

Experiences Concerning the Introduction of a Manualized Treatment Program and a Large Scale Clinical Trial in Two Outpatient Psychiatric Clinics in Norway

Graham Clifford
Norwegian University of Science and Technology

Willy-Tore Mørch
University of Tromsø, Norway

Since 1998 four research centres and two clinics in Norway have conducted a large-scale clinical trial of Webster-Stratton's methods of treatment for children suffering from severe behavioural disturbances. This multi-centre project was initiated as part of a broad government-funded programme designed to stimulate the use of up-to-date methods in working with children and young people with behavioural problems.

Until the mid-1990's, children and young people with severe behavioural disturbances, and their families, received little useful help from the health, social and educational services in Norway. There was general awareness of this, but little progress was made. In part this was due to the lack of promising methods which might serve as a basis for intervention, a problem which of course has been encountered in many other countries too. Responsibility for helping affected children and families was also divided between a number of different agencies and services. Help was difficult to obtain, and poorly coordinated. This meant that parents who were concerned about their children often were frustrated. There was also little awareness of the fact that children can show signs of severe behavioural difficulties at an early age, and no basis for early intervention could be said to exist.

Research and method development in the 1990's

led to a situation in which there was some hope of better provision. The main difficulty which health, educational and social services in Norway confronted, was that a coordinated effort would be required to introduce such methods.

The group of researchers who developed proposals for a large-scale trial of Webster-Stratton's methods work at the universities in Trondheim and Tromsø. In 1998 the Norwegian research council (NFR) published a report from an expert committee, which provided a summary of available research dealing with severe behavioural problems among children and young people. Per Rypdal, a clinical psychologist working at the University of Trondheim, served on the expert committee, and it was his initiative which led to the decision to initiate project planning designed to provide a platform for for introduction of Webster-Stratton's methods in Norway.

The expert committee had been set up as a response to general concern about behavioural problems, anti-social and delinquent behaviour among children and young people. It recommended adoption of certain methods (Parent Management Training and Multi-Systemic Therapy) as well as trials of Webster-Stratton's methods. The main weakness of the material assembled by the expert committee was the lack of empirical material that

might throw light of the prevalence of behavioural problems among children and young people.

PMT and MST were introduced and disseminated in a programme supported by the Ministry for Child and Family, conducted by a group based at the university of Oslo. The group of researchers who initiated the Webster-Stratton trial were supported by the Ministry of Health, and this was logical in the sense that their proposals involved a trial conducted in treatment facilities based in child psychiatric services. Both groups started their work in 1998-99.

The rationale for a clinical trial of Webster-Stratton's methods reflected the project team's scepticism relating to adoption and dissemination of new methods, as this has traditionally been practised in Norway. All too often, new methods have been introduced without adequate investment in preparation and training, and this has often meant that the version of a method that is introduced may not be particularly faithful to the original, and that evaluation procedures are neglected. Even at the very start of our work, it was apparent that expertise in behavioural analysis and learning theory would be crucial in the project that was envisaged. This led to the establishment of close cooperation between the project group in Trondheim and a similar group at the University of Tromsø, led by Willy-Tore Mørch.

At a very early stage, it became apparent that a project would have to maintain a dual focus:

1. New and demanding manual-based treatment methods would have to be introduced, and such approaches were (and still are) novel in child psychiatry in Norway. In particular, the scope and intensity of training procedures involved would represent an innovation, which clinics might well find difficult to cope with. Personnel recruited for the trial would have to be selected on the basis of their suitability and their willingness to work in a manual-based treatment programme. A lengthy period of training (lasting one year before the clinical

trial could begin) added to the overall cost of the project. We also found it imperative that maintenance of standards and programme/treatment fidelity in a clinical trial conducted at two sites (Trondheim and Tromsø) should be secured by giving overall direction and coordination of training and clinical work to one person (Willy-Tore Mørch, who took over as project leader in february 2001, after the clinical trial had started).

2. Much of the difficulty in developing programmes for helping families with young children suffering from behavioural disturbances arises from the fact that few of the affected children are identified before they have reached the age of eight or nine years, that is to say, an age when disruption of peer relationships and school performance will often have developed. Even if parents and community service professionals, including kindergarten and school, see that the child needs help, this may not be enough. It may take time for adults to accept that the problems are real and severe, and that the child will not "grow out" of them. To refer a child for psychiatric help is, quite reasonably, seen as a serious matter by professionals and parents alike; and referral procedures are often a barrier in themselves. We decided to make special efforts to reach affected families and children, by providing help and advice from independent coordinators in the catchment areas where the clinical trial was conducted, and we also monitored referral. This was done with the intention of being able to compare referral data with material from a prevalence study which also was included in the project plan. No satisfactory epidemiological material has been available to assess the prevalence of severe behavioural disturbances (ODD and CD) among Norwegian children. These project components aimed at securing referral of children to the clinical trial were entrusted to Child Protection Research Units in Tromsø and Trondheim and were coordinated by Torill Tjelflaat.

Our project (in its scope more a programme than a project) was far too large to have much hope of securing support from the Norwegian Research Council. It involved the development of special treatment facilities with appropriate staffing in Trondheim and Tromsø, the work of a moderately large research team, the work we have briefly described above relating to referral and epidemiological study, training and the direction and coordination of treatment in two child psychiatric clinics, and not least, extensive preparation and planning which in fact it took almost two-and-a-half years to complete, and which in itself represented a considerable outlay of resources and time. Almost a quarter of the funding resources we have used have been devoted to planning and preparation, including training. Graham Clifford who led the project (or more accurately, served as coordinator) from 1998 until the end of 2000, had the advantage of having a group of researchers with different backgrounds and specialities to draw on, all of whom work in directly funded government-sponsored research centres in child psychiatry or child protection. Though a project of this scope and size is more or less unprecedented in Norwegian psychiatry or child research (it is one of only two randomized treatment studies ever attempted in Norwegian psychiatry, and over and above this included other research components), government support and commitment has been consistent and reliable. The research centres that have worked on the project are set up to facilitate innovation and implementation, so that the legitimacy of the very considerable effort devoted to the project was hardly an issue. There have been some informed critics who doubted the wisdom of such large resources devoted to trials of a single group of methods, but the project on the whole has been well received.

At the present date, the clinical trial based on a three group design (parent groups, child groups ("Dinosaur School"), and waiting list controls) is nearing completion. Webster-Stratton parent groups have been introduced in a number of other clinics with guidance and training from our project

staff, and a programme designed to assist teachers, and a preventive intervention (a variant of Webster-Stratton's parent groups), are being developed. Proposals for broader implementation of Webster-Stratton methods are under consideration, and many agencies and clinics have expressed an interest in acquiring the methods. We have so far resisted the temptation to say much about the results of our efforts in terms of effectiveness of treatment. We have to wait until the trial is complete.

What we can offer, are some reflections about the benefits and costs of large-scale clinical trials designed to serve as a framework for introducing new treatment methods:

1. There is nowadays a good deal of support for a movement towards evidence-based methods in treatment, and the health authorities in Norway have been consistent in this respect. Within the stringent framework implied by replication of a treatment method, there are some considerable costs that cannot be avoided. Both preparation of treatment material (video vignettes, texts, manuals) and training, are very expensive and the work takes time. It has to be supervised carefully. Some methods may be simpler to replicate than the ones we are concerned with here, but as a rule it seems that the costs involved will be considerable. Even in terms of preparation and training, it seems to us that many worthwhile methods innovations cannot be properly accomplished without multi-centre organisation, and this involves proper coordination, clarity as to roles and responsibilities, and good communication. In Norway, at least, few agencies or clinics and few university research and teaching facilities could carry through such a project alone.
2. Multi-centre, multi-disciplinary projects have been uncommon in the context of services for children in Norway. The reason for this must be partly that research centres are heirs to a tradition in which they compete for funding and status. Contemporary research evaluation and research council funding

systems probably do little to reduce these pressures. The prevailing ethos of treatment in Norwegian child psychiatry is still one of relatively small projects based on a single institution or setting.

3. A good working relationship with the originator of a treatment approach is also indispensable. Carolyn Webster-Stratton has supported our work in many ways, the goodwill and interest that she has shown has been unstinting and a great source of encouragement.
4. Our experience seems to indicate that programme fidelity and coordination are the two big issues in innovative work within an evidence-based framework. Both, to put it simply, require adequate funding and the maintenance of high standards under pressure.
5. Our experience has been that a multi-disciplinary research-led approach works well. Our project was designed, and its parameters set, so to speak, before discussion with clinical staff started. We also took care to recruit teams of therapists with a variety of professional backgrounds, and to recruit from a variety of agencies. Both professional cultures and workplace cultures may involuntarily obstruct innovation. On the other hand, we have found that our therapists responded very well to the challenge imposed by rigorous training procedures, with close and extensive supervision. Professional staff wants to have methods that work, and to feel that their contribution is valuable. Given the opportunity, they work very hard to make treatment work. Motivation is not a problem if the project has sufficiently clear aims and the ground rules for therapists' contributions are established.

The two "big" questions one might reasonably have asked in 1999 when our project planning was properly under way, were:

1. *Can a treatment intervention that is substantially*

concerned with training parents in management of children's behaviour be successfully translated from one culture (North America) to another (Scandinavia)?

2. *Is there a valid basis for intervention of the kind developed by Webster-Stratton in a Norwegian setting? Will parents want the treatment, which in practice demands considerable commitment from them? How can we locate the young children who will benefit from intervention?*

Webster-Stratton's parent group intervention seems to have been a considerable success judged by our experience in Norway. Parents are most usually enthusiastic and there has been practically no drop-outs after the commencement of treatment. Attendance at group sessions has also been good. All this despite the fact that much of the content of the sessions will initially seem unfamiliar and strange to Norwegian parents, for example the emphasis placed on positive reinforcement which to some extent might well be seen as being at odds with what are seen as traditional cultural values. Parent participation in follow-up interviews and questionnaires associated with treatment evaluation has been much better than we expected, and in all it seems that the supposed cultural barriers that might make it difficult to use the methods, have had little practical impact in the project. We have some evidence that parents can react negatively to the (fairly extensive) assessment procedures associated with the research and evaluation that are an integral part of the project, but our experience is that, once treatment has started, parent groups have a considerable appeal for parents, who experience the content as being useful for them in their situation. Much the same could be said of our experience in using a Webster-Stratton method designed to help teachers. Here too the user response has been overwhelmingly positive.

Not only parents, but also therapists, have to make adjustments if an imported method is to be applied successfully. On the whole, our experience is that this has gone well. It has to be remembered that the therapist working in our project in Tromsø and Trondheim were selected partly on the basis of their motivation and willingness to accept

the framework implied by the methods. On the whole, it seems that clinical staff willingly accept a manual-based treatment approach, and that they do not perceive that this in some way imposes unreasonable limits on their own creativity or professional integrity. We feel that the prerequisite for this should be emphasised: an obvious cost of using these after all rather demanding methods is that supervision must be reliable and regular, and the training itself systematic and thorough. It should be remembered that only a minority of the therapists we recruited in Tromsø and Trondheim had previous experience of working as therapists in a clinical setting. Our experience in the project indicates that transfer of these particular methods to a new cultural and service setting is quite feasible, though much investment of time and attention will be necessary.

Preliminary findings from our standardisation and prevalence studies indicates that far fewer children under the age of nine suffer from severe behavioural disturbances in Norway, than have been reported in studies in the USA. Though it must be emphasised that our findings so far are only preliminary, it looks as if 2.5% - 3% of children are affected in Norway, as compared with 5% - 7% in some North American studies. If these findings stand up to further analysis, the implications for service development in Norway are obvious. Webster-Stratton treatment facilities which can offer help to families will have to be located primarily in larger regional population centres where there will be sufficiently large demand for them. Teacher-targeted methods and the preventive variant briefly referred to earlier, will probably be more feasible alternatives for provision in smaller local centres and communities, such as are still very important in Norway with its thinly spread population.

Although we have no direct evidence that low prevalence has actually and adversely affected recruitment of children to the trial project, the fact remains that recruitment proved unexpectedly difficult. In the project team we believed that sufficiently large numbers of families with affected children under the age of nine would occur, and

our recruitment policy was based on optimising information made available to parents and community service workers, on the assumption that parents would be motivated to seek help. This strategy did work to some extent, but produced fewer referrals than we had expected, and far fewer referrals of children under six, than we had hoped for. We know that some of the shortfall in the numbers of referrals might be due to hesitancy on the part of parents and community service workers, particularly in the health services and pre-school/ kindergarten. If our treatment facilities had been located in the community services rather than child psychiatry, this hesitancy might have been easier to overcome. It is a big step to refer a small child to a child psychiatric clinic, something not to be done lightly, and very properly so. The implication of our experience in the project is that prevalence of severe behavioural disturbances among small children in Norway is probably substantially lower than was assumed in the expert committee's report. This would be good news. Given that the interventions we have tested prove to be effective, the total cost of building up competence in the methods in larger regional centres in the country will be less than with a higher prevalence.

In conclusion, it still has to be emphasised that the impressive effort by the Norwegian government in this field is likely to be vindicated. Also in our country, relatively small numbers of children and young with conduct disorders cause disruption and strain for families and peer groups, and of course kindergarten and schools. The children and young people themselves are at severe risk of developing persistent anti-social behaviour pattern which at a later stage will be very difficult to change. Far too many children with conduct disorders do not get help before they are nine or ten years of age, or even older, that is to say at an stage when considerable deterioration and disruption of their environment has already occurred. In view of this, and given the fairly clear indications we have that suggest that the methods we have used can be successfully applied in a Norwegian context, the stage has been set for implementation of the methods on a larger scale.