material should also be developed covering the first year of age and adolescence.

3. Also, there should be clear suggested guidelines for day-to-day agendas for the eight recommended meetings (suggestions are now given based on an implementation for six meetings) (Hundeide, 2007, p. 71-72).

11.3 Recommendations for further research on the Ministry implemented Parental guidance programme/ICDP

Research utilizing randomized controlled methodology

This research operated in a field situation and endeavored to provide both baseline and comparative information. Such field studies are limited as the ethics of randomized controlled studies may affect community availability. In the current study the basic ICDP attenders scored lower than the comparison group at baseline, suggesting that the change in the intervention group could partly be explained by this group having more room for improvement. Also, the effects of the programme were affected by education level. A future evaluation should therefore strive for recruiting a sample that does not differ at baseline. Furthermore, future research could be set up to select specific sub groups based either on parental characteristics/situations or child factors (such as behavioral or emotional levels) and a randomly selected group exposed to ICDP compared to alternative interventions, different

forms of the ICDP intervention, or waiting list controls. Such initiatives have been carried out in other settings (Cooper et al., 2009) and may well be appropriate in Norway. This methodology would advance the knowledge base. Cooperation with Bufdir on recruitment of facilitators for participation is crucial in future studies.

Research on broader child outcomes

This project was focused specifically on the impact of ICDP on caregivers. Child outcome data was gathered via parental report. The effect of changes in the parents and parent-child relationship on child development needs further attention. Future studies would be needed to understand the direct observable outcomes on child related variables and this would necessitate a more complex and child focused design.

Research on ICDP for caregivers with minority backgrounds

Future investigations should strive to be anonymous as ethnic caregivers in the minority version were less likely to give their full name and contact information to the evaluation research team and many of them therefore fell out of the six month follow up study. This unwillingness can be explained by the fact that some of the minority women participated without the consent of their husband.

Facilitators gave feedback on less corporal punishment after ICDP participation, but that many of the mothers did not dare to report this. A trend for more positive regulation was detected in the present study. Anonymous investigations could therefore also reveal more detailed information about corporal methods in child rearing before and after ICDP intervention. Furthermore, questionnaires should be shorter, as the average educational level for this group of caregivers is significantly lower as compared to caregivers attending the basic version of the ICDP programme.

Research on ICDP in prisons

The high scores from incarcerated fathers on a variety of parenting and parent-child related items before the intervention may indicate that the incarcerated parents “fake good” and that the intervention made them more sensitive toward their own parental role and their child, as they decline in these scores in post measures. Incarcerated fathers also declined in emotional and mental well-being from before to after ICDP intervention. This is a concern since they already score low on these outcomes, and the current data cannot determine whether this is because of the course content or from a natural decline caused by the imprisonment. More research including a comparison group drawn from prisons is needed to address these questions. Moreover, questionnaires need to be short, as this is population typically has lower education, and questionnaires need to be piloted well and adjusted to this target group.

Children of incarcerated parents are in many ways a forgotten vulnerable group, and further research should focus on the effect of ICDP on these children. Prison facilitators report improvements in the classrooms and that children have become more peaceful after the incarcerated parent started in a parental group. Only further research would tell if the learning, empowerment, and consciousness rising from the ICDP intervention would be sustained after discharge; whether it would affect the children of the incarcerated, and whether it would prevent re-offending. This should be put in focus for further research in order to explore the long term effects of prison implemented parental programmes on child development within a Norwegian context.

Previous research reports more parental involvement post release when the parent and child had more contact during imprisonment (LaVigne, Naser, Brooks & Castro, 2005). Further knowledge is needed as to whether increased visitations as part of the ICDP programme implementation benefits the child. Research on children visiting prisons is unclear, with the majority of studies reporting parent and child benefits, while some report increased child difficulties (Poehlmann et al., 2010 for a review). Incarcerated parents and their children should therefore be followed up after release to see whether parental intervention and the extent of parent-child contact during imprisonment would improve parental and child outcomes. Studies designed to explore this explicitly would be a major contribution to the

knowledge about the effects of imprisonment on children, and whether parental intervention and visitation during imprisonment would decrease the vulnerability towards psychological and adjustment problems of these children.

Research on ICDP targeting parents of children with special needs

The current evaluation did report positive outcome for parents of children with special needs, however more research is needed as the current study relied on few participants in post intervention interviews only.

Research on ICDP within child protection

ICDP for parents in the child protection system has been piloted in Oslo municipality with good results. To our knowledge, only three ICDP groups were targeting these parents within the project period of 1.5 years. Even if earlier smaller reports suggest ICDP as a positive method for this group, it is unclear how the programme affects parents with various degrees of challenges. Children within child protection generally have high developmental and behavioural difficulties (Stahmer et al., 2005) and special health needs (Ringeisen, Casanueva, Urato & Cross, 2008) in addition to increased risk for behavior and emotional difficulties. Interventions targeting these parents could potentially hamper some of these risks and more research is therefore needed regarding ICDP within child protection in order to show how the programme should be adjusted for this target group.

Research on ICDP guidance for professional caregivers

The current evaluation did not include groups run for professional caregivers in kindergartens, child health centers, schools etc. Research on the implementation and impact of this on professional environment and child development should be investigated as many facilitators use their ICDP competence in their work with colleagues.

Research on the quality of implementation

The current data shows that the ICDP programme is implemented only half way according to usage of check list and log books, and according to caregivers using homework exercises. Further research should therefore examine the effect of high versus low quality of implementation on the effects on parents.

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