Overcoming Barriers to Effective Early Parenting Interventions for ADHD: Parent and Practitioner Views.

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Abstract

Background: The importance of early intervention approaches for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) has been increasingly acknowledged. Parenting programmes (PPs) are recommended for use with preschool children with ADHD. However, low "take-up" and high "drop-out" rates compromise the effectiveness of such programmes within the community.

Methods: This qualitative study examined the views of 25 parents and 18 practitioners regarding currently available PPs for preschool children with ADHD-type problems in the UK. Semi-structured interviews were undertaken to identify both barriers and facilitators associated with programme access, programme effectiveness, and continued engagement.

Results and Conclusions: Many of the themes mirrored previous accounts relating to generic PPs for disruptive behaviour problems. There were also a number of ADHD specific themes. Enhancing parental motivation to change parenting practice and providing an intervention that addresses the parents' own needs (e.g. in relation to self-confidence, depression or parental ADHD), in addition to those of the child, were considered of particular importance. Comparisons between the views of parents and practitioners highlighted a need to increase awareness of parental psychological barriers among practitioners and for better programme advertising generally. Clinical implications and specific recommendations drawn from these findings are discussed and presented.

Introduction

Although most frequently diagnosed during the school years, ADHD is now acknowledged to affect individuals across the lifespan (Barkley *et al.* 2004) with such problems being recognised as one of the most common reasons for preschool referrals to mental health services (Wilens *et al.* 2002). A combination of pharmacological and psychological treatment approaches are recommended for school-aged children with ADHD (Taylor *et al.* 2004). However, medication can have side effects (Graham and Coghill 2008, Handen *et al.* 1991) and parents can have reservations about its use for controlling behaviour, particularly in young children (Berger *et al.* 2008). The need for an alternative early intervention approach using purely non-pharmacological treatments, such as parenting programmes (PPs), has been increasingly recognised (Charach *et al.* 2013, Daley 2006, Sonuga-Barke and Halperin 2010, Sonuga-Barke *et al.* 2011).

In line with this view current clinical guidelines, for instance those published by the National Institute for Clinical Excellence (NICE 2008), recommend the use of group-based PPs for preschool children with ADHD. Evidence from systematic reviews show that PPs can improve a range of outcomes (Barlow and Parsons 2007, Bunting 2004, Charach *et al.* 2013). However, effects on core ADHD symptoms are less well established (Sonuga-Barke *et al.* 2013) and factors such as low "take-up" and high "drop-out" rates can have a significant impact on

effectiveness within the community. Studies found 35-68% of families with a child with disruptive behavioural problems declined to take part in a PP (Barkley *et al.* 2000, Cunningham *et al.* 2000), and where families do start treatment, dropout rates can be high (up to 40% for PPs (Forehand *et al.* 1983, Patterson *et al.* 2005) and 40-60% for child mental health services (Kazdin 1996)).

Understanding the barriers to treatment "take-up" and "drop-out" is crucial for the development of more effective interventions. The current literature has considered such barriers relating to PPs for children with disruptive behaviour problems generally. Poor engagement and "dropouts" have been found to be influenced by demographic variables including; low income, single parent status, education/occupation, family size, minority status and maternal age (Cunningham *et al.* 2000, Kazdin 1995, Reyno and McGrath 2006, Webster-Stratton and Hammond 1990). Other factors include child variables (e.g. severity of behaviour), and parent variables such as maternal psychopathology (Kazdin 1995, Reyno and McGrath 2006). A recent meta-synthesis of qualitative research highlighted a range of psychological (e.g. stigma), situational (e.g. childcare issues) and programme/service barriers (e.g. unhelpful) faced by parents (Koerting *et al.* 2013). These findings are broadly consistent with Kazdin's "barriers to treatment" model which has been used to predict increased rates of cancelled and/or missed appointments (Kazdin *et al.* 1997, Kazdin and Wassell 1999). However, a sizable proportion of variance in early termination of treatment remained unexplained and it has been suggested that as Kazdin's model was driven predominantly from the standpoint of clinicians, it may not adequately encompass the parents' views (Owens *et al.* 2007). In addition, dropout rates have been found to vary across different diagnostic groups, with ADHD resulting in one of the highest dropout rates (Johnson *et al.* 2008). This suggests that it would be beneficial to examine such factors in relation to specific disorders and to ensure both parent and professional views are considered.

The current paper focusses on the specific issues around early PPs for ADHD to understand the reasons for low uptake and completion of programmes. Opinions of families with the most complex needs (e.g. presence of maternal psychopathology, child comorbidity) and those who may be considered 'hard-to-reach' and 'difficult to treat' (e.g. living in areas of social deprivation) were sought. The barriers experienced by these groups are relatively unexplored in the literature. Our study is also the first to investigate views of both 'hard-to-reach' parents of children with preschool ADHD-type problems, and PP practitioners. The research questions were:

- What are the barriers faced by these parents in relation to accessing and engaging with currently available PPs for preschool children with ADHD?
- What could be done to help maximise "take-up" and minimise "drop-out" rates from such programmes?
- How could treatment be improved in order to maximise the effectiveness for families?

Method

A qualitative approach involving semi-structured interviews was adopted. Such methods capture participants' views and have been identified as appropriate tools for generating valuable information on clinical decision making and policy development (Jack 2006).

Participants

Purposeful sampling (Ritchie and Lewis 2003) specifically targeted families who may be considered 'hard-to-reach', and those with complex needs. A number of sources were used to recruit these parents along with practitioners with ADHD-related experience. All sources were based within one NHS Trust in the South of England. These were;

- *Sure Start Children's Centres*: Sure Start centres aim to improve services for families with preschool children in areas of high deprivation (Melhuish *et al.* 2008);
- *Adult Mental Health Services* and *Child and Adolescent Mental Health Services (CAMHS)*
- *Speech and Language Therapy (SALT)* Clinics and *Portage Home Visiting Service*: Both services work with preschool children with complex needs.

Eighteen practitioners, all of whom had experience with providing services for and/or running PPs for preschool children with ADHD-type problems, were recruited: (Sure Start; n = 5, Adult Mental Health Services andCAMHS; n = 6, SALT and Portage; n = 7). Thirteen parents were referred to the study by practitioners who worked with the family and identified their child as presenting with preschool ADHD-type problems (Sure Start; n = 11, Mental Health; n = 2) and an additional 12 were recruited via three local ADHD support groups. These were parents of slightly older children (up to 12 years) many of whom had a formal diagnosis of ADHD. See Table 1 for full demographics.

Table 1 here

A number of participants volunteered additional information of note. Three parents had mental health issues (depression or ADHD), two had large families (5+ children), one had learning difficulties, one had been a teenage mother, and several had other children with difficulties (ADHD, Oppositional Defiance Disorder, Downs Syndrome). Other issues included domestic violence (n = 1) and substance abuse (n= 1). Two parents had also previously dropped out of a PP. These reports, together with their demographic details, are consistent with of the notion of a 'hard-to-reach' sample (Cortis *et al.* 2009, Doherty *et al.* 2003).

Procedure

Semi-structured interview questions were based on themes derived from our qualitative literature synthesis (Koerting *et al.* 2013). Interview questions were piloted and refined through two focus groups consisting of 1) parents from an ADHD support group and 2) Sure Start practitioners and Educational Psychologists. Questions

focussed on three areas: 1) Barriers and facilitators to accessing PPs for preschool ADHD; 2) Factors that impact on the effectiveness and success of PPs for these children, and; 3) Barriers and facilitators to continued engagement with PPs.

The study received approval from both University and NHS Research Ethics Committees. Heads of services from which participants were recruited were provided with information relating to the study. This was passed to potential staff members and families with a preschool child whom they considered to have ADHD-type problems. Practitioners were usually interviewed in their place of work and parents in their home. All participants gave signed informed consent for participation and audio-recording of the interviews. Recruitment continued until data saturation was reached.

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Analysis

Transcripts were organised and stored within *ATLAS ti* and analysed thematically using a Framework Analysis approach (Ritchie and Spencer 1994). Analysis was primarily conducted by ES, JK and MK, who had close supervision and regular meetings with SL, experienced in qualitative methods. The Framework Analysis approach involves a systematic process of sifting, charting and sorting data to facilitate the emergence of key concepts and themes. This involves five stages: i.) familiarisation; ii.) identifying a thematic framework; iii.) indexing; iv.) charting and v.) mapping and interpretation. During the familiarisation stage all transcripts were read and discussed by ES, JK and MK. Early coding was completed *in vivo* (line-by-line, using respondents' own language and meaning to represent their statements) which formed the basis of our thematic framework and was developed using both parent and practitioner data. This emerging thematic framework was applied to all data within *Atlas ti* during the indexing stage. Data were then sorted according to the initial emerging themes (charting) enabling examination of the whole range of responses within each initial theme. Parent and practitioner interview transcripts were also grouped and analysed separately so that disparities could be explored within each theme. During the final stage themes and concepts were refined and associations examined.

Results

Thirteen themes are presented under the following three domains: 'Parent Factors' (psychological barriers, situational barriers and motivation and capacity to change parenting practice); Programme Factors (initial approach to families, support for parents' own needs, individually tailored and flexible programme, implementation of strategies at home, importance of realistic expectations and highlighting progress, additional contact and group delivery format) and Service Factors (awareness and advertisement, inter-agency collaboration and therapist characteristics). Within each theme differences and similarities between parent and practitioner views are discussed.

1. PARENT FACTORS

3.1 Psychological barriers

A range of psychological barriers were identified. Parents often mentioned problems with low self-confidence, mostly relating to attending a group-based PP.

"Mainly because they'll be going on their own I imagine, and wouldn't know anyone. That's my big thing, when I think of it. I'm not very good at going somewhere on my own." Parent P62

Feelings of shame and embarrassment were also common. Parents expressed a fear of being judged as a 'bad parent' or being looked down on. They were also concerned about involvement with other services, especially Social Services.

…Worrying - Will that judgement then lead to something? Will I be considered an 'okay parent' and if I'm not an 'okay parent' will they start intervening more than I want them to in my family life?" Parent P36

Some practitioners showed awareness of such issues but others did not mention this theme.

3.2 Situational barriers

Both parents and practitioners highlighted a range of situational barriers, including being a single and/or young parent, having several children, or having an unsupportive family/partner. Both groups also highlighted issues with the time commitment required to attend a PP and that this might not be the top priority when families are faced with multiple challenges.

"*It might just be like, where X is really active all the time it's hard work to do anything - just go to the shop takes an hour to get ready. So, it might be like a time thing, like, can I really fit that 2 hours into my day when I've got all of this to do*." Parent P53

Other factors, mainly mentioned by practitioners, included; lack of education, cultural issues, domestic violence and financial difficulties.

Inconvenient session times and locations, child care issues and the lengthy duration of programmes were seen as important factors limiting "take up" and increasing the risk of "dropping out". A number of practitioners specifically said that 8+ weeks was too long. Practical reasons for missing sessions included illness and medical appointments, work commitments, and difficulties relating to their child's behaviour (e.g. getting excluded, phone calls from school). Other factors included changes in circumstances and 'getting a better offer' e.g. shopping with a friend.

3.3 **Motivation and capacity to change parenting behaviour**

Both parents and practitioners reported how difficult it can be to change established parenting approaches. It was suggested that parents who believe that their child's problems have nothing to do with their parenting or do not feel ready, sufficiently motivated, or able to make changes to their *own* behaviour reduced their desire to access and/or engage with PPs. This was also seen to be linked with programme effectiveness.
"I think sometimes people expect you to do the work for them - so they expect a miracle cure by the end without putting in anything themselves" Parent P59

Families' feelings of being overwhelmed by numerous challenges associated with their child's problems were also seen to limit their capacity to change behaviour.
"I think there is something about living with an ADHD child that just overwhelms you. There's not enough space to think differently." Practitioner P48

In terms of methods for increasing motivation, both practitioners and parents spoke about the use of rewards, praise and encouragement, focussing on the positives and having realistic expectations about improvements in the child's behaviour. Some parents suggested using tangible rewards, such as an end of course party or day trip, whereas for others their motivation was primarily driven from seeing improvements in their child's behaviour. A number of parents also spoke of the encouragement and motivation they gained from other parents whose child had similar problems. Both groups suggested that sharing successful strategies with other parents helped improve self-confidence, motivation and a feeling of being valued within the group.
"To actually know other people have similar problems makes you realise you can help someone else with their problems. It gives you a sense of achievement and that's what I think you get a lot of from these things." Parent P33

2. PROGRAMME FACTORS

2.1 Initial approach to the family

An initial home visit was suggested by a number of practitioners as a good opportunity to build trust with the parent, providing time to explain the programme and highlight how it could be of benefit. Providing reassurance and listening to parents' concerns was seen as key to initial take up. This was also suggested as a good time for the professional to set up a realistic expectation regarding behavioural change/progress.
"At the first step you need to demystify what it is all about. And if you are going to have to use the word 'parenting' then it is going to have to be alongside something that reassures them that all those concerns will be taken into consideration. This isn't a failure, you are not here because you have failed, you're not here because you've done anything wrong, you know…" Practitioner P42

Both groups also highlighted the importance of parents feeling able to make their own decision about starting a programme as opposed to being made to attend. The use of a buddy scheme (where parents are paired up with

each other or introduced prior to the course starting) or bringing a family member, friend or 'family support worker' was also suggested to help support parents with either low confidence and/or mental health problems.

2.2 Support for parents' own needs

In order for parents to be able to follow a PP successfully and implement new strategies both groups felt that parents needed to have their own needs met first. Specific support in relation to mental health problems, domestic violence, and low confidence was considered vital.

So if you've got a parent with mental health problems, with horrendous childhood experiences, with domestic violence, with any of these really horrible experiences, unless you do some work about getting them to understand their own behaviour, and also letting go of that hurt, you really haven't got a chance in getting them to change what they're doing with their child. Practitioner P50

The identification and treatment for specific conditions such as depression and parent ADHD was also regarded as important.

"Parents need their own diagnosis and medication. That is probably top of the list because if you have ADHD yourself then doing a parenting group and trying to be consistent is an absolute nightmare. So actually in almost every group I've run I've ended up with one or two parents probably going off to their GP and asking for their own diagnosis. We had two on this group, which was really frustrating." Practitioner P48

2.3 Individually tailored and flexible programme

Both groups spoke of parents disengaging if they found the programme/therapist boring and/or not relevant for their own child. Parents often commented that they would like a range of different strategies to try to work out which is best suited to their child.

"Everyone's personality is different so having an absolutely rigid programme isn't going to work for everyone because everyone will react in a different way. I think everyone needs to work together to get to know each other and only then you can actually really tailor it for their actual behaviour, or communication level or just generally their personality." Parent P59

Practitioners spoke about the need for flexibility, particularly with regards to dealing with 'crisis moments'. The importance of adapting the programme to support children with more complex problems (e.g. additional language, communication and/or learning difficulties) was raised. The use of both generic and specifically targeted programmes, as well as linking with other specific support services (e.g. Speech and Language Therapy) was also mentioned.

2.4 Implementation of strategies at home

Difficulties implementing strategies within the home context was a common theme within both groups. Practitioners stressed the importance of modelling strategies and giving relevant, real life examples.

"Yes, it's the modelling actually. I think these parents - group of parents - they haven't seen a role model of dealing with difficult behaviour or ordinary behaviour, and they can't put the energy to do that because of their own problems. So that modelling is so important, and to show them that's how it's done. When you talk, er, theoretically to those families it doesn't fit and that's why a lot of time they will withdraw from the group because they can't take it." Practitioner P44

Involvement and support from partners/fathers and other key family members were also suggested as important. The need for information to be presented in small, 'bite-sized chunks', with plenty of opportunities for practice was also reported to be helpful.

2.5 Realistic expectations and perception of progress

Both groups reported that parents were more likely to "drop-out" if the expected improvements did not materialise within a given timeframe. The importance of having realistic expectations and the ability to spot small and subtle changes was highlighted. Having such improvements specifically pointed out by the therapist and understanding that strategies may not work all of the time was also reported as beneficial by parents.

"…actually looking at what you've achieved so far and although you think that you're rubbish at it you're actually not cos you've achieved quite a lot!" Parent" P3

Practitioners spoke of the usefulness of video recordings for demonstrating progress.

2.6 Additional contact

The importance of regular practitioner-parent contact between sessions was highlighted by both groups. Telephone calls and/or text messages as reminders of upcoming sessions or when a parent missed a session were seen to be particularly important. Some respondents mentioned that text messages were preferable as they could be less threatening. The availability of catch up sessions and additional individual one-to-one support was also seen to be valuable. This was seen as especially important for those families with complex needs. A wish for some form of follow up refresher session(s), or additional support for after the programme ends was also raised by a number of parents.

2.7 Group delivery format

The group delivery format of PPs received more coverage from parents than practitioners. Views were polarised with intra-group relationships.

Positive aspects included; finding out that other people have similar problems, feeling less alone, building relationships with likeminded people, sharing problems and solutions, gaining a support network and feeling valued.

"Sometimes you feel as if it must be in your head - it's like, is my son the only one like this - but when you hear other parents actually saying 'oh my son does this, and my child does that - oh, he does that too, and then you pick up pointers from other parents - what they do and stuff, so I think it is helpful". Parent, P56

In contrast some parents mentioned difficulties going to a group programme by themselves, highlighting issues with confidence and socialising. This was a particular problem raised by the majority of parents who had not actually attended a PP themselves. Feelings around *'not fitting in'* with the group were also mentioned as reasons for dropping out. This appeared to be driven by disparities in factors such as age, culture, education, marital status, severity of child's problems, and perception of progress. Personality clashes were also mentioned and issues with sharing things with the group.

"They'll typically say - I sat there when they were talking about they won't eat their dinner nicely and my child is running around the room trying to strangle the dog and screaming and shouting, running in the road and blah, blah, blah, and it just felt so awful because I had to talk about what mine was doing and it was so different to what everyone else's child was doing - and that's a real turn off." Practitioner P48

3. SERVICE FACTORS

3.1 Awareness and advertising

Only a single practitioner mentioned lack of awareness of PPs as a reason for not attending a PP whereas this was a common point raised by parents.

Suggestions from parents for raising awareness of PPs mainly focussed on ***where*** information/leaflets should be placed. The most common suggestion was within GP surgeries. Both groups highlighted the importance of 'word of mouth', e.g. through groups of parents where those who had attended PPs could share their experiences.

"Yes, we've got to be there, it's our job. Parents haven't got to turn up, but if you've got a parent saying to a group of parents 'yes I came and I only missed one for a doctor's appointment because it is really working for..' it goes far further than me saying 'please come - it's great'" Practitioner P42

The use of parent testimonials in the form of leaflets, DVDs or internet clips was also suggested.

3.2 Inter-agency collaboration

Parents expressed a desire for all practitioners who come into contact with young children (e.g. GP, health visitors, school staff) to be able to both spot potential clinical issues (e.g. ADHD) and have up-to-date information of PPs to pass on.

Practitioners mentioned the need for agencies to collaborate to optimise the referral process (e.g. using existing agencies with a good relationship with the family) and to provide better holistic care, especially for those with the most complex needs.

"I think it is multi-agency working. It is not only the child and the family in those… [hard-to-reach]. You have to identify the whole family dynamic in those, and mostly there are a lot of social issues in those families. Mental issues in the mum, personality disorder in the mum, learning difficulty in mum, and not being able. It's mainly factors around the mum or the dad themselves - the parents or the carers themselves - and that's a big piece of work". Practitioner P4

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3.3 Therapist's characteristics and therapeutic relationship

The role of the therapeutic relationship was seen as crucial. Parents most importantly wanted the therapist to have plenty of direct experience working with children with very challenging behaviour and for him/her to be a parent. Both groups highlighted the importance of good knowledge of specific disorders such as ADHD.
"It's no use going to see someone that hasn't really had the hands on experience and then give a group and don't really know what they're talking about…" Parent P53
Being a strong enough personality to control the group and establish a safe environment for sharing stories without the worry of breaches in confidentiality was also mentioned.

Both groups spoke of the importance of a strong relationship between the parent and the therapist. This was facilitated by commonalities between them and by the therapist adopting a non-judgemental, informal and caring approach. Parents specifically wanted to feel on 'the same level' as the therapist. In addition practitioners mentioned the need for supervision and support for therapist and the importance of considering the mix of personalities when co-facilitating group programmes.

Discussion

Low "take-up" and high "drop-out" rates are significant barriers to PP effectiveness. Whilst previous research in this area has considered this with regard to programmes for disruptive behaviour problems generally, the aim of the current study was to focus specifically on early PPs for ADHD. In addition, we purposely sampled for families living in areas of high deprivation and those with the most complex needs, considering the views of both parents and practitioners. This enabled us to sample those considered 'hard to reach' and 'difficult to treat', who are often overlooked. The current study also placed a greater focus on seeking potential solutions and improvements rather than concentrating solely on barriers in order to help clinicians and service providers to better support these complex families.

Our themes were broadly consistent with the existing literature relating to PPs in general (see Table 2). These included both psychological and situational barriers, and a desire for a PP that is individually tailored, flexible and incorporates additional contact in-between sessions, if required. The importance of raising awareness and advertising of PPs, good inter-agency collaboration and a positive therapeutic relationship were also consistent with existing literature (Koerting *et al.* 2013). The current sample highlighted difficulties in implementing new

strategies within their own environment. Also, whereas previous studies demonstrated that parents "drop out" if they find the programme unhelpful (Attride-Stirling *et al.* 2004, Friars and Mellor 2009, Patterson *et al.* 2005) our sample spoke of this more specifically in relation to perceptions about the child's progress, highlighting the importance of realistic expectations and a desire for progress to be made explicit by the therapist. We also identified a number of additional elements when considering early PPs for ADHD specifically. These new themes were 'motivation and capacity to change parenting practices', 'initial approach to the family' and 'additional support for parents' own needs'. These themes are likely to be either associated with the specific focus on ADHD and/or our complex, 'hard-to-reach' sample.

(Table 2 here)

Parental motivation was specifically highlighted by the current sample in relation to access, engagement and effectiveness of early PPs for ADHD. This could be an area of particular importance and relevance for families with ADHD as motivational deficits have been found in adults with ADHD (Cubillo *et al.* 2012, Volkow *et al.* 2009). Previous research has demonstrated the benefits of a brief intervention designed to increase parents' motivation in relation to attendance and reported adherence with a PP for children with conduct problems (Nock and Kazdin 2005). The second novel theme 'Initial approach to the family' covered suggestions relating to early contact with families. Explaining the benefits of the programme, addressing parental concerns, and setting up realistic expectations were all considered to be highly beneficial. The final novel theme focussed on the desire for intervention to be targeted towards the parent's needs in addition to those of the child, e.g. through identification and treatment of parental depression and ADHD. This is especially important considering the strong familial component to ADHD (Williams *et al.* 2010) and findings from previous research which suggest that PPs are less beneficial for children whose parents demonstrate symptoms of ADHD themselves (Harvey *et al.* 2003, Sonuga-Barke *et al.* 2002).

In general, lack of parental self-confidence and sense of self-efficacy could be seen as factors underlying many of the barriers (e.g. 'psychological barriers', 'motivation and capacity to change parenting practice', 'additional support for parents' own needs' and 'group delivery format'). Previous research has highlighted the importance of parenting self-efficacy as a predictor for positive treatment experience among mothers participating in a behavioural PP for their school-aged child with ADHD (Johnston *et al.* 2010). This would suggest that the use of underpinning theory and evidence based practices to guide the delivery of PPs may be an important step forward.

Overall, there was often a good level of agreement between the accounts from parents and practitioners. However, some practitioners demonstrated poor understanding of psychological barriers and little recognition of parents' lack of awareness of available programmes. Parents also spent a considerable proportion of their interview speaking of the social/group aspect of the programme which were less pronounced in practitioners'

accounts. This suggests that practitioners had less awareness of pertinent issues for parents implying a potential for greater understanding of their views to inform programme delivery.

Recommendations and Implication for Clinical Practice

On the basis of the current findings we make the following recommendations to improve engagement in early treatment interventions for children with ADHD:

1. Awareness and Advertisement
    - Raise awareness among professionals of potential psychological barriers faced by parents.
    - Greater advertisement of programmes aimed at hard to reach groups.
    - Maintain good communication between agencies about currently available PPs

2. Thorough initial assessment
    - Explore and address potential psychological and situational barriers faced by the family in addition to the specific needs of the child.
    - Provide a clear explanation of what the PP involves and how it could be of benefit whilst setting up realistic expectations regarding behaviour change/progress.
    - Consider the appropriateness of group-based - v - individual programme.

3. Provision of support for parents' own needs
    - Consider the needs of both the parent and the child.
    - Assessment and treatment of maternal mental health problems such as depression and adult ADHD.
    - Support to improve self-confidence, parenting self-efficacy and motivation.

4. Provision of a flexible, individually tailored programme with targeted support relating to ADHD core symptoms.
    - Place emphasis on helping parents to implement strategies at home, through techniques such as modelling and scaffolding.
    - Additional contact in-between sessions is desirable.
    - Therapists need to have a good knowledge and experience specifically relating to ADHD.
    - Highlight improvements/progress explicitly (e.g. through video clips).

Limitations and Future Direction

It should be borne in mind that our findings are limited to a parent sample of white females, all of whom spoke English as a first language. It is possible that different or additional themes may have emerged when interviewing fathers, or parents from an ethnic minority background; both of these groups are also considered hard to reach. A number of the parents were also selected via practitioners and thus may not necessarily be typical. In addition,

some parents had children who were school-aged rather than pre-schoolers. Whilst interviewers enquired specifically about the time when their children were pre-schoolers, there is always a potential for bias in retrospective accounts. Finally, not all parents had attended a PP by the time of the interview, so they did not have direct experiences of attending a PP. However, if was felt that ascertaining the views of these families, particularly with regards to why they have not accessed such a programme, was of importance.

Future research is needed to develop instruments that help provide a thorough assessment of both the needs of the parent and the child. Psychological factors such as confidence levels, parenting self-efficacy and motivation should also be considered as these may also impact on treatment effectiveness. Research is needed to investigate the potential benefit such factors may have on increasing "up-take", reducing "dropouts" and with regards to effectiveness of PP within the area of early parenting intervention for ADHD. Evaluating the cost effectiveness of these, perhaps more intensive treatment approaches, will also be of importance.

Key messages:

- PPs should address the needs of the parent in addition to those of the child.
- PPs need to be better advertised and raising awareness of possible parental psychological barriers among practitioners would be beneficial.
- Parental motivation was considered influential with regard to both accessing and engaging with PPs and treatment effectiveness. This may be an area of particular importance for families of children with ADHD.

Table I: Sample demographics for parent participants

Parent Characteristics (*n* = 25)	***n* (%)**
Gender	
Male	0 (-)
Female	25 (100)
Age	
20-30	11 (44)
31-40	10 (40)
41 +	4 (16)
Ethnicity	
White	23 (92)
Mixed Race	2 (8)
First language	
English	25 (100)
Education	
None	4 (16)
GCSE	12 (48)
A Level/NVQ	5 (20)
Undergraduate degree	3 (12)
missing	1 (4)
Marital status	
Single	12 (48)
Married/ Living with partner	13 (53)
Employment	
Employed/Self Employed	6 (24)
Unemployed	19 (76)
Actual Experience of Parenting Programmes	
None	7 (28)
Attended $\geqslant$1 group based programme	17 (68)
Attended an individual programme	1 (4)

Table 2: Comparison of themes from the current study with existing previous qualitative research on PPs for children with general disruptive behaviour as synthesized in Koerting et al., 2013.

		Themes from existing literature on general disruptive behavioural problems**	**Themes from current study on PPs for children with ADHD**
Parent factors	Psychological Barriers	✓	✓
	Situational Barriers	✓	✓
	Motivation and capacity to change parenting practices	×	✓
Programme factors	Initial approach to the family	×	✓
	Support for parents' own needs	×	✓
	Individually tailored and flexible programme	✓	✓
	Additional contact	✓	✓
		*Difficulties following the programme *Programme regarded as unhelpful	*Implementation of strategies at home *Realistic expectations and perception of progress
	Group issues	✓	✓
Service factors	Availability of services	✓	×
	Awareness and advertisement	✓	✓
	Interagency collaboration	✓	✓
	Therapist factors	✓	✓

*These themes share some aspects but are not entirely congruent; ** based on a recent meta-synthesis of the qualitative data by Koerting et al., (Koerting *et al.* 2013).

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