Service Improvement Project

Non-Violent Resistance training for parents of adolescents misusing substances: a mixed-methodology service improvement evaluation

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Abstract

Introduction: Adolescent substance misuse is increasingly being viewed as a systemic as well as individual problem and several studies have shown the benefits of increased parental involvement.

Aim: To evaluate the effectiveness and acceptability of a Non-Violent Resistance group parent-training programme delivered within a Young People's Specialist Substance Misuse Treatment Service.

Method: Questionnaire measures were administered to 18 participants before and after the programme, and at follow-up. Semi-structured interviews were also conducted with 8 participants.

Results: Measures of parental self-efficacy, family functioning, and goal-based outcomes all showed significant improvement at the end the programme. Improvement in parental self-efficacy, but not family functioning, remained significant at follow-up. The interview data suggests that all parents experienced the programme as helpful, however, also highlighted some challenges.

Conclusion: This study provides evidence that group NVR training is effective and acceptable for parents of adolescents misusing substances. Limitations and ideas for further research are discussed.

Introduction

Substance use disorders in adolescence are associated with poor educational attainment, crime and delinquency, risky sexual behaviour, school exclusion, and mental health problems (Chassin, 2008; Macleod et al., 2004). 18,349 young people under the age of 18 receive specialist treatment for substance misuse in the UK each year and whilst individual interventions are largely effective, many young people will either decline or drop out of treatment (Public Health England, 2015). Historically, substance use disorders have been viewed as individual problems requiring individual treatment, however, accumulating evidence supports the effectiveness of systemic approaches (Klostermann & O'Farrell, 2013) and commissioning guidance for young people's specialist substance misuse services outlines five key interventions including family interventions using psychosocial methods (NHS National Treatment Agency for Substance Misuse, 2008). A meta-analysis of psychosocial treatments for adolescent substance misuse found evidence of effectiveness for Multidimensional Family Therapy (MDFT) (Liddle & Rowe, 2002) and Functional Family Therapy (FFT) (Alexander & Parsons, 1982) (Waldron & Turner, 2008). However, both approaches require formal training and supervision, and the engagement of the young person which can limit access in many cases. Therefore, adolescent substance misuse is increasingly being viewed as a systemic problem, whilst current evidence based systemic interventions may not be suitable in all cases.

The case for parenting interventions

Parenting styles can be characterised based on the concepts of *demandingness*, the extent to which parents control their child's behaviour, and *responsiveness*, the degree to which parents are sensitive to their children's emotional and developmental needs (Baumrind, 1967, 1991). An *authoritative* style is characterised by clear rules, high expectations, and high responsiveness, and is associated with healthy emotional and social development, whereas an *authoritarian* style is characterised by strict rules, high expectations, and low responsiveness, and is associated with low self-esteem, mental health problems, and increased risk of problem behaviours (Baumrind, 1991). *Permissive* styles, characterised by a lack of rules and expectations, with either high or low responsiveness, are also associated with poorer outcomes including problems with self-control, difficulties in relationships, and substance misuse. Several studies have also shown that authoritative, as opposed to authoritarian, parenting and increased parental involvement and monitoring can protect young people from substance misuse (Calafat, García, Juan, Becoña, & Fernández-Hermida, 2014; Fallu et al., 2010; McLaughlin, Campbell, & McColgan, 2016; Petrie, Bunn, & Byrne, 2007). Furthermore, a randomised controlled trial which found Multi-Dimensional Family Therapy (MDFT) (Liddle & Rowe, 2002) to be superior to a peer group intervention for adolescents found that the change occurred through improved parenting practices (Henderson, Rowe, Dakof, Hawes, & Liddle, 2009). Taken together, this suggests that parent-training may be a helpful intervention for adolescents misusing substances. Guidance for psychosocial interventions for substance misuses in over 16's only recommend information sessions and signposting for families (National Institute for Health and Care Excellence, 2007), however, parenting interventions are currently recommended as the first line treatment for antisocial behaviour and conduct disorder in guidance for child up to the age of 12 (National Institute for Health and Care Excellence, 2013) and there

is evidence that parenting programmes can be equally effective with adolescents (Woolfenden, Williams, & Peat, 2001).

Parenting interventions

Guidance recommends that parent-training programmes should be based on social learning theory (National Institute for Health and Care Excellence, 2013). Parent-training programmes based on social learning theory typically address five key areas: promoting positive relationships, rewarding sociable behaviour, consistent rules and commands, consistent and calm consequences for unwanted behaviours such as ignoring the child or removing positive reinforcement, and reorganising the child's routine to avoid difficult situations (Scott & Gardner, 2015). The Incredible Years Programme (Webster-Stratton, 2001) and Triple-P Positing Parenting Programme (Sanders, 1999) both have a strong evidence base and have been successfully implemented in the UK for younger children with significant improvements reported in parental self-efficacy, parental mental wellbeing and child behaviour (Lindsay, Strand, & Davis, 2011). Qualitative studies of the experience of parent-training programmes also highlight that parents feel powerless before taking part and perceive that the knowledge they gain alongside support from other parents helps them gain control and feel more able to cope, less guilty and socially isolated, more empathic towards their child, and more confident in their parenting (Kane, Wood, & Barlow, 2007). Teen Triple-P (Ralph & Sanders, 2003) has been successfully adapted for adolescents with a stronger emphasis on growing independence and risky behaviour, however, improvements in family conflict and parental confidence were not maintained at six-month follow-up (Chu, Bullen, Farruggia, Dittman, & Sanders, 2015).

Non-Violent Resistance (NVR)

Many families who present to services for help with child and adolescent behaviour problems are living in a context of multiple stressors and inter-generational patterns of interpersonal difficultly (Jakob, 2016). Furthermore, child to parent intimidation and violence is becoming more widely recognised by researchers and policy makers (Coogan, 2014). Non-Violent Resistance (NVR) (Weinblatt & Omer, 2008) is a parent-training programme that has been proposed as having the potential to respond to these issues. NVR is based on coercion theory, an extension of social learning theory, which proposes that antisocial behaviours develop in childhood when attempts to control problematic behaviour lead to escalation, and ultimately reinforcement when these attempts to control are abandoned (Patterson, 2016). In line with coercion theory, there is evidence that coercive, harsh and conflictual parenting styles are a significant risk factor for the development of childhood behaviour problems, and that childhood behaviour problems elicit harsher parenting practices (J. D. Smith et al., 2014). NVR trains parents to resist rather than attempt to control their child's behaviour and manage their own reactions, and this redirection of parents' attention towards their own behaviour is proposed to improve parental efficacy, reduce conflict, and improve family functioning (Omer 2001, 2002). Like other programmes, NVR recognises the need to strengthen the parent-child relationship, and also trains parents to use reconciliation gestures which increase parental responsiveness to the needs of the young person (Jakob, 2015). A significant difference to other programmes is that NVR also trains parents to engage their wider system and form an ongoing support network (Jakob, 2016).

Evidence base for NVR

One controlled trial of fourty-nine families in Israel found evidence that NVR reduced self-reported helplessness and permissiveness in parents of children with a range of behavioural problems, with parents also reporting significant reductions in problem behaviours at one-month follow-up (Weinblatt & Omer, 2008). NVR has also been applied in UK Child and Adolescent Mental Health Services (CAMHS) with evidence of reduced parental stress, improved family relationships, and reduced problem behaviour (Newman, Fagan, & Webb, 2014). NVR has also been piloted with foster carers in Belgium, with evidence found of significant improvements in child behaviour and parenting stress (Van-Holen, Vanderfaeillie, & Omer, 2016), and in Germany where it was found to be equally effective as Teen Triple-P (T-PPP) in improving parental presence and reducing parental helplessness and depression, and more effective than both T-PPP and a waiting list control in improving behaviour (Ollefs, Von Schlippe, Omer, & Kriz, 2009). Therefore, although there is currently limited evidence for the effectiveness of NVR, the few studies to date report significant improvements.

The current service improvement project

The Bristol Young People's Specialist Substance Misuse Treatment Service (YPSSMTS) is a Specialist Child and Adolescent Mental Health Service (CAMHS). To be referred the young person must have a substance misuse problem and mental health issues or other complex needs. The service does not have the provision for MDFT or FFT and individual work can be slow and limited for many clients whilst others remain very difficult to engage. A 10-week NVR programme for parents (Table 1) was developed by a nurse and a specialist substance misuse worker from Bristol YPSSMTS and a specialist substance misuse worker from South Gloucestershire

Young People's Drug and Alcohol Service (YPDAS) following their attendance at training provided by Partnership Projects UK.

Table 1: NVR programme weekly content

Week 1	Goal setting, outcome measures looking after yourself, case study
Week 2	Learning about functional behaviour, button pushing and escalation
Week 3	Creating a de-escalation plan
Week 4	Learning about reconciliation gestures, recruiting supporters
Week 5	Learning about refusing orders and breaking taboos, developing a safety plan
Week 6	Preparing to announce the plan to resist the behaviour to the child
Week 7	Reviewing the announcement to the child
Week 8	How to use supporters, role playing the 'sit in'
Week 9	Feedback and troubleshooting, developing a sustainability plan
Week 10	Outcome measures, feedback forms, reflections on ending

Aim of the project

The service required an evaluation of the programme to assess effectiveness, acceptability, and identify areas for improvement.

Method

Project design

A mixed-methodology design was used. The quantitative component involved collecting questionnaire data at the beginning and end of the group, and at follow-up (6-8 weeks after the final session). The qualitative component involved individual interviews with a proportion of participants at follow-up.

Participants

Individuals were eligible to take part in the study if they had completed the NVR programme. Data collection spanned four rounds of the programme (Groups 1-4). 8 participants were recruited from Groups 1 & 2 to provide questionnaire data and participate in individual interviews. 10 participants were recruited from Groups 3 & 4 to provide questionnaire data only and were sent follow-up measures by post. Group 1 ended in July 2016, Group 2 in December 2016, and Groups 3 and 4 in April 2017. Demographic information for all 18 participants is presented by group and in total in Table 2.

Recruitment

Participants were informed of the project when the programme began and given an information sheet and contact details in the final session. 100% of those eligible from groups 1 and 2 agreed to participate and were retained at follow-up. 100% of those eligible from groups 3 and 4 agreed to participate and 40% were retained at follow-up.

Table 2: Group and overall demographic information

	Group 1 (n=4)	Group 2 (n=4)	Group 3 (n=6)	Group 4 (n=4)	Total (n=18)
Parent age	44-60 years (M= 50.75, SD = 7.27)	32-52 years (M = 41.75, SD = 9.60)	38-51 years (M = 47, SD = 5.24)	50-53 years (M = 51.5, SD = 1.12)	32-60 years (M=47.26, SD = 7.05)
Parent gender	Female 100% (4) Male 0% (0)	Female 50% (2) Male 50% (2)	Female 80% (5) Male 20% (1)	Female 50% (2) Male 50% (2)	Female 72.2% (13) Male 27.8% (5)
Parent situation	Single mother 75% (3) Mother alone (father living at home) 25% (1)	Single mother 25% (1) Father living elsewhere 25% (1) Cohabiting couple 50% (2)	Single mother 50% (3) Married couple 33.3% (2) Mother alone (father living at home) 16.7% (1)	Married couple 50% (2) Cohabiting couple 50% (2)	Single mother 38.9% (7) Married and/or cohabiting couple 44.4% (4) Mother alone (father living at home) 11.1% (2) Father living elsewhere 5.6% (1)
Parent level of education	University 75% (3) Secondary school 25% (1)	University 25% (1) Secondary school 75% (3)	University 80% (5) Unknown 20% (1)	University 100% (4)	University 72.2% (13) Secondary school 22.2% (4)
Parent ethnicity	White British 100% (4)	White British 100% (4)	White British 100% (4)	White British 100% (4)	White British 100% (18)
Child age	16-17years (M = 16.75, SD = 0.43)	16years (M = 16, SD = 0)	14-17years (M = 15.17, SD = 1.34)	17years (M = 17, SD = 0)	14-17years (M = 15.98, SD = 1.10)
Child gender	Male 100% (4)	Male 100% (4)	Male 80% (5) Female 20% (1)	Male 50% (2) Female 50% (2)	Male 83.3% (15) Female 16.7% (3)

Setting

Interviews were conducted at the Bristol YPSSMTS base. Interview participants were given travel expenses and a £5 voucher as a thank you for their time and effort.

Ethics

Approval as a service evaluation was granted by the Avon and Wiltshire Mental Health Partnership Trust (AWP) Research and Development Department (R&D). Ethical approval was obtained from the University of Bath Psychology Ethics Committee (Reference Number 16-130).

Epistemology

Realism assumes that true cause and effect relationships exist and can be uncovered through a process of experimentation whereas *relativism* searches for meanings within a given context and assumes that objective reality does not exist because observations are always socially constructed (Willig, 2008). A *critical realism* position has been taken to this project because it aims to gain evidence about the programme that can be generalised whilst acknowledging that it will be socially constructed.

Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) assumes that people naturally reflect on the meaning of significant life experiences, and aims to uncover the sense that people make of their experiences (J. A. Smith, Flowers, & Larkin, 2009a). It involves detailed examination of single cases and does not aim to generalise experiences across participants within the analysis, and because of this can highlight hidden and potentially important areas of similarity and differences within a sample. IPA was therefore chosen for this study because of its high sensitivity to individual experience.

Another important element of conducting IPA is that the researcher is explicit about the potential biases they bring to the analysis. This is important because as a trainee clinical psychologist I have experience of running groups and working with parents, and may be prone to imposing my own views on the data.

Sample size and power

There is no prescriptive guidance around what sample size should be used in IPA, however, it is recommended that four to ten interviews is adequate for doctoral level research (J. A. Smith, Flowers, & Larkin, 2009b). A total of 18 participants took part in this project. A power calculation using G-Power found that a sample size of 15 would detect a medium effect size with adequate power of 80% for the quantitative measures.

Procedure

Participants completed questionnaires at the beginning and end of the programme, and at follow-up (6-8 weeks later). The 8 participants from Groups 1 and 2 met with the researcher in person at follow-up and gave written informed consent before completing the follow-up questionnaires and taking part in a 45-minute semi-structured interview. The interviews were recorded using a Dictaphone and the interview transcripts were typed verbatim with all identifying information omitted. The 10 participants from Groups 3 and 4 gave written consent in the final session of the programme and were sent follow-up measure by post to be returned using a pre-paid envelope.

Measures

The questionnaires used by the service are all recommended for routine outcome monitoring by the CAMHS Outcome Research Consortium (CORC).

Parental self-efficacy

The Brief Parental Self-Efficacy Scale (pSEQ) (Woolgar, 2013) (Appendix 1) was used to measure parental self-efficacy. The pSEQ is 5-item self-report questionnaire and items are rated on a 5-point likert scale ranging from 'strongly disagree' to 'strongly agree', with higher scores indicating higher parental self-efficacy. No psychometric data is currently available.

Family functioning

The Score-15 (Stratton et al., 2014) (Appendix 2) was used to measure family functioning. The first part of the Score-15 is a 15-item self-report questionnaire that assesses family patterns of interaction. Items are rated on a 5-point likert scale ranging from 'describes us very well' to 'describes us not at all', with lower scores indicating better functioning. The Score-15 has been found to have good internal consistency .89 (n=515) and sensitivity to clinical change in a large clinical sample (Stratton et al., 2014).

Substance misuse

The Young Persons' Specialist Substance Misuse Outcome Record (YPOR) (Public Health England, 2013) (appendix 3) is a self-report measure of substance misuse behaviour and general wellbeing. It was used to assess for reductions in substance misuse. The YPOR includes some questions taken from validated surveys, but is not a clinically validated measure.

Goal based outcomes

The Goal Based Outcomes (GBO) (Law & Jacob, 2015) (appendix 4) measures how far participants feel they have come towards reaching their goals. Up to three goals are

rated on a 0-10 scale with 0 indicating not reached at all and 10 indicating reached completely. Psychometric data is not available.

Semi-structured interview

A draft topic guide was discussed with a previous programme attendee and then piloted with a second previous programme attendee. The topic guide (Appendix 5) included several prompts; however, the interviews were conducted flexibly so that the focus remained on topics the participants felt were relevant.

Analysis

Quantitative data was analysed using SPSS. Qualitative data analysis followed the steps provided by Smith, Flowers & Larkin (2009). The transcript for Participant 1 was read and re-read and initial notes were made in the right-hand margin. The left-hand margin was then used to write down emerging themes. Emerging themes and accompanying quotes were then put into a list in order of when they appeared in the data and combined into clusters of subordinate and superordinate themes. This same process was then carried out for Participant 2, and the theme clusters were combined with those of Participant 1. This process was then followed for Participant 3 and then 4, which yielded a set of superordinate and subordinate themes for Group 1. Theme clusters were expanded, collapsed, or added as necessary. As the data from Group 2 was relating to an entirely different experience, the process was followed from the start and the themes from the two groups were combined at the end.

Validity checks

To check for satisfactory administration of the topic guide and obtain guidance on identifying themes, the transcript for Participant 1 was analysed using IPA by the third

author, a clinical psychologist working in a CAMHS service with experience of qualitative research. Themes and supporting quotes at both group and overall level were developed in discussion with the second and third author.

Results

1. Quantitative data

Parental self-efficacy

A one-way repeated measures ANOVA was conducted to compare scores on the pSEQ at Time 1 (pre-intervention), Time 2 (post-intervention) and Time 3 (6-8 week follow up). The means and standard deviations are presented in Table 3. There was a significant effect for time, Wilk's Lambda = .28, F (2,8) = 10.57, p = .006, with multivariate partial eta squared = .73 indicating a medium effect size. Post hoc tests using the Bonferroni correction revealed that pSEQ scores significantly increased from Time 1 to Time 2 (p = .003) with a mean increase of 4.80 and confidence interval of 1.90 to 7.79. There was also a significant increase in pSEQ scores from Time 1 to Time 3 (p = .009) with a mean increase of 4.90 and confidence interval of 1.34 to 8.47. There was no significant difference in scores between Time 2 and Time 3 (p = 1.00) with a mean increase of .10 and confidence interval of 2.11 to -2.31. This suggests that parental self-efficacy improved by the end of the programme and that this was maintained at follow-up.

Family functioning

A one-way repeated measures ANOVA was conducted to compare scores on the SCORE-15 at Time 1 (pre-intervention), Time 2 (post-intervention) and Time 3 (6-8

week follow up). The means and standard deviations are presented in Table 3. There was no significant effect for time, Wilk's Lambda = .57, F (2,7) = 2.63, p = .14, multivariate partial eta squared = .43. As data from only 9 participants was complete for the ANOVA, three paired samples t-tests were also conducted with all the available data for the SCORE-15. There was a statistically significant increase in SCORE-15 scores from Time 1 (M = 2.80, SD = .58) to Time 2 (M = 2.36, SD = .57), t(14) = 3.70, p = 0.002 (n=15) with a mean difference of 0.44 and confidence interval of .19 to .69. There was a non-significant increase in SCORE-15 scores from Time 1 (M = 2.57, SD = .52) to Time 3 (M = 2.19, SD = .46), t(9) = 1.70, p = .124 (n = 10) with a mean difference of 0.34 and confidence interval of -.13 to .88, and a non-significant increase in SCORE-15 scores from Time 2 (M = 2.10, SD = .08) to Time 3 (M = 2.15, SD = .16), t(8) = .26, p = .80 (n=9) with a mean difference of -.05 and confidence interval of -.52 and 41. This indicates that family functioning had improved by the end of the programme but that this did not remain significant at follow-up.

Table 3: pSEQ and Score-15 outcomes

Measure	Pre		Post		Follow-up	
	M	SD	M	SD	M	SD
pSEQ (N = 10)	16.10[ab]	3.51	20.90 [a]	1.73	21[b]	1.49
Score15 (N = 15)	2.80[c]	0.58	2.36[c]	0.57		
Score15 (N = 10)	2.57	0.52			2.19	0.46
Score15 (N = 9)			2.10	0.08	2.15	0.16

[a] $p < 0.05$; [b] $p < 0.05$; [c] $p < 0.01$

Substance misuse

It was not possible to obtain most YPORS because of the infrequent nature of the adolescents' contact with the service. It was not possible to conduct any analyses.

Goal based outcomes

GBO scores were available for 8 participants for both for Time 1 and Time 2. The goals that were chosen by these participants are presented in Table 4 and descriptive statistics of this sample are presented in Table 5.

Table 4: No. of times goals selected (n=8)

Goal theme	No.
To stop or reduce drug or alcohol use	7
For my child to be less aggressive or violent	3
For my child to stop stealing	3
For my child to come home on time or stop going missing	2
For my child to be happier	1
To be able to trust my child again	1
For my child to stop selling drugs	1
To spend more time with my children	1
For my child to stop harming himself	1
For my child to attend school	1
For my child to have hobbies	1

Table 5: Descriptive statistic GBO scores at Time 1 and Time 2.

Measure	Pre		Post	
	M	SD	M	SD
GBO (N = 8)	3.90 [a]	1.80	6.66 [a]	2.20

[a] $p < 0.01$

A paired samples t-test was conducted between Time 1 and Time 2. There was a statistically significant increase in GBO scores from Time 1 to Time 2, $t(7) = 10.03$, $p = 0.00$, with a mean difference of 2.77 and confidence interval of 2.17 to 3.43.

2. Qualitative data

The final analysis of the interview data produced three superordinate themes: experience of the group, change and challenges.

Experience of the group

The data from the interviews suggests that parents experience the programme as supportive, collaborative, and different to other approaches (Table 6).

Support

All participants spoke to some extent of how they felt desperate for support and willing to try anything before attending the programme. All participants also spoke of feeling less alone in the group, and for some participants this was linked to feelings of guilt and shame. Some participants also spoke about how being open in the group encouraged them to break their silence outside of it.

Collaboration

All participants felt that working together with the facilitators and each other helped them to learn. A theme endorsed by most participants was that clarity was an important factor. In Group 1, there was a theme of a lack of clarity, whereas in Group 2, the clear and structured format of the programme following improvements was commented on. Some participants also described valuing that the facilitators did not assume the role of expert.

A different approach

Amongst those participants who had already attended other parenting courses (n=5), some spoke of experiencing the programme as less authoritarian. Others spoke of seeing NVR as a less conflictual approach.

Table 6: 'Experience of the group' themes and supporting quotes.

Support	*Desperate for support*	*'My son's behaviour was getting so bad, likely really aggressive, I was just hoping to get some support. I was willing to try anything.' (Participant 1)* *'I needed to do something, I'd got to the end. I'd done everything else that I could do.' (Participant 4)*
	Feeling less alone	*'It was nice because you feel like you're not the only one with a child's who just like, heading down' (Participant 7)* *'It was just really comforting for one thing to know you weren't on your own…. there's a deep shame isn't there, if you're going through stuff like this.' (Participant 3)*
	Encouraged to break the silence	*'Yeah that's probably the major, the most that I took away from the course, that I would definitely recommend; talking to friends, if they've got any, not just about drug abuse problems, but any problems really; to share them and to let that individual know that you are sharing them with certain people, so you're not brushing it under the carpet' (Participant 2)* *'the fact that things are no longer hidden – it means that behaviour has to be confronted, it has to be acknowledged, there's no need to be, it's not private.' (Participant 3)*
Collaboration	*Working together*	*'I think it's just helpful when you're understanding something because different people put things in different ways, so you get the same thing from different angles.' (Participant 3)* *'Yeah, I think you need to do it as a group, it wouldn't be as good on a one to one… you need to know other people's problems because you pick up on things that they're doing with their child and we actually took some of the things that they were doing.' (Participant 8)*
	Desire for clarity	*'It got clearer as we kept asking for more clarity and more visuals, but it needs to be much clearer up front.' (Participant 4)* *At the beginning of each session it was very clear what we were going to cover in that session and then as we went along.'*

		(Participant 6)
	Not an expert model	*''We were able to chat freely and help each other out if we thought we knew what the other person was trying to get at. It wasn't a strict classroom environment.' (Participants 5)* *'They weren't telling you what to do they were giving you suggestions, like 'why don't you try this?' rather than 'do this'.' (Participant 7)*
A different approach	*Less authoritarian*	*'I actually thought it was going to be some sort of parenting course and they were going to tell us 'so here are some techniques' and so on, but that's not what it was like at all'. (Participant 1)* *'No, it was different. Usually it's 'don't do this, do that', and I suppose it was another way of looking at it.' (Participant 7)*
	Less conflictual	*'So many parenting courses is to have more conflict with them isn't it, and to start putting up so many barriers really with the parenting, which then just escalates' (Participant 2)* *'It's something to do with teaching people to engage with equality, to not escalate, to not, to have healthy relationships and to assert themselves as parents that is very very valuable, and I've not come across it anywhere else.' (Participant 4)*
	Uniquely valuable	*'I just think that we've just got the whole thing backwards, so much of the time, and we invest in the easy answers, so things like this that take people, that give them skills and techniques that they can actually use are probably a little bit more expensive than say a prescription, but ultimately they work or have the potentially to genuinely make a difference to a number of other people's health.' (Participant 3)* *'It's definitely worth the government investing more money in it. It's definitely better than the other courses.' (Participant 7)*

Change

The data from the interviews suggests that participants felt that they had taken new learning from the programme and had adopted new behaviours which they felt had impacted their child, self and wider family (Table 7).

New learning

Some participants felt that attending the course had highlighted their lack of power within their relationship with their child. All participants spoke of learning about the reciprocity of the relationship between them and their child, and about how their responses could escalate conflict. All participants also spoke of how they felt the programme had helped them learn how to de-escalate conflict with their child.

New behaviour

All participants reported enforcing boundaries with their child more after attending the programme. Some participants also spoke of spending more time with their child as a way of helping to repair the relationship, and for some also as a way of monitoring their child's behaviour more closely. There was also an overall theme that participants had recruited supporters to help them.

Impact on child, self and wider family

All participants with one exception reported that communication between themselves and their child had improved since attending the programme. Many participants also felt that they were less stressed since attending the programme, and that this helped create a more relaxed home environment. There was one exception to this as Participant 4 reported feeling that taking part in the programme had an adverse outcome.

Table 7: ‘Change’ themes and supporting quotes.

New learning	*Reciprocity of the relationship*	*‘So, I’d had an argument with [my son] that week and they’d pulled it out and said ‘see if you’d of stopped it here that wouldn’t have happened’ and it was like ‘yeah I can see it now’.’ (Participant 7)* *‘The key is keeping calm, as soon as you start bubbling up, the child’s gonna start bubbling up.’ (Participant 8)*
	Learning how to de-escalate conflict	*‘The main thing that I found helpful was the sort of, how to deal when things get out of hand, the de-escalation and things to do in order to stop a situation from becoming a battlefield. That was very, very useful.’ (Participant 6)* *‘[The facilitators] said about you know striking while the iron’s cold. There’s no point is there, when you look at it like that? When someone says it and there’s so much sense in that.’ (Participant 5)*
	Lack of power	*‘I became aware that I was in a situation where my power wasn’t what it should be.’ (Participant 4)* *‘I just always went with him, and just ended up giving in…. I was too scared basically.’ (Participant 1)*
New behaviour	*Enforcing boundaries*	*‘I think it also gave me as well confidence that it’s OK to hold the line as a parent. Even if they don’t do what you say, just to keep saying it and to keep putting that message in.’ (Participant 4)* *‘If I say I’m going to do something, I do it, whereas before I’d just say and say and say and repeat myself because he knows I’m not gonna do it.’ (Participant 7)*
	Spending more time with my child	*‘Cos it's very difficult because he's a teenage boy you know, he doesn't want to do stuff with him mum because it's just not cool is it, but I think things like going to the cinema are things that we can do together, and he says thank you afterwards, so yeah, it's really nice.’ (Participant 6)* *‘I got us both into a gym and he loves swimming so every Sunday I do my session on the bike then get in the pool with him. I’m keeping tabs on him, every time I can get him out and see how he is and know what he’s thinking’. (Participant 5)*

	Using supporters	*'so yeah I can text or call, and they don't necessarily think they have to do anything expect just turn up, you know just have a cup of tea and be present, and that by itself completely diffuses.' (Participant 3)* *'We've got supporters and he knows the one I've got, in fact we're all going [away] together at the weekend' (Participant 5)*
Impact	*Communicating more*	*'I also feel like he's telling me more about what he's doing, so I'm more aware of what's going on.' (Participant 1)* *'I'm communicating more with him, and that's become two-ways.' (Participant 2)*
	Less stressed	*'I'm not as stressed, it was very very stressful when [my son] was at a really really bad point.' (Participant 6)* *'It's given people in the family a more relaxed time. Cos if I'm worried, [my partner]'s worried, and then if they kids are up they can sense it, they're not stupid'. (Participant 8)*
	Change for the worse	*'The current situation is that my youngest son, he reacted really badly. They both become really resentful and more difficult.' (Participant 4)*

Challenges

The data from the interviews suggests that participants experienced challenges in the programme in the form of emotional demands, barriers to sharing, and difficulties engaging their wider systems (Table 8).

Emotional demands

Two participants from Group 1 spoke of how taking part in the course had challenged them personally because it involved addressing past trauma. Another participant from the same group reported concerns over listening to disclosures. Only these participants expressed a desire for further support.

Barriers to sharing

This was another subordinate theme only found in Group 1. Two participants spoke of how feeling different to other group members limited how comfortable they felt to share. One participant also reported concerns over confidentiality.

Engaging the wider system

Three participants described how difficulties encountered in getting people in their wider system engaged in supporting them influenced the extent to which they could put their new learning into practice. One participant spoke of experiencing difficulties in recruiting supporters, and another participant spoke of feeling like the changes that they had tried to make after attending the programme were being undermined by their ex-partner. Another participant described how it had been difficult for siblings to understand the approach and that this could lead to new conflicts in the family system.

Table 8: 'Challenges' themes and supporting quotes.

Emotional demands	*Facing past trauma*	*'part of the reason why he has these problems is I was in a very violent relationship…. So, it's really hard to manage my own responses and to know what's appropriate.' (Participant 3)* *'some of the stuff that needed unpacking for me was surviving my previous marriage and the impact that it had on me as a woman and on my sense of self and parenting style.' (Participant 4)*
	Listening to disclosures	*'if you were in a little bit more of an emotionally unstable position, where I think possibly some of these other parents on the course were, it may be difficult to listen and hear what some of the others have been dealing with.' (Participant 2)*
	Desire for follow-up support	*'Well just a little bit of, well obviously, you can't make changes overnight, and yeah a continued presence would be helpful.' (Participant 3)* *'I think you're only just getting into the grit of changing the family system when the course stops, I think it's a much longer programme.' (Participant 4)*

Barriers to sharing	*Feeling different*	*'I didn't share as much maybe with the group because I felt they might look at me and think 'well why is she here' because I've got no problems or, you know, compared to them.' (Participant 2)* *'Well, I was quite a bit different because I don't actually mind him smoking cannabis, and that was different to other people in the group. I suppose I was a bit worried that they might think that I was a bad mum, but I think we're just different.' (Participant 1)*
	Concerned about confidentiality	*'Yeah um because, our two sons are good friends. I didn't want to say things that maybe would drop the other son in in it, you know, into trouble, and also maybe incriminate my son because she may come back and have a go.' (Participant 2)*
Engaging the wider system	*Difficulty recruiting supporters*	*'The couple of friends that I have tried to talk to, they just don't want to know.' (Participant 2)* *'We were supposed to do like sit ins and that type of thing, and we haven't done any of that because my parents turned round and said that they didn't want to do it.' (Participant 2)*
	Being undermined	*'I think that the system the parent parenting is in is an important factor as to how you can uphold it or not, so if you have an undermining parent I think there's a high risk of damage.' (Participant 4)*
	Explaining to siblings	*'I did say in there that it would be nice, he's got a sister…. And she didn't, still doesn't really understand why, in her eyes we're mollycoddling him, you know spoilt bother thing, but it's not, we're just not escalating.' (Participant 5)*

Discussion

The pSEQ data suggests that participants experienced a significant and maintained improvement in feelings of parental self-efficacy. This fits with evidence from other programmes in the UK (Lindsay et al., 2011) and previous studies of NVR (Weinblatt & Omer, 2008). The SCORE-15 data suggests that family functioning was significantly improved post-intervention but that this improvement was not entirely maintained. This fits with a previous UK based study of NVR which found evidence of improved family relationships post-intervention (Newman et al., 2014). It is plausible that lack of

maintenance may be related to some of the issues highlighted in the qualitative analysis about engaging supporters; however, this requires further research. The lack of engagement from adolescents with the service in most cases meant that the YPOR could not be used to measure for change in substance misuse. However, the GBO data highlights that for some participants, issues such as aggressive behaviour, stealing and going missing were of equal importance, though reducing substance misuse was identified as one goal by most. Participants reported a significant improvement in reaching their goals by the end of the intervention, which suggests that the programme had a positive impact on behaviour as has been found with other approaches (Lindsay et al., 2011) and NVR (Weinblatt & Omer, 2008).

The qualitative data highlights that participants found the group supportive, collaborative, and less authoritarian than other parenting courses. This fits with previous qualitative studies of parenting interventions in that participants felt powerless and de-skilled before taking part, and found the group support helpful (Kane et al., 2007). The themes of collaboration and difference to other courses are unique to this study and suggest that NVR may have been a welcome change of approach. The participants were explicitly asked how their experience of NVR compared to other parenting interventions at the end, however, all five participants had spontaneously commented on this earlier in the interview. The qualitative data also highlighted that participants learnt about issues of power in their relationship with their child, and how to avoid and de-escalate conflict. They also reported that they had become more proactive in enforcing boundaries and spending time with their child, which is of note as enforcing boundaries is not an explicit aim of NVR training. Participants also spoke about how supporters helped them to make these changes, and how they felt their child was communicating more with them and that they were feeling less personally

stressed. Previous qualitative studies have highlighted similar processes (Kane et al., 2007), however, the themes around de-escalation and using supporters are unique to this study which is perhaps unsurprising as these are particular features of NVR. Previous qualitative studies have highlighted that participants felt that they had more empathy for their child and this did not arise in this study. Participants did speak of spending more time with their children, which is hypothesised as increasing parental awareness of the child's needs in NVR (Jakob, 2015).

Also unique to this study was a theme of challenges. It is not known whether this might reflect a reporting bias in previous studies, but highlights that parents might find it difficult to engage due to feelings of difference and concerns about confidentiality which may be common to other parent-training programmes. Participants also spoke of the emotional demands of facing past traumas and listening to disclosures. Three out of eight interview participants spoke of past abuse from fathers which fits with previous research which found that 38% of families participating in NVR had multiple stressful issues including intergenerational patterns of abuse (Freeman et al., 2013). Some participants also spoke of difficulties in building a supportive network outside of the programme and how this limited how much of their learning they could apply. This fits with recent developments within NVR to manage the issues of multi-stressed families, and Jakob (2016) cites the work of Madsen (2007) in suggesting that therapists help clients identify and distinguish between safe and supportive, critical and prescriptive, and coercive relationships, and help clients to utilise the relationships that will be most helpful for them in making changes (Jakob, 2016; Madsen, 2007). Despite ongoing challenges, most interview participants felt satisfied with informal follow-up support.

Limitations

Because of the small number of participants, the generalisability of the quantitative data is limited. 38.9% of families in the sample where single-parent, which is close to the latest local census statistic of 35.3%, however, all participants were White British, whereas 16% of the local population are of Black or Ethnic Minority (BME) origin, and there was also an over-representation of university educated participants, with 72.2% educated to degree level or above compared to the latest local census statistic of 32.8% (Bristol City Council, 2011). This raises important questions about the accessibility of the programme to BME populations and less educated families. A related limitation is that only those who had completed the programme were approached, creating a selection bias towards only recruiting individuals who found the programme accessible, and follow-up data was only obtained from 40% of questionnaire-only participants. It was also unfortunately not possible to obtain data regarding the frequency of substance misuse from the perspective of the adolescents.

Implications for service improvement

The study was designed as a service improvement project and the results were discussed with the programme facilitators. Several recommendations were made (Table 9).

Table 9: Recommendations for Service Improvement

1. Have a clear visual structure including timeline of weekly content
2. Pre-screen participants for potential trauma issues and signposting needs
3. Discuss issues of difference and confidentiality early in the programme
4. Prepare participants for potential difficulties in recruiting supporters
5. Allow time for feedback of experiences of recruiting supporters
6. Offer to include siblings in sessions and other meetings
7. Include a standard follow-up session for all participants
8. Consider a regular drop-in NVR ‘clinic’
9. Consider issues of accessibility in course materials and pre-course information

Future research

Further research should use a larger sample to ensure generalisability of the quantitative outcomes and saturation for the qualitative themes. It should also investigate the experiences of people who do not continue with the programme as this is likely to highlight some important issues. It would also be helpful to repeat the study with a more ethnically and educationally diverse sample. Lastly, it will also be important to explore the views of adolescents themselves in future research, perhaps by including adolescents in the programme somehow or utilising social media to collect data.

Conclusions

The qualitative data suggests that participants felt that the programme was a positive and helpful experience. The sustained improvement in parental self-efficacy supports this. The patterns of scores for family functioning also reflects the interview data, and suggests that positive gains are made, but these may be difficult to maintain for some families. Evidence was also found that attending the programme led to improvements in a broad range of problem behaviours, however, further studies will need to assess whether these gains are maintained.

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