Drawing on parents' experiences to explore how to prevent high-risk primary school children developing antisocial and criminal behaviour

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Declaration of authorship

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List of acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ASB	Antisocial and criminal behaviour
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CSRI	Child Service Receipt Inventory
DAWBA	Development and Well-Being Assessment
GP	General Practitioner
HFP	Helping Families Programme
PhD	The term is used in the thesis to distinguish the data collection timepoints which took place during the doctorate study phase from the preceding timepoints
SDQ	Strengths and Difficulties Questionnaire
SEN	Special Educational Needs
TA	Teaching Assistant
T1	Time one data collection point
T2	Time two data collection point

Abstract

Much evidence links early childhood factors to later antisocial and criminal behaviour. However, many ‘at-risk’ children do not develop such behaviours. Some families are subject to intensive intervention from services including social, health, criminal justice and special education services, yet little is known about what aspects of support are useful for the most vulnerable families in the longer term.

This mixed methods study investigates parents’ experiences of the full range of services with which they and their children are involved during middle childhood. The major component is a longitudinal five-year qualitative interview study of eleven families, including practitioners parents nominated as helpful. Children were at-risk because of their difficult behaviour and additional family risk factors. Inductive thematic analysis suggested factors which appeared important in changing child behaviour and family functioning. A subset of these factors were further investigated using quantitative longitudinal analysis of a large cohort data set, the Avon Longitudinal Study of Parents and Children (ALSPAC), to examine associations with antisocial and criminal behaviour at ages 16–21.

The original contribution to knowledge is identification and explanation of factors influencing how families benefit, or fail to benefit, from intervention. These include the conflicting roles of services tasked with support, reform and surveillance of families. Some parents are skilfully supported to make lasting changes in their parenting behaviour, but non-familial influences such as peers, neighbourhood and school experiences mean improvements in parent-child relationships do not necessarily translate to improvements in the child’s behaviour and wellbeing outside the family. In addition, the study contributes analyses linking middle childhood factors to lower chance of future antisocial and criminal behaviour. These factors include changes in maternal hostility and depression, financial circumstances and children’s relationships with teachers. Findings suggest families could be helped by easier-to-access, on-call, non-judgemental support and, in schools, attention to consistent, supportive relationships.

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Chapter 1

Introduction

> What happens is people say, 'Oh they'll grow out of it'. And they don't, they don't grow out of it… if you've got a family that's got a number of children with troubles, the chances are they're going to need support. *Family worker*

The concept of 'problem' families has been around a long time, as have policies to address their perceived needs with a view to preventing the future antisocial and criminal behaviour of children being raised in them (Jones, 1950). Much is known about factors associated with poor outcomes for children, including family background characteristics, and there is a strong relationship between behaviour problems in childhood, which cause disruption in families and schools, and the later antisocial and criminal behaviour which can blight lives and neighbourhoods (Patterson et al., 1989).

There are regular policy pronouncements about both the problem and the solutions, but politicians with short-term goals and the need for re-election rarely engage with the wider potential determinants of family wellbeing, tending to focus solutions on changing individuals' (usually parents') behaviour. Much of the evidence of effectiveness for current favoured approaches, such as parenting programmes, uses study designs which take little account of contexts, and of the multitude of service and other influences affecting families' experiences.

The subject of this study is those families where there is a high risk of a child having serious behaviour problems in the future. The risk is high because of characteristics of the child (presence of a conduct disorder) and of the family which are known to be associated with antisocial and criminal behaviour in the longer term. The study takes a developmental perspective, looking at changes in family functioning, child behaviour and relationships with services over time. The study also explores in detail across service types and broader experiences at each timepoint to look at the different spheres of influence on children's and families' behaviour.

Middle childhood (about ages 5–13) is the developmental stage of interest because at this age children start school, families come into contact with a new set of services, many children with difficulties are not identified until this time and despite the implications of some commentators (e.g. Allen & Smith, 2008) there is no compelling evidence that children's outcomes are largely set in stone by age 5 (Blakemore, 2008). The middle childhood years have been identified as a time when later problems can take root as children begin to seek independence, and are subjected to a greater variety of influences, and this can be a key time to intervene to prevent delinquency, poor school attendance, smoking and alcohol use (Madge et al., 2000).

The causes and developmental pathways of conduct problems are complex, as are the many efforts, and potential interventions, to address them. This mixed methods study aims to unravel some of the complexity in the responses to children's behaviour problems. By drawing on the experiences of parents and practitioners, focussing in-depth on a few families' stories, and then examining survey data from a larger sample, this thesis aims to contribute to theory about what helps families with children at risk of antisocial and criminal behaviour.

This research takes a step towards addressing the much larger research agenda of what can be done to improve children's life chances and how we might go about finding out what public intervention will make a lasting difference to them and their families. In particular, the research is interested in what can be done to prevent children becoming involved in criminal and antisocial behaviour. The study does not seek to look at pre-existing or pre-school determinants of antisocial behaviour but instead looks at what aspects of intervention *after* the age of starting school can be effective, or may prevent intervention being effective.

Many spheres of influence affect children's lives, and the lives of their parents. Services trying to help them can potentially intervene in many ways. Despite a plethora of research on troubled families and children with behaviour problems it remains unclear how most of these families can best be helped, as will be explained in Chapter 2. First, however, the theoretical and conceptual framework of this thesis and the specific research questions to be answered are set out. Although these both derive from the literature discussed in Chapter 2 it is useful to state them at the outset.

This study aims to contribute to understanding what forms useful intervention might take, using a mixed methods approach. The primary, qualitative component is an interview study following eleven families over five years allowing an in-depth exploration of parents' and practitioners' experiences, uncovering factors which appear to be helpful in efforts to support them. This phase of the research is referred to as the *interview study.* The quantitative component uses existing data from a large cohort study, the Avon Longitudinal Study of Parents and Children (ALSPAC), to see if such data provides evidence to indicate the importance of these factors for longer term criminal and antisocial behaviour. This phase is referred to as the *ALSPAC study.*

1.1 Theoretical and conceptual framework

Reviews have identified the need for research into risk and protective factors for delinquent behaviour to be theoretically grounded and policy-relevant (Jennings & Reingle, 2012). Figure 1 illustrates the conceptual framework for this thesis, a summary representation of the complicated relationships and processes linking risk factors to outcomes. It is known, as will be explained in Chapter 2, that children exposed to the risk factors on the left of the figure are more likely to be involved in later antisocial and criminal behaviour. However, the causal pathways linking the risk factors to the outcomes are unclear and may be affected by factors at the various levels of families' lives and experiences. The research investigates how services, interventions and policies, as experienced by parents and the practitioners working with them, fit into the picture, and how they might have an impact on the trajectories of children at high risk of later antisocial and criminal behaviour. The foundations of the investigation are the views of families who receive services, and practitioners who deliver them.

The concentric circles in Figure 1 represent different spheres of influence within which causal factors may explain the relationship between risk factors and outcomes. They also are the spheres of influence at which services could aim intervention, or government could aim policy. The circles represent the following different levels at which interventions and policies could try to have an impact:

1) The *intra*personal level, for example by improving mental health, self-esteem or behaviour (in the child or adult);

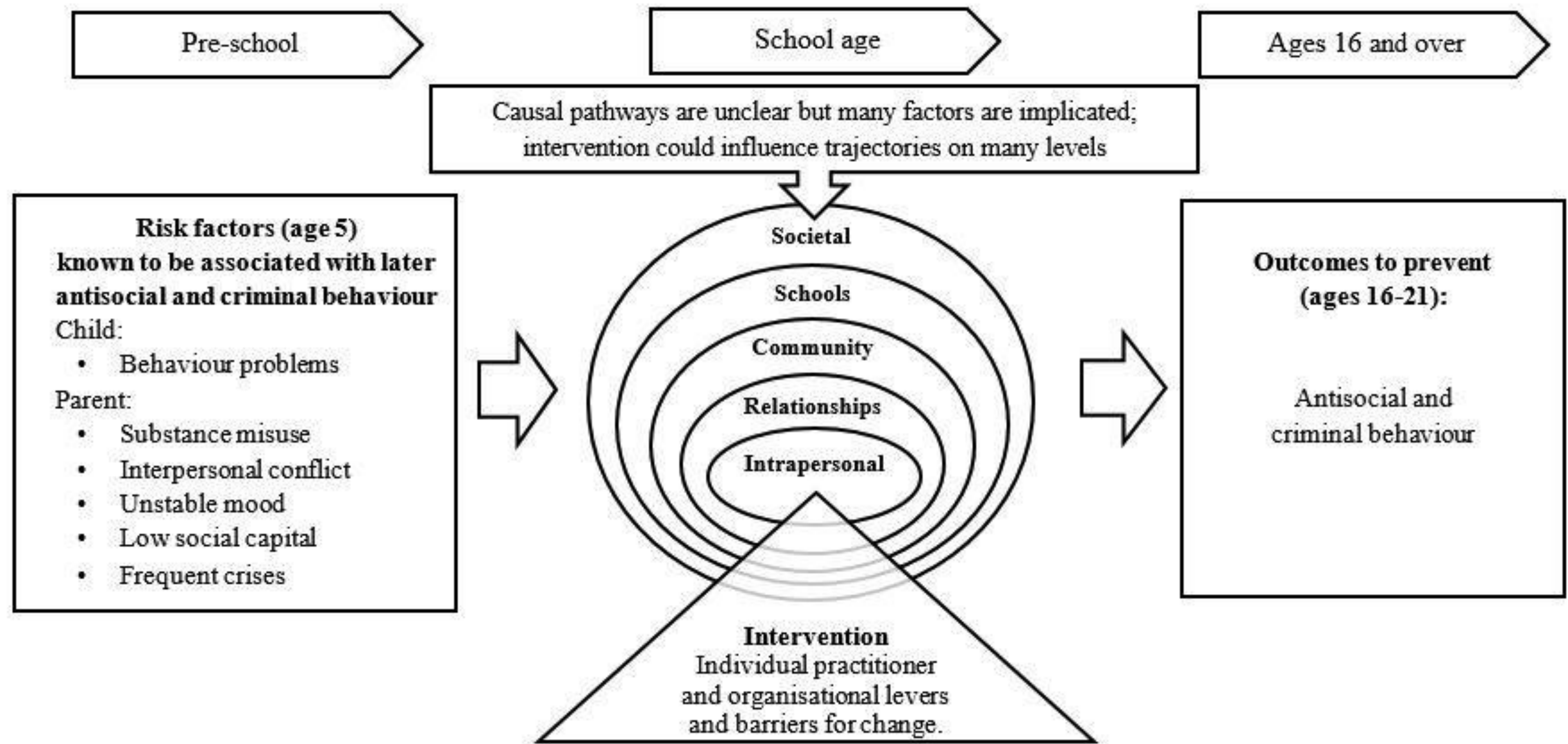
2) The relationships level, for example improving parent-child interactions or the way parents interact with other adults including service providers;
3) The community level, which here refers to the people and places in families' local environment, for example improving neighbourhoods by providing places and activities for young people;
4) The school level, for example changing the way behaviour is dealt with in schools, or enhancing the curriculum to improve children's school engagement; and
5) The societal level, for example adjusting social security, employment, housing or childcare policies or improving attitudes to disadvantaged families.

From the perspective of this research a useful theoretical understanding of how change could be brought about would take into account these potential layers of influence on children's trajectories. The framework is derived from the literature discussed in Chapter 2 and also draws on social ecological models which emphasise the wider network families may live within and the multi-directionality of influences (Bronfenbrenner, 2005). It has links to Burchardt and colleagues' framework for analysis of social exclusion (2002:9).

The conceptual framework takes into account all the levels of influence listed above, each a potential site of intervention, in acknowledgement that making an environment (be it the home, school, neighbourhood or nation) more conducive to change makes it easier for individuals to alter their behaviour (Whittaker & Cowley, 2012). Bronfenbrenner's later theories took account of intrapersonal characteristics and included a developmental perspective. He noted that two children can have the same 'resource characteristics', that is, mental, emotional, social and material resources, but will follow different developmental trajectories if one is motivated to succeed and persists in tasks, and the other is not (Bronfenbrenner & Ceci, 1994). His later work highlighted the role of processes in theorising about person-context interrelationships, with *proximal processes*, those experienced directly by the individual, key to development (Bronfenbrenner & Morris, 2006; Tudge et al., 2009). The current research, then, takes both a developmental and an ecological perspective, investigating the proximal processes affecting both parents and children as well as the broader

spheres of influence which can affect children's trajectories more indirectly, sometimes referred to as *distal processes* (Schoon et al., 2010).

Figure 1 Conceptual framework: Levels at which middle-childhood intervention could influence causal pathways



A simplified version of Figure 1 will be included at the beginning of each chapter to highlight which section of the framework is under discussion.

1.2 Research questions

The over-arching research question the study aims to answer is:

What helps families prevent high-risk primary school children developing future antisocial and criminal behaviour?

This overarching question is investigated by exploring answers to the following research questions.

Research Question 1 concerns families where a combination of child behaviour problems and family risk factors mean the primary-school-aged child is at high risk of later antisocial and criminal behaviour.

Research Question 1 is primarily addressed with the qualitative *interview study.*

Research Question 1:
How do families benefit, or fail to benefit, from intervention?

Research Question 1 encompasses the following research questions:
1a) What factors amenable to intervention influence family functioning and child behaviour?
1b) What features of intervention help bring about change? Conversely, what features of intervention prevent families benefitting?

Research Question 2 is primarily addressed with the quantitative *ALSPAC study* but is based on the interview study's findings addressing Research Question 1.

Research Question 2:
Which factors revealed as potentially beneficial in the qualitative analysis influence the later antisocial and criminal behaviour of children with primary-school age behaviour problems?

The word ‘families’ is used to capture a variety of different situations in which the ‘at-risk’ child lives, and it also underlines the perspective of the study, which is that helpful intervention could come from many different sources and not necessarily be aimed directly at the target child or even at the parent. The term ‘family functioning’ refers to behaviours and relationships within the family. The McMaster model of family functioning, for example, covers problem-solving, communication, role functioning, affective responsiveness (responding to each other with appropriate feelings), affective involvement (mutual sharing of emotions) and behaviour control (Epstein et al., 2003). In the research for this thesis, no formal measure of family functioning is taken and the term is used as a way of referring in general to families’ wellbeing, that is, how they are feeling, and getting on with each other, and how well they are coping with day-to-day life.

1.3 Overview of the thesis

The thesis aims to look at what helps and what does not help in intervening with high-risk families to avoid future antisocial and criminal behaviour. Following this introduction which has described the theoretical framework for the study and the research questions, Chapter 2 reviews the most relevant literature. The chapter begins by summarising the evidence on the prevalence of behaviour problems and later antisocial and criminal behaviour, and on risk and protective factors, because an understanding of the known risks contributes to understanding attempts to intervene. This is followed by an overview and critique of current and recent policy relating to families considered ‘high risk’ or ‘high need’, and a discussion of the evidence on effectiveness of intervention to prevent at-risk children developing antisocial and criminal behaviour. The available evidence indicates that successful intervention is likely to be highly cost-effective because of the high costs associated with later antisocial and criminal behaviour. However, the effectiveness literature often lacks applicability to real world contexts and evidence on whether effects of intervention are maintained in the longer term.

Chapter 3 explains the decision to use a mixed methods approach and details the methods used in both phases of the research. The empirical findings from the research are presented in Chapters 4 to 8. The qualitative analysis of interviews constitutes the

major contribution of the thesis and is reported in Chapters 4, 5, 6 and 8. Chapter 4 is mainly descriptive, introducing the eleven families from the interview study and describing their behaviour and service-use trajectories over the five years of the study. It illustrates the range of experiences and views of services in the sample, and how the impact of intervention may change over time.

The main themes from the qualitative analysis of interviews with parents, and practitioners working with them, are presented in Chapters 5, 6 and 8, identifying themes that address Research Question 1. Chapters 5 and 6 mainly address subquestion 1a while Chapter 8 mainly addresses subquestion 1b. The themes relate to aspects of families' experiences which indicate helpful intervention, that is, intervention that could lead to improvements in child outcomes and family wellbeing, as well as aspects which seem to hinder progress.

Chapter 5 concentrates on issues around parenting, looking at relationships between parenting and children's behaviour over time and at community and societal influences on parenting and children's behaviour. In terms of the conceptual framework diagram (Figure 1) Chapter 5 presents, in its first part, themes relevant to the Intrapersonal and Relationships levels and, in its second part, themes relevant to the Community and Societal levels. The aim is to see how these influences are, or could be, affected by services' actions. The limits of how helpful addressing parenting can be are also discussed. In the second part of the chapter themes are explained which show how parenting does not stand alone, and that other influences affect how the child and family are managing and developing.

Chapter 6 looks at intervention that is primarily delivered via the child, particularly within schools, the remaining level from the conceptual framework, although aspects of mentoring relationships with children outside school are included. The chapter looks at the evidence around what features of school experiences help children and which do not. A difficult balance is revealed between nurturing children and promoting their independence, a balance often upset at the point of transition to secondary school. Explanations of what helps and what goes wrong are presented.

The analysis for both Chapter 5 and Chapter 6 reveals themes for which it was possible to build hypotheses to test using the ALSPAC data. These hypotheses, and the results from regression analyses addressing them, are presented in Chapter 7. The analyses look at whether or not there is longitudinal evidence from ALSPAC to support the role of factors identified in the interview study in reducing the likelihood of future antisocial and criminal behaviour (addressing Research Question 2).

Chapter 8 looks at the themes arising from the qualitative analysis of interviews with parents and practitioners which relate to the organisation and implementation of services, and what aspects are helpful or unhelpful for families. Themes presented here, addressing Research Question 1b, could not be addressed by the data collected for ALSPAC. The themes concern characteristics of individual practitioners and organisations which emerged as levers or barriers for change. In the conceptual framework diagram (Figure 1) these are within the Intervention triangle, which represents how services can aim to alter potential influences on children's trajectories at one or more levels.

Chapter 8 contrasts with Chapter 5 because these two chapters in some ways present two sides of a coin. Chapter 5 looks at parenting, the impact of changes in parenting on children's behaviour and what can influence parenting; the chapter looks at what aspects of parents' lives services could help to change. Chapter 8, on the other hand, looks at parents' experiences with the services that are trying to bring about those changes and what aspects of their practice make effective intervention more or less likely. Chapter 8 shows the challenges for, and constraints on, practitioners in their interactions with parents. The chapter ends by describing the features of effective parent-practitioner relationships, and the characteristics of practitioners who help bring about positive change.

The thesis findings are brought together, summarised and discussed, with reference to the wider literature suggested by the study findings, in Chapter 9 to draw out answers to the overarching question: What helps families prevent high-risk primary school children developing future antisocial and criminal behaviour? The chapter discusses how parents can be supported to be better able to manage difficult lives and challenging children, how children's school experiences could be enhanced and how the various

environments families inhabit could be made more enabling. Finally, the chapter reflects on the limitations of the research and outlines implications for policy and practice and for future research.

The question of whether the families are best described as high need or high risk turned out to be closely linked to themes emerging from the qualitative analysis, particularly those discussed in Chapter 8. Describing families as high need implies the need for support whereas describing them as high risk perhaps implies more of a need for surveillance. This study began before the UK riots of August 2011 and before the term 'Troubled Families' was in general use as a result of the Cameron government's programme. The Troubled Families Programme had its own difficulties defining troubled families and then operationalising that definition, as is discussed in Chapter 2.

In this study, 'high need families' are defined as those where a primary-school-aged child has severe and persistent behaviour problems (referred to in the psychology literature as conduct problems or, clinically, as conduct disorders) and has been, or is at risk of being, excluded from school. In addition the parent exhibits one or more risk factors associated with children's later development of antisocial behaviour: harmful substance use; interpersonal conflict with their child or other close family or school; inability to maintain a stable mood; or lack of supportive family or social networks.

The perspective of this study is a hopeful one; it does not focus on what intervention should have occurred earlier, but considers what changes and what type of support during middle childhood could help children with difficult behaviour to grow up to have good life experiences.

Chapter 2

Affecting trajectories: A discussion of literature and policy regarding pathways to, and prevention of, antisocial and criminal behaviour

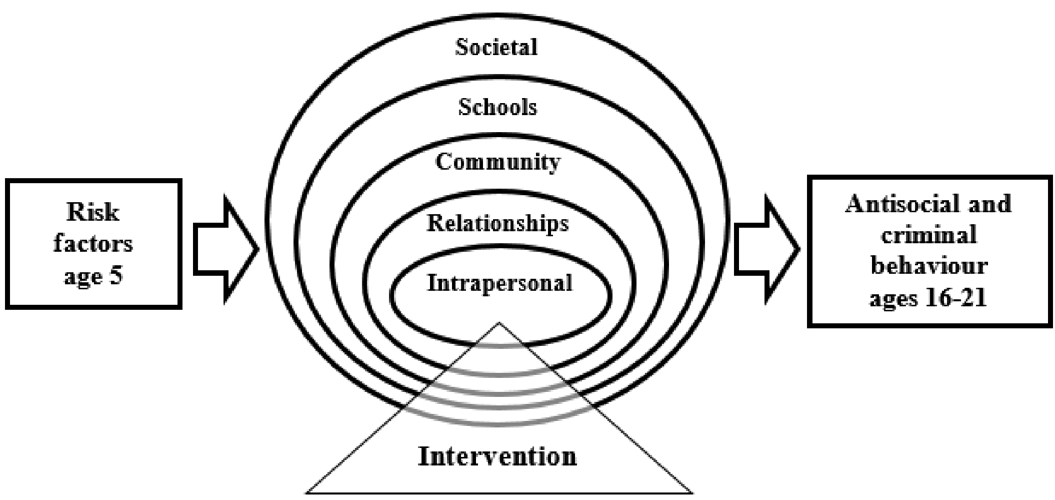


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> The quantity of research evidence is, however, more of a warning than a promise. It usually means that the issue is too complicated for any conclusions to be reached. (Shipman, 1997)

This chapter explores the literature and policy most pertinent to setting the scene for the study, as well as the limitations of current evidence looking at how best to intervene with families in order to avoid children's antisocial behaviour in the future. Firstly, the nature of the problem is explained with reference to the numbers, characteristics and outcomes of behaviour problems in childhood. Next, the evidence on risk and moderating factors which appear to affect the association between childhood behaviour problems and later antisocial and criminal behaviour is briefly described, covering parental, school-related and environmental factors (in a broad contextual sense, including socioeconomic factors and mother's mental health). The remainder of the chapter looks at intervening with at-risk families. The policy context over recent decades is described followed by an assessment of the evidence on the effectiveness of interventions to prevent behaviour problems and future antisocial behaviour. The thesis is concerned with how changes can be brought about during middle childhood, approximately ages 5 to 13, and so factors and intervention occurring during these years are the prime focus.

The motivation for the study grew out of the author's involvement with the evidence-based practice movement, particularly in relation to children's behaviour problems. In the evidence-based practice paradigm parenting programmes are considered one of the most promising interventions for preventing behaviour problems because there is 'gold standard' evidence for their effectiveness; that is, there are systematic reviews showing a pattern of positive results from randomised controlled trials — children's behaviour has improved at the end of their parents' involvement in a parenting programme. However good the evidence, compared to that of other approaches, these trials present a very partial picture of the influences on families. The conceptual framework diagram (Figure 1) illustrates the thesis's purpose: to take a broader view of the context of parents' and children's lives, as well as the variety of services they are involved with, in order to look across intervention types at what factors can make a difference for families.

2.1 Difficult children and future outcomes

> Emotional disturbance is a symptom not of individual pathology but of a malfunctioning human ecosystem. (Hobbs, 1982)

All children display problematic behaviour sometimes but here we consider children with persistent challenging behaviours fitting the diagnostic criteria for a clinical conduct disorder. The term ‘conduct disorders’ encompasses both oppositional defiant disorder, a consistent pattern of defiant and disruptive behaviour, or the more severe form, conduct disorder (DSM-IV-TR, APA, 2000; see the criteria set out in Chapter 3). Therefore, while the term ‘behaviour problems’ is generally preferred in this thesis it is used interchangeably with the terms ‘conduct problems’ and ‘conduct disorders’ which are more common in psychology and psychiatry literatures.

The symptoms of conduct disorders in childhood include aggression and threats of harm to people or animals, repeated violation of rules at home, school or both, frequent lying to avoid consequences or obtain benefits, stealing, deliberate destructiveness and running away from home (Searight et al., 2001). Conduct disorders are common. UK prevalence is estimated at 4.9% of children aged 5–10, 6.6% of 11–16-year-olds (5.8% of all children), with three times as many suffering from non-clinical levels of problem behaviour (Green et al., 2005). This data is over a decade old and the UK’s Chief Medical Officer’s report has noted the need for more recent statistics on the extent of children’s mental health problems (Davies, 2014). An epidemiological review of UK and US surveys found a median 12-month prevalence rate of 6% and a range from 5% to 14% (Merikangas et al., 2009). Boys are more likely to be identified as having a conduct disorder; 6.9% of British boys aged 5 to 10 have a conduct disorder compared to 2.8% of girls, the gender difference narrowing as children grow older (8.1% versus 5.1% at ages 11 to 16) (Green et al., 2005).

Conduct disorders are sometimes referred to as ‘externalising problems’, and the absence of these problems as ‘self-control’ and ‘self-regulation’. Self-control and its association with ‘conscientiousness’ form the cornerstone of Gottfredson and Hirschi’s (1990) general theory of crime, indicating the extent to which children can overcome impulsivity; impulsiveness is the intrapersonal factor most closely associated with crime (Farrington, 2015).

Conduct disorder has been referred to as childhood antisocial behaviour (Curtis, 2016) and persistent conduct problems in middle childhood are associated with later delinquency and criminality, poor educational and employment outcomes (including dropping out of school) and, for about 50% of children with clinically diagnosed conduct disorders, antisocial personality disorder (Broidy et al., 2003; Farrington, 1989; Fergusson et al., 2005; Hemphill et al., 2015; Kretschmer et al., 2014; Moffitt et al., 2008; Tremblay et al., 1992). Poor childhood mental health has also been found to independently predict adult health outcomes (Ogollah, 2010) including obesity (White et al., 2012) and is a key pathway by which inequality affects health (Friedli, 2009). Childhood conduct disorders are also associated with later domestic violence, unemployment, substance abuse and severe mental illness (Fang et al., 2010; Knapp et al., 2011; Maughan & Kim-Cohen, 2005; Richards et al., 2009; Robins, 1966; Shepherd et al., 2009; Stringaris et al., 2014). The 5% of a New Zealand cohort with the most severe childhood conduct disorders were later responsible for 21.7% of all crimes, including 35% of violent offending and 24% of inter-partner violence (Fergusson et al., 2005). Criminal outcomes account for much of the estimated long-term costs of conduct disorders (Bonin et al., 2011).

Children first displaying conduct problems before, rather than during, adolescence are more likely to persist in antisocial behaviour as adults (Moffitt, 1993; Moffitt & Caspi, 2001). The long-term costs to individuals, families and society are high (Friedli, 2009; Scott et al., 2001) and economic models have suggested that large savings would result from effective early intervention with vulnerable families (Aos et al., 2004; Bonin et al., 2011; Dartington Social Research Unit, 2011; Heckman et al., 2010). Bonin and colleagues, for example, estimated that total net savings would be 5-11 times the cost of an effective preventative parenting intervention. The savings reported by economic models can only include areas where cost-saving estimates can reasonably be made, namely, from reduced use of health services, educational support, social care, voluntary agencies and crimes averted, whereas areas of potential savings could be much broader. However, models rely on assumptions about long-term effectiveness of intervention which are not as yet supported by evidence and it seems probable that families least likely to benefit could become the most costly (Stevens, 2014).

A Home Office (2004) typology of antisocial behaviours (delinquency in American terminology) covers four categories: misuse of public space; environmental damage; disregard for community/personal wellbeing; and acts directed at people. Estimates for rates of young people's involvement in antisocial behaviour in the Western world range between five and 17 per cent, depending on the definition used (Curtis, 2016). Curtis suggests the concept of anti-social behaviour as a specific problem for which specific solutions are needed has become prevalent in the past 20 years, stemming from New Labour's Respect Action Plan. Tony Blair described antisocial behaviour as stemming from 'a lack of respect for values that almost everyone in this country share – consideration for others, a recognition that we all have responsibilities as well as rights, civility and good manners' (Respect Task Force, 2006, p1).

Survey data on children with conduct disorders in Britain has indicated that they are high users of services, with just over half these children (55%) receiving related educational input, 38% accessing primary health services, 27% specialist health and 27% social services (Snell et al., 2013). However, families with high levels of need tend to be underrepresented in surveys and longitudinal studies (Wolke et al., 2009). Little is known, therefore, about the level and full range of services used by the most vulnerable families, such as those where, as well as the child's behaviour problems, there are further risk factors for longer-term conduct disorder such as parental mental illness or substance misuse.

2.2 Risk factors and trajectories: Pathways to antisocial and criminal behaviour for children with conduct disorders

> Given the complexity of influences on individuals, it is hard to make sense of the term 'cause' in the context of social exclusion at all. (Burchardt et al., 2002:8)

In the previous section we saw that children's behaviour problems are a risk factor for future antisocial and criminal behaviour. Targeting childhood behaviour problems is consequently seen as a way to reduce future crime. However, many children with behaviour problems do not go on to have these issues but instead 'grow out of' the problems. To see how intervention might address other determinants of antisocial and criminal behaviour, the research on other risk factors is now summarised.

Biological, psychological and social processes are all implicated in the development of conduct disorders; correlated risk factors include poverty and social disadvantage, and neighbourhood factors (over and above family-related predictors) such as levels of violence and disrupted social organisation (Hill, 2002). Inadequate parenting, neurocognitive problems and temperament, as well as behaviour problems, predict childhood-onset delinquency (Moffitt & Caspi, 2001).

Many studies point to associations between early childhood factors (that is, prior to starting school) and the development or continuance of middle-childhood problematic behaviour. For example, Barker and Maughan (2009) found maternal anxiety during pregnancy, partner cruelty to the mother, harsh parenting and higher levels of child undercontrolled temperament were all robust predictors of following an 'early-onset persistent' rather than a 'childhood-limited' trajectory. They conclude that intervention should begin antenatally. However, here we are interested in school-age factors which could potentially be addressed by intervention. Factors linked to parents' capacity to care for their children are risk factors relevant to prevention and are therefore included below. These are presented broadly according to the levels of influence conceptualised in Figure 1, although research relevant to the 'relationships' level is divided into parenting behaviours, and factors associated with parenting capacity.

2.2.1 Child's intrapersonal influences

Intrapersonal social and emotional characteristics of the child associated with resilience to future antisocial and criminal behaviour include high self-esteem (Orth et al., 2012; Piquero et al., 2010a; Trzesniewski et al., 2006). Low self-esteem is associated with gang membership in adolescents, although in young adults being a gang *leader* is associated with *higher* self-esteem (Dmitrieva et al., 2014) and while low self-esteem at age 10 predicts later hostility and violent behaviour, the effect is small when many factors are controlled for (Boden et al., 2007). 'Locus of control' is a related aspect of self-perception; childhood internal locus of control, a belief in one's ability to affect life events, has been shown to be characteristic of resilience (Goodman et al., 2015) while external locus of control, a belief that events are outside one's control, is associated with offending behaviours (Ahlin, 2014; Kelley, 1996).

2.2.2 Parenting behaviours

Parenting behaviours such as low warmth, high criticism, poor supervision and low involvement have been shown to predict poor social and emotional adjustment in children (Patterson et al., 1989; Rutter et al., 1998). Early-onset antisocial behaviour is seen as resulting from harsh (or unresponsive) punitive and inconsistent parenting practices leading to patterns of coercive behaviours on both sides (Patterson et al., 1992). At the extreme end of poor parenting, serious neglect and physical abuse have both been shown to predict children's future delinquency or violence, and there is mounting evidence that neglect may be at least as damaging as physical or sexual abuse (Gilbert et al., 2009). Parental warmth, conversely, appears to be protective in the presence of other family and home risk factors (Hill, 2002).

A wealth of literature concurs, though different terms can be used, that parenting styles that are associated with lower levels of problem behaviour in children involve a combination of support/responsiveness/warmth/acceptance and control/involvement/authority, rather than hostility/rejection and permissive/neglectful or authoritarian approaches (Baumrind, 1966, 1971) (see Power, 2013, for a historical review). Two types of theories have been prominent in explanations of relationships between parenting and children's behaviour: Attachment theories and social learning theories. In the former, the quality of early parental care, responsiveness and sensitivity directly influences the child's attachment to the carer (O'Connor & Scott, 2007). Although subsequent outcomes do not need to be seen as shaped deterministically, numerous studies demonstrate associations between early attachment relationships and later child and adult functioning (Cummings & Cummings, 2002; Dykas & Cassidy, 2011), and a meta-analysis of 74 published and unpublished studies found a 'small to medium' effect of attachment on delinquency (Hoeve et al., 2012). Some evidence indicates that coercive (power-assertive) relationships follow insecure attachment, and these coercive relationships in turn predict rule-breaking and aggressive child behaviours (Kochanska & Kim, 2012). Among some social work professionals there has been a move away from attachment-based theories, seen as pathologising and doom-laden, towards thinking about 'different patterns of attachment behaviour – a more hopeful position' (Goodman & Trowler, 2012:115).

Social learning theories see children as imitating behaviour of those around them and learning from others' responses to their own behaviour. Behaviours are either positively reinforced or, if they elicit negative responses, avoided (Bandura, 1977; Patterson, 1996). These principles strongly influence the content of behavioural parenting programmes (O'Connor & Scott, 2007).

Because of the evidence discussed above, improving parenting has been seen as key to improving outcomes for children (Department of Health, 2004; Field & Government, 2010). However, for many apparent risk factors causal mechanisms may work in both directions (Hill, 2002). The vast majority of studies included in Hoeve's meta-analysis of the relationship between parenting and delinquency (69%) were cross-sectional (28% were longitudinal and 3% were retrospective), looking at co-occurring parenting characteristics and delinquency outcomes, a study design which cannot discount the possibility that the delinquent behaviours preceded and caused the parenting behaviours. Indeed, studies have shown that children also affect parents' behaviour (Crouter & Booth, 2003; Pearl et al., 2014) and that children's difficult behaviour can precede hostile or detached parenting (Belsky, 2005). Hoeve and colleagues (2012) conclude that studies looking at longer-term relationships between parenting factors and delinquency are needed.

Lone parenthood is associated with increased risk of offspring's antisocial behaviour (Farrington, 2005; Murray et al., 2010), and while poverty is an important mediator, differences in parenting behaviours in single-parent households have also been linked to children's outcomes (McLanahan & Sandefur, 1994). However, twin studies show that if fathers themselves engage in high levels of antisocial behaviour, their presence in the home is associated with more conduct problems in children (Jaffee et al., 2003). Nevertheless, Waldfogel (2010) and colleagues, reviewing existing literature as well as reporting their own findings, found single parenthood, and not just family instability, to be a risk factor for conduct problems.

Prospective cohort studies cannot show that associations are causal; other factors may be responsible for both the associated childhood factors *and* the later antisocial behaviour. For example, while youth of mother is a known risk factor for child's delinquency, Barnes and Morris found the relationship was not mediated by parenting

or neighbourhood factors, but 'was completely mediated by the child's level of exposure to drug-using peers' (Curtis, 2016:32, quoting Barnes & Morris, 2012). In order to unpick factors which are causal from those which are merely associated with the development of antisocial behaviour Farrington points out the utility of examining *changes* in these risk factors in individuals, and sequential results.

Associations with parenting are stronger for school-age children than for older adolescents when other factors, particularly peer affiliations, become more important (Hoeve et al., 2012; Patterson et al., 1989, 1993). Patterson's developmental/family interaction model sees ineffective childhood behaviour management by parents as contributing to antisocial childhood behaviour resulting in peer rejection and poor academic performance, deviant peer group affiliations and delinquency (Patterson et al., 1989, 1993). A similar model proposed by Hawkins (1999) shows antisocial youth lacked protective positive and developmental experiences.

2.2.3 Factors associated with 'parenting capacity'

As well as the literature linking aspects of parenting to children's antisocial behaviour outcomes, another set of studies investigates the precursors, or correlates, of those parenting behaviours (Thomson et al., 2014). Factors related to parenting characteristics are often also associated with children's later antisocial behaviour so it is difficult to see where causality lies. For example, intrapersonal maternal resources (age, aggressive personality, empathy) predict a rejecting style of parenting, controlling for toddler temperament, which in turn predicts antisocial behaviour (Trentacosta & Shaw, 2008).

Parenting capacity has been shown to be associated with domestic abuse, substance misuse, mental health problems and learning disabilities, as well as poor housing, poverty and unemployment (Ward et al., 2014). Quantitative (Shaw et al., 2012) as well as qualitative (Hansen, 2005) findings have suggested that informal support may be protective and Thompson's analysis (2014b) suggested targeting intervention at young pregnant women lacking social support as these mothers were more likely to have negative interactions with their child. Waylen and Stewart-Brown (2010) concluded programmes aiming to improve parental health and social support were likely to pay dividends; their multifactorial analysis found both improvements and deterioration in maternal mental health were associated with corresponding changes in parenting scores.

Parenting behaviours, as well as parental mental health, appear to partly mediate the relationship between poverty and children's outcomes including antisocial behaviour (Schoon et al., 2010; Shaw, 2013). Suggested mechanisms for the relationship between poverty and children's outcomes include the Family Stress model, which sees economic hardship as leading to parental stress, depression and relationship difficulties, all of which have a negative impact on parenting behaviours (Conger et al., 1999). Another is the Investment Model, which concerns the effects of limited financial resources on the physical home environment, including toys and learning materials as well as socially enriching and educational activities (Magnusson & Duncan, 2002), while Scarcity theory suggests that the mindsets of parents in poverty change, with attention becoming dominated by problems of scarce resources, while other problems are neglected (Shah et al., 2012). Food poverty has been linked to behaviour problems (Slack & Yoo, 2005) and a review found evidence that poverty itself matters, not just the disadvantages correlated with it, with these findings evident in 29/34 studies (Cooper & Stewart, 2013). Family stress may also be exacerbated by a growing stigma, instead of compassion, attached to poverty (Featherstone et al., 2013).

Maternal depression has been shown in meta-analyses to predict a number of adverse child outcomes including externalising behaviours, although the associations are small (Goodman, Rouse, et al., 2011; Goodman & Gotlib, 1999). Comparison of two birth cohorts found that maternal mental health problems had increased between 1986 and 2006, coinciding with increases in adolescent emotional problems (Schepman et al., 2011).

2.2.4 Community/neighbourhood influences

Links have been demonstrated between children's conduct problems and various neighbourhood characteristics, including residential instability, environmental toxins and 'substandard institutional resources' (Galan et al., 2016). Neighbourhood influences are generally found to become greater after age 5 and with increased risk for future antisocial behaviour during middle childhood (Ingoldsby et al., 2006; Ingoldsby & Shaw, 2002). Neighbourhood danger appears to exacerbate negative impacts of harsh parenting on conduct disorders in children (Callahan et al., 2011) but neighbourhood cohesion can moderate harsh parenting's effects (Silk et al., 2004). The UK's

Environmental Risk Longitudinal Twin Study suggests that living next to more affluent neighbours increases the likelihood of engagement in antisocial behaviour for low-income boys (Odgers et al., 2015).

Investigating a social contextual (ecological) model, Slattery and Meyers found that experienced levels of community violence were a strong direct predictor of antisocial behaviour, a relationship moderated by parental monitoring (Slattery & Meyers, 2014). Australian (Edwards & Bromfield, 2009) and US (Felner et al., 1995) studies have found children's conduct problems to be associated with neighbourhood socio-economic status, after controlling for family demographics. In another US sample Lynam and colleagues showed that impulsivity predicted criminal behaviour in poorer neighbourhoods but not in better-off neighbourhoods and that involvement in criminal activity did not differ by neighbourhood for non-impulsive boys (Lynam et al., 2000). Such findings support arguments for an 'ecological-mediational perspective' for understanding the link between social disadvantage and adolescent problems (Felner et al., 1995) and fit with Bronfenbrenner's theory that the quality of parenting children receive may vary as a function of neighbourhood context (Bronfenbrenner, 1986).

2.2.5 School influences

The association between poor academic achievement and later antisocial behaviour has been repeatedly shown in longitudinal surveys (Farrington, 2015) and some evidence suggests school failure is a mediator of the known relationship between low IQ and antisocial and criminal behaviour (Lynam et al., 1993). However, school-related factors are also among the environmental influences on children's behaviour. School ethos has been linked to behaviour outcomes (Bonell et al., 2013; Jamal et al., 2013), and Reinke and Herman (2002) describe the importance of administrative staff's attitudes and behaviours, consistent rules and high expectations in creating positive outcomes. Many of the features of parent-child interaction that prove problematic (or protective) are also found in interactions between school personnel and children with behaviour problems. Where practices which appear to be linked to the development of aggressive behaviour are replicated at school, conduct problems can be 'maintained and exacerbated' (Reinke & Herman, 2002). Reinke and Herman describe how schools' reactions to antisocial behaviour can unintentionally reinforce negative behaviours. However, school environments and experiences can also be protective as many studies have shown, in

particular where at-risk children perceive social support from school staff (DuBois et al., 1994; Jenkins & Keating, 1998). Warmth, acceptance and supervision from non-parental adults are associated with resilience in the absence of these being provided by parents (Werner, 1995). Although the original research on 'significant others' specifically highlighted the motivational influence of others' expectations (Haller & Woelfel, 1972), significant non-familial relationships are associated with children's wellbeing more generally, as well as with resistance to antisocial behaviour (Walsh, 1996; Werner, 1993).

A cumulative benefit for UK children's behaviour at age 10 has been shown to follow one or more of: a good home learning environment, high quality preschool and highly academically effective primary school (Sammons et al., 2007). Bowen and colleagues, using ALSPAC data, examined the importance, for resilience to antisocial behaviour for at-risk children, of a range of factors suggested by existing literature. School enjoyment was the most predictive of resilience, ahead of family and individual characteristics (Bowen et al., 2008).

An important event in middle childhood with implications for future trajectories is the transition to secondary school, particularly challenging for children with behaviour problems (Roberts, 2015). Child behaviour is a key predictor of post-transition teacher-rated adjustment (Bailey & Baines, 2012) and mother-rated wellbeing (Gutman et al., 2010). Parents remain implicated in relation to school effects, as studies show parental support (Coffey, 2013) and parental warmth (Rice et al., 2015) are linked to successful school transition, and that parental involvement in school is strongly related to academic achievement and adjustment, over and above sociodemographic effects (e.g. J. Epstein & Sanders, 2000). However, emotional and behavioural wellbeing become more important in explaining school engagement as children move through the system, while demographic and other characteristics become less important (Gutman & Vorhaus, 2012).

2.2.6 Societal influences and the field of forces impacting on families

The idea of 'structural violence' has been used to refer to the 'invisible social machinery' which explains continuing inequality and its effects on disadvantaged groups (Scheper-Hughes, 2006). Societal discourses affect the environment around

families, and how they are treated; for example, discourses of 'youth violence' have been seen as contributing to the greater likelihood of antisocial and criminal behaviour developing in certain groups (World Health Organisation, 2015). Housing, benefits systems and employment opportunities and conditions all have a significant impact on family wellbeing (Power & Mumford, 2003). Qualitative longitudinal research with lone mothers and their children, for example, has shown their vulnerability to even quite small shocks to their incomes or circumstances, and an 'inability to effect any significant increase in income over time' because of the trade-off between wages and benefits (Millar & Ridge, 2013). Children who were initially supportive of mothers' entry into paid employment are reported as losing faith in the value of work when it fails to improve their family's social and economic circumstances (Ridge, 2009).

The above summary gives a flavour of the complexity of the network of causes and outcomes which intervention, discussed below, comes to be part of. There is a good deal of evidence on aspects of parenting which are related to antisocial behaviour/delinquency. There is also a large literature showing factors which predict poor parenting, including societal-level factors affecting access to resources, and showing relationships between school, peer and environmental factors and later behaviour problems. Additional societal risk factors for antisocial and criminal behaviour globally include 'weak governance, poor rule of law, cultural, social and gender norms, unemployment, income and gender inequality, rapid social change and limited educational opportunities' (WHO, 2014; WHO, 2015). Rutter and others have shown that the biggest risk occurs when multiple risk factors are present simultaneously (Fergusson & Lynskey, 1996; Rutter et al., 1975).

Belsky concludes there are multiple determinants of parenting, and attempting to understand why people parent the way they do requires looking at the accumulation of stresses and supports experienced; each factor needs to be looked at in the context of the others. The implication is that there is no single way to 'promote growth-fostering parenting' (Belsky, 2005). Anthropologists Robert and Sarah LeVine (2016) concur, having documented a huge variety of global parenting practices, concluding that there is no one correct way to parent although two particular factors seem important: physical affection, and the parent-figure's confidence in their authority.

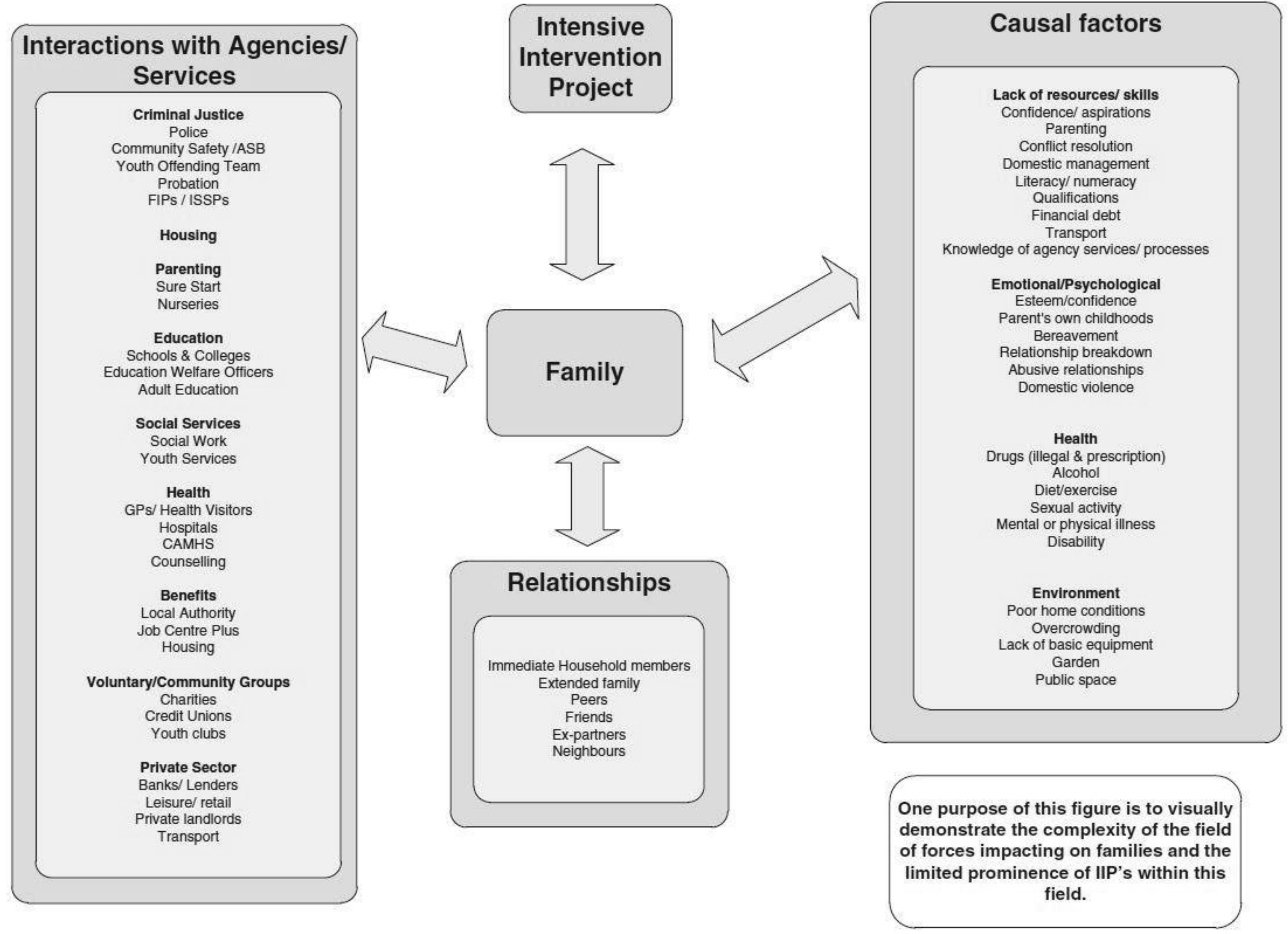
Batty and Flint's (2012) model of the Field of Forces Impacting on Families usefully lists a range of 'causal factors' potentially influencing child and family outcomes, collected under the following headings: *lack of resources/skills*, *emotional/psychological factors*, *health*, and *environment*. These, along with the impact of *relationships*, and of interactions with a potentially large number of *agencies and services* form their framework, which is used to illustrate the limited prominence of an intensive intervention project as just one among these many forces (reproduced with permission in Figure 2). Such complexity is the reason for the current study's conceptual framework (summarised in Figure 1) looking across spheres of influence, similar to an ecological model. This is combined with a developmental perspective, capturing change over time and underlining that there are no deterministic conclusions to be drawn from the presence of risk factors.

The evidence above shows, on the whole, association not causation; the factors discussed may be markers, rather than causes of, child outcomes (Waldfogel & Washbrook, 2011). Statistical modelling of trajectories is becoming more sophisticated and ever-more-complicated pathways are suggested (Hemphill, 2013). Factors associated with future antisocial and criminal behaviour could potentially be sites for intervention and this is often what study authors conclude. For example, Hoeve and colleagues (2009) conclude that their meta-analytic findings suggest parents should be taught how to monitor their children's behaviour and know their whereabouts, and to encourage child disclosure, despite a lack of evidence that this can be done, while Moffitt and colleagues state that the strong evidence linking lack of self-control to criminal behaviour implies that 'interventions addressing self-control might reduce a panoply of societal costs, save taxpayers money, and promote prosperity' (Moffitt et al., 2010). Weitzman and Wegner, meanwhile, have argued the case for increased behavioural screening in the US to promote 'optimal development' (Weitzman & Wegner, 2015), although at least one trial has found no long-term effects of parenting programmes for a screened community sample while finding positive effects for a clinic-referred sample (Scott et al., 2014).

Although studies can statistically control for some background factors it remains the case that other unmeasured factors could be responsible for both the hypothesised explanatory factor and the antisocial behaviour outcomes. For example, children who

enjoy school may be less likely to be involved in antisocial behaviour when they get older, but this does not mean the relationship is causal. Nevertheless, it might reasonably be concluded that making efforts to ensure at-risk children are happy at school could be preventative. These types of considerations, as well as ideas stemming, for example, from attachment theory or social learning theory, have informed the development of interventions to address behaviour problems. It is to these that we now turn for an overview of the policy and service responses to the known relationship between childhood risk factors and costly antisocial and criminal behaviour outcomes.

Figure 2 Fields of Forces Impacting on Families (Batty & Flint, 2012), showing the limited prominence of an Intensive Intervention Project (IIP), reproduced with permission



2.3 Intervening: Policy responses, services and support

> There is an obsession with evidence-based policy. If No 10 says bloody evidence-based policy to me one more time I'll deck them one and probably get unemployed. *Louise Casey* (in Johnson, 2005)

The wide range of factors which can have an impact on parenting, children and families' well-being and future antisocial behaviour, mean there are many ways in which intervention could hope to affect outcomes. Improving the life chances of at-risk children is likely to involve enhanced provision across a number of policy areas, including parenting support (Waldfogel, 2004). How the mechanisms by which risk factors lead to poor outcomes are understood affects the policy responses considered appropriate, particularly with regard to preventative approaches. The evidence leaves much open to question; the inferred implications for policy may be strongly affected by ideology. For example, is the association between parenting and poverty due to it being more difficult to parent when you are poor or because characteristics of some individuals make them both poor and liable to poor parenting practices? How this question is answered might affect whether one thinks it better to offer parent training or to reduce parents' poverty, or indeed to discourage poor families from having children (Grove, 2016; Joseph, 1974; Perkins, 2016).

Louise Casey has perhaps echoed her above comment more recently regarding the evaluation of the Troubled Families Programme (Public Accounts Committee, 2016). Despite the near 100% success rate of families the programme 'turned around', according to the payment by results criteria local authorities needed to achieve to get paid, the independent national evaluation concluded that the programme had 'no significant impact' on families (Day et al., 2016). Casey and others responded to the Public Accounts Committee, that the evaluation did not prove the programme did *not* work, while the Department for Communities and Local Government Permanent Secretary claimed that no other programme, such as the Dundee Project (with which the Troubled Families Programme was unfavourably compared by the committee), had been asked to prove itself against a counter-factual in this way. Indeed, reanalysis of evaluation data from the Dundee and Family Intervention Projects suggested the methods were not able to answer the question of whether observed benefits were due to

programme participation (Gregg & Mcmahon, 2010). The defenders of the Troubled Families Programme, as with the earlier programmes, pointed to many outcomes of the programme they believed to be valuable, based partly on the testimony of those receiving and delivering the projects, and on the successes in meeting the payment by results criteria. These responses brought into question the tenets of evidence-based practice.

This section briefly describes recent UK policy and practice history relevant for an understanding of the service environment surrounding families today as also illustrated in Batty and Flint's Field of Forces diagram (Figure 2). This is followed by an overview of the evidence base for the effectiveness of intervention aimed at children's conduct problems and prevention of antisocial behaviour, and a discussion of problems with the evidence.

In terms of the simplifying conceptual model (Figure 1) intervention delivered to individuals may be directed at the intrapersonal level (targeting factors *within* the person, self-regulation of mental state for example) or the relationships level (targeting parenting behaviours or peer interaction for example) or both of these. Intervention aimed at individuals (children or parents) seems practicable and also makes it easier to identify where to look for effects to measure. Intervention aimed at affecting practitioners' behaviour or attitudes also seems practicable though it is harder to measure the ultimate outcomes of interest (in their clients, or clients' children). Evaluating effects of interventions in schools is more difficult, especially if intervention is at the 'whole-school' level, although many trials have been conducted in the US. The difficulties of showing effects in community intervention are even greater. Changing systems, such as the reforms recommended for social work by the Munro review, requires broad commitment to fundamental reorganisation and realignment of the immediate aims of practice and mechanisms of accountability (Munro, 2011). The relevant effects which could be measured will be equally complex and multifaceted, and may be difficult to attribute to the system change rather than to other factors which changed over the same period. Changes to political, social and economic systems which affect individuals' life chances are seldom examined in a causal relationship with behaviour problems, and can usually only be looked at in a before-after framework, albeit with potentially large numbers of subjects (Lupton et al., 2016).

2.3.1 Policy context: Overview of recent history of policy and intervention regarding 'high risk' families, from Family Service Units to the Troubled Families Programme

There has been high-profile policy intervention aiming to affect parenting in recent years, with a particular emphasis since the 2011 riots on improving parenting in order to reduce antisocial behaviour. The suggested problems, and proposed solutions, are in many ways similar to what has come before. The role of evidence, however, has changed, with the rise of 'Evidence-Based Practice' in the 1990s, which followed research and inspections revealing little monitoring of family support services (Macdonald, 1999; Statham & Holterman, 2004). Some key policy, and policy-influencing events, relating to high need families and children at risk of antisocial behaviour are shown in Table 2.1.

Table 2.1 Timeline of select family and youth policy and policy-influencing events

Policy/event	Year	Comments
Foundations of the welfare state	1948	Children's Departments set up for the first time
Family Service Units formed	1948	Following wartime Pacifist Services Units, later merging with Family Welfare Association
Children and Young Persons Act	1963	Unruly youth become a locus of intervention; councils given a duty to reduce numbers of children in care and in court
Children's departments moved into social services	1970s	Followed by 'golden age of prevention' with community social work
Conservative government	**1979**	
Children Act	1989	Allocated duties regarding child safeguarding and promotion of child welfare. Established multiagency working as a requirement
Blair speech 'tough on crime, tough on the causes of crime'	1993	
Blair 'moral vacuum' speech following Bulger murder	1993	
Dundee Family Project begins	1996	To assist families made homeless, or at risk of being made homeless, due to antisocial behaviour
Labour government	**1997**	
More financial support for families	1997–2010	Child benefit increased, tax credits for low income in work, Child Trust

		Fund, Educational Maintenance Allowance
Sure Start Local Programmes	1997	First in most deprived areas, then rolled out more widely. Included outreach and home visiting. Aims included 'school readiness' and 'extended schools'
Crime and Disorder Act	1998	Introduced Parenting Orders, and ASBOs. Established Youth Justice Board
National Family and Parenting Institute	1999	Independent charity set up by government to provide expertise
The Children's Fund	2000	To fund projects to help disadvantaged school-age children. 50% of services targeted by the Fund were based in schools
Death of Victoria Climbie	2000	Professionals involved with family accused of 'blinding incompetence' by judge; Laming inquiry led to changes in Child Protection procedures
What Works for Children	2001	Part of ESRC Evidence Network aiming to get evidence into practice in Children's Fund projects
The Parenting Fund	2002	Funded voluntary organisations to support parents aiming to build the sector's capacity
Every Child Matters	2003/2004	Part of policy response to Climbie death, set out aims for every child with a holistic view of wellbeing
Louise Casey leads antisocial behaviour unit	2003	
National Service Framework for Children, Young People and Maternity Services	2004	Standard 2 concerns support for parents and carers
Children Act	2004	Amended 1989 Act. Strengthened requirement for multiagency working
Family Intervention Projects	2006	FIPs set up as part of Respect Action Plan to challenge and support families with an ‘assertive’ and ‘persistent’ style of working to address root causes of antisocial behaviour
Children's Plan	2007	Set out 10-year strategic vision with emphasis on partnership working and targeted parenting and family support including schools and early years care
Death of Peter Connelly	2007	Caused outrage due to more than 50 contacts with police, health and social workers prior to his death. But subsequent vilification of social

		workers later blamed for un-called-for rise in care proceedings (Lees et al., 2013)
National Academy for Parenting Practitioners	2007	Aimed to transform the quality and size of the parenting workforce across England
Social Exclusion Task Force's Think Family report	2007/2008	Emphasising parenting and family support; encouraged closer working between adults' and children's services
Social Work Task Force	2008/2009	Set up in response to death of Baby P to help improve quality and status of social work profession
Financial crisis	2008	
Marmot review of health inequalities published	2010	Proposes an evidence-based strategy to address the social determinants of health
Child Poverty Act	2010	Required government to produce a plan every three years to abolish child poverty by 2020
Coalition government	**2010**	
Working Families Everywhere	2010	Targeted at 100,000 'never-worked' headed households — closed following allegations of fraud at A4E
Field Review: Independent Review on Poverty and Life Chances	2010	Commissioned by Cameron Government, argued government should invest in parenting rather than income-transfers
Allen Review	2010	Set out how costs to taxpayer could be saved through use of evidence-based early intervention programmes
Parenting Early Intervention Pathfinders reports	2011	Looked at a set of evidence-based programmes to see how they could be rolled out maintaining effectiveness
Munro review of child protection	2011	Identified sector's 'compliance addiction' and recommended move to a learning culture, with a broad systems perspective (Lane et al., 2016)
Riots following death of Mark Duggan in Tottenham	2011	
Cameron 'moral collapse' speech	2011	
Troubled Families Programme	2011	Led by Dept for Communities and Local Government
Health and Social Care Act	2012	
College of Social Work	2012–2015	Set up following Social Work Task Force recommendation. Closed due to insufficient fee-paying members and government's rejecting of alternative proposals

CANparent trial	2012–2014	Look at universal provision to de-stigmatise parenting classes; vouchers trialled to stimulate demand and a market of providers. Did stimulate demand but not as much as expected; high average costs, great variety
Early Intervention Foundation	2013	What Works Centre launched
Education Health and Care Plans Introduced	2014	Replacing Special Educational Needs and Learning Difficulty Assessments
Conservative government	**2015**	
Children and Young People's Mental Health Taskforce report 'Future in Mind'	2015	Announced plans for improving mental health services for young people, building resilience and early intervention
Welfare Reform and Work Act	2016	Abolished Child Poverty Act, including targets to reduce child poverty. Emphasis moved from tackling poverty to tackling worklessness and troubled families. Government attempted to drop requirement to publish child poverty rates, but eventually agreed to continue
Life Chances Strategy launch cancelled	2016	Scheduled for June, the strategy was to include plans for expanding parenting provision, addressing child poverty, and the future of Children's Centres. Launch cancelled following the EU referendum and Cameron's resignation

Based on sources referred to in chapter and policy documents, speeches and commentary available at www.gov.uk/government/policies and www.cypnow.co.uk

The term 'Problem Families' appeared in 1945, as the title of a pamphlet based on the wartime relief work of the Pacifist Service Units, later established as the Families Service Units to provide practical help and 'friendship with a purpose' (Starkey, 2006, 2012). Family Service workers visited families regularly, encouraged children's school attendance and helped with cleaning and decorating homes, claiming benefits and managing budgets. Their reach was expanded after the war, in the developing welfare state, working alongside the newly set-up Children's Departments. The intensive family casework and pattern of close supervision, referred to as 'rehabilitation in the home' (Patterson, 1960) presages today's Troubled Families Programme approach (Starkey, 2006). Many of the causes identified by these intensive family support workers were similar to those considered critical today: limited educational opportunities, marital

breakdown, physical and mental health problems, unemployment or underemployment, bad housing and irresponsible landlords (Power et al., 2008; Starkey, 2012).

Welshman and others note the similarities in the policy and practice approach towards ‘problem families’ in the 1950s and the ‘troubled families’ of recent times in terms of identification of families and the nature of suggested intervention; there are differences, however, in the modern-day emphasis on measuring outcomes and in the accompanying rhetoric; today’s talk of ‘troubled families’ and antisocial behaviour is much higher profile (Welshman et al., 2016). Similarities have also been pointed out between the 1970s rhetoric of Keith Joseph ('social workers, teachers and others know only too well the sort of situation I am referring to') and Cameron’s talk of Troubled Families (‘the ones that everyone in their neighbourhood knows and often avoids’) (Macnicol, 2015; Starkey, 2006). This rhetoric also points to the conflation of at-risk and risky, troubled and troublesome which has been a recurring trope (Macnicol, 2015). This language was prominently employed regarding the Troubled Families Programme where a finding of 120,000 families *experiencing* multiple problems (Social Exclusion Task Force, 2007) was used to refer to the number of families who were *causing* problems and therefore needed to be ‘turned around’ to prevent antisocial behaviour. The 120,000 figure represented families who met five of the following criteria:

- no parent in work,
- poor-quality or overcrowded housing,
- no parent with qualifications,
- maternal mental health problems,
- a parent with long-standing limiting illness, disability or infirmity,
- low income, and/or
- unable to afford a number of items of food or clothing.

Local authorities were asked to find, and turn around, their share of the 120,000, but identifying them with the following criteria:

- are involved in crime and anti-social behaviour,
- have children not in school,
- have an adult on out of work benefits, and/or
- cause high costs to the public purse.

They were referred to by Cameron as ‘people with a twisted moral code’ (Department for Communities and Local Government, 2012; Economist, 2016; Levitas, 2012).

Prior and Paris (2005) date the acceptance of parents as a locus of intervention with unruly youth back to 'at least' the 1963 Children and Young Persons Act. Keith Joseph implicated parenting in a 'cycle of deprivation' proposing 'preparation for parenthood' (or also, notoriously, birth control) for mothers who were 'producing problem children, the future unmarried mothers, delinquents, denizens of our borstals, sub-normal educational establishments, prisons, hostels for drifters' (Joseph, 1974). Research found little evidence to support the existence of such a cycle (Macnicol, 1987) and many scholars regarded structural, or external, factors as the key explanations of the behaviour of the poor (e.g. Holman, 1978). The debate around agency and structure in explanations of poverty did not re-emerge as a major theme in social policy until the 1990s when research demonstrated the interplay between 'proximal and distal risk mechanisms', within the family (e.g. parenting) and outside (e.g. living conditions) (Welshman, 2007). Researchers' growing appreciation of complexity, and, writes Welshman, 'understandable reluctance' to offer definitive answers around causal processes, pathways and mechanisms 'has created a space in which alternative policy prescriptions can flourish':

> This means that alongside the focus on social exclusion, child poverty, and inter-generational continuities in economic status, there is a parallel and increasing emphasis on anti-social behaviour, parenting and problem families. (Welshman, 2007)

A common feature of the Troubled Families Programme, and its earlier incarnations, has been the overstating of rhetoric blaming families for antisocial behaviour when project data shows more salient features to be maternal mental ill health and domestic violence (Gregg & Mcmahon, 2010).

While echoing approaches from the fifties and sixties, then, New Labour's focus on intervening with families turned strongly towards causes and consequences of antisocial behaviour (Jones et al., 2015), and the 1998 Crime and Disorder Act was seen as a turning point in intervening with parents for the misdemeanours of their children (Prior & Paris, 2005). The 1998 Act introduced Parenting Orders as a response to serious child misbehaviour, compelling parents to attend parenting programmes and ensure school attendance and adherence to any imposed curfew, although these were little used in practice (Burney & Gelsthorpe, 2008). Although some measures introduced to address antisocial behaviour were punitive, there were also more holistic approaches such as the

Dundee Families Project (Nixon et al., 2010), and later Family Intervention Projects (Action for Children, 2011) which provided the 'evidence base' for the Cameron coalition government's Troubled Families Programme.

The Labour government spoke about basing practice on evidence both in relation to effectiveness of interventions and in relation to targeting of intervention based on evidence of need; Sure Start, the Children's Fund and the academies schools programmes were all initially targeted at disadvantaged areas. Norman Glass's case to Her Majesty's Treasury for supporting Sure Start was based on the idea of preventative intervention saving money in the long term (Eisenstadt, 2012a), partly informed by the delayed but dramatic social and economic benefits shown by families receiving the holistic High Scope Perry preschool programme in the US, compared to a control group (Heckman & Masterov, 2007). However, Sure Start's ethos and design was also modernising, aiming to involve services' users in the process of policy and practice planning (possibly a feature that made it useful to families, but also difficult to evaluate because of the heterogeneity of approaches) (Belsky et al., 2007).

A less holistic approach from the subsequent coalition government was perhaps hinted at by Michael Gove's renaming the 'Department for Children, Schools and Families' to 'Department for Education' on arrival as minister, and his instruction to replace the phrase Every Child Matters (the New Labour policy which set out five key aims of support for all children[1]) with 'helping children achieve more'. Ofsted no longer had to grade schools on their promotion of children's spiritual, social and emotional well-being (Jones, 2012).

While there is continuity in the emphasis on parenting between the New Labour and subsequent governments, there was a change in rhetoric. New Labour saw child poverty as a cause of families' problems and made the elimination of child poverty a policy target, whereas the subsequent Coalition and Conservative governments moved the focus from poverty to social mobility (Stewart & Roberts, 2016). The Coalition government attempted to remove income from its measurement of child poverty (Stewart & Roberts, 2016) and presented parents, particularly those without work, as the

[1] The five Every Child Matters aims were: Stay safe; Be healthy; Enjoy and achieve; Make a positive contribution; Achieve economic well-being.

main barrier to change (Gillies, 2013; Lister, 2006). Despite continued stated political belief in the cost-effectiveness of early intervention for families in need, preventative services have seen budgets cut (Stewart, 2015) and commentators have noted the increasing apportioning of blame to those on benefits to accompany cuts in benefits for both those in and out of work (Toynbee, 2016).

Focussing on greater economic efficiency, and improved outcomes, risks valuing efficiency over equity (Sefton, 2000:19). It has been suggested, on the basis of a rapid review of systematic reviews of public health interventions, that preventative interventions are likely to increase inequalities compared to more ‘upstream’ interventions (societal or policy-level determinants such as pricing and resource provision or structural workplace interventions) because lower-risk groups can benefit more than high-risk groups (Lorenc et al., 2012). Sure Start faced criticism for providing services to those who were not in the greatest need, although to others its universalism was its greatest asset (Eisenstadt, 2012b). Eisenstadt (one of the architects of Sure Start) told of centres threatened with closure because of the failure to bring in those in the greatest need, where the mothers set out to bring in those other parents in order to keep the centre going. Labour’s Every Child Matters agenda was taking a move towards a more universal outlook in a child welfare system that has been described as taking a ‘neoliberal’ and ‘residual’ approach, for focussing on intervention targeted at ‘at-risk’ groups (Boddy et al., 2009).

Marmot and colleagues, responding to the enduring relationship between disadvantage and ill health, recommended universal intervention but with attention and intensity proportionate to need (proportionate, or progressive, universalism) (Marmot et al., 2010, 2012). The universality, they argued, could help overcome stigma. ‘Processes of exclusion’ should be addressed rather than characteristics of excluded groups; responses should be based on ‘the resilience, capabilities and strengths of individuals and communities’, while addressing the hazards and risks they are exposed to. Providing support for effective parenting, including parenting programmes, was a key recommendation of Marmot’s review. Early years preventative intervention, as in the Black Report (1992), was seen as the best investment, including family-friendly work practices, early education and high quality, affordable childcare. Marmot’s recommendations were welcomed in the final months of the Labour government, and

further investment was made in Sure Start children's centres, but others arguing for reduced public spending took the view that insufficient targeting meant wasted resources (Kaffash, 2010).

A growing perception of the importance of basing practice on research evidence, for greater cost-effectiveness, has meant a concomitant increase in the need for intervention to prove its value. An emphasis on parenting, individual-level intervention and cost-effectiveness, downplaying structural factors, is a feature of the Field (2010) and Allen (2011) reviews, with the second Allen report titled 'Early Intervention: Smart investment, massive savings'. Allen's review has been criticised for constructing failures of mothering as the cause of social ills, and the early intervention it promotes has been seen as 'part of a longer-term project of moral regulation' (Grover & Mason, 2013; Wastell & White, 2012).

Despite the evidence on the social determinants of health and wellbeing, the focus of much policy has been on programmes which can be replicated by following a manual, and evaluated by measuring outcomes, ideally comparing those who receive the programme with those who do not (Allen, 2011a; Field & Government, 2010). Such evaluations can provide effect sizes for use in economic modelling to estimate long-term savings to the public purse if gains relative to control groups were maintained (Aos et al., 2004; The Social Research Unit at Dartington, 2013). The evidence reviews of the Early Intervention Foundation, launched as one of the coalition's What Works Centres in 2013, in response to the Allen review, continue an emphasis on manualised programmes, stressing the importance of fidelity to the programme. The following section highlights the main findings from research on what works to reduce and prevent conduct disorders and antisocial and criminal behaviour.

2.3.2 The effectiveness of interventions to prevent at-risk children developing antisocial and criminal behaviour

A number of reviews have assessed the evidence base for interventions aiming to reduce conduct disorders and/or future antisocial behaviour. Evidence that an intervention is effective is considered to be most robust when the intervention has been evaluated in randomised controlled trials (RCTs). RCTs are seen as the best way of taking into

account unknown moderating factors that may have an impact on the effectiveness or cost-effectiveness of the interventions under study. When several RCTs have been carried out with different populations, the results can be compared in systematic reviews and meta-analyses, which, if results are consistent can give more confidence of a robust effect. Most reviews only look at a particular type of intervention, although some compare different types of intervention for the prevention of antisocial behaviour (e.g. O'Connor & Waddell, 2015; Pilling et al., 2013; Ross et al., 2011; World Health Organisation, 2015). A selection of relevant reviews are listed in Appendix 2.

Early childhood intervention, particularly home visiting, is often found in reviews and meta-analyses to have the strongest (although still only moderate) effects on future behaviour problems (Cohen et al., 2010; Farrington & Welsh, 2003; Piquero et al., 2009) and it is considered likely to be the most cost-effective (Heckman & Masterov, 2007). However, so far evaluation has failed to prove benefits of, for example, the Family Nurse Partnership in the UK, to mirror success in multiple randomised controlled trials in the US (Olds, 2006). A possible explanation often offered when effects fail to transfer is that control groups in the UK are receiving a better level of support, although alternative explanations include problems with both implementation and evaluation methods. Despite the famous success of the High Scope Perry multimodal early intervention programme, however, there is little additional evidence of lasting effects for these interventions (Cohen et al., 2010). However, pre-school intervention is beyond the scope of the current study. Here the principal recommended interventions are briefly described, according to the main level (as represented in Figure 1) at which intervention is aimed.

<u>Intervening directly with the child</u>

There is some experimental evidence that teaching at-risk children skills such as anger management, problem-solving and self-control may be associated with less delinquency (Augimeri et al., 2007; Burke & Loeber, 2015). This can involve calming techniques such as counting to ten and deep breathing, using coping statements, planning solutions and learning to identify their own triggers. A high-quality systematic review of 34 studies concluded that self-control improvement programmes were effective in improving self-control and reducing problem behaviour (Piquero et al., 2010b). The review only included studies of children aged under 10, based on arguments that self-

control becomes relatively fixed after that age (Gottfredson & Hirschi, 1990). However, evidence of effectiveness is mainly from the US and reliant on self-report (e.g. Botvin, Griffin, & Nichols, 2006). Such training is often a feature of school-based intervention and features that have been found to be associated with improved effectiveness are smaller class sizes, the use of cognitive behavioural techniques and delivery to older children (over 12) and higher risk groups. As is also found with parent training, evaluations of programmes delivered by the programmes' developers find larger effect sizes, which has been attributed to greater fidelity to the programme design, as do studies with smaller samples (Losel & Beelmann, 2003), sometimes an indicator of publication bias (Rothstein et al., 2005).

McCart compared individual (child) cognitive behavioural therapy (CBT) with parent-training in a meta-analysis and found bigger effects for parent training in school age children, but bigger effects for individual CBT in older adolescents (McCart et al., 2006). Effectiveness of individually-oriented CBT for adolescents with severe aggression unsuitable for group participation has also been found in a meta-analysis of six studies (Hoogsteder et al., 2015). Overall, Pilling and colleagues' meta-analytic review for NICE found moderate quality evidence indicating a small reduction in antisocial behaviour following child-focussed intervention compared to controls, but only low-quality evidence of longer-term effects (NICE/SCIE, 2013).

Mentoring programmes, which in many cases could be included under the Community heading, aim to provide a protective relationship for an at-risk young person, perhaps where this has been lacking, based on the findings about the importance of a 'significant other' for improved outcomes. The research base is of variable quality with some evidence of harm, particularly when mentoring relationships collapse (Roberts et al., 2004). Systematic reviews and meta-analyses have come to differing conclusions, with one finding the highest quality studies showed no evidence of effect on antisocial behaviour (Jolliffe & Farrington, 2007) while others report modest positive effects in a majority of studies (Farruggia et al., 2011; Tolan et al., 2013). Interestingly, Tolan and colleagues found stronger effects when mentors stated that professional development was an explicit motive for their participation, perhaps associated with a greater commitment. They also found larger effects of programmes which emphasised emotional support and advocacy.

Reviewers seem to concur that interventions involving young people themselves are most effective when parent, school or community interventions are also incorporated (Liabo & Richardson, 2007; Pilling et al., 2013; Ross et al., 2011). Based on expert opinion, NICE's guidance also recommends more assessment of children in order to provide timely preventative intervention and more referral to Child and Adolescent Mental Health Services (CAMHS)(NICE/SCIE, 2013). Crucially, in what could be regarded as a societal issue, NICE call for greater awareness of conduct disorder as a mental health problem for which there is recommended treatment.

Intervening with parent-child and family relationships

As we have seen, mothers' intrapersonal factors are associated with parenting capacity and with children's outcomes. However, interventions aimed at maternal wellbeing are not usually described as being aimed at children's antisocial behaviour outcomes. Conversely, parenting programme evaluations do sometimes collect outcomes on maternal mental health and a Cochrane systematic review found evidence of post-intervention improvements in depression, stress, anger, guilt, confidence and partner relationship satisfaction, although there was no evidence that effects remain after one year (Barlow et al., 2014). Nevertheless approaches aimed at improving children's outcomes by intervening with parents, usually mothers, are generally directed at affecting relationships between the parent and the child, rather than maternal wellbeing.

Quality of parenting is often seen as the most easily modifiable of the influences affecting children's behaviour as well as a host of other developmental outcomes and life opportunities (Sanders, 2012). Several systematic reviews of randomised and quasi-randomised trials have supported the effectiveness of parent training programmes for parents of children between ages 3 and 12 in reducing harsh parenting practices and children's behaviour problems in the short term (Dretzke et al., 2009; Furlong et al., 2012). Behavioural programmes such as the Incredible Years (Webster-Stratton, 2000) and Triple P (Sanders, 2012) help parents learn skills to increase their children's prosocial behaviours and reduce problem behaviours including aggression, tantrums and excessive non-compliance, for example through play, consistent discipline, and giving attention and praise to positive behaviours. Statistically significant improvements have been found in children's behaviour as well as in parental mental health and parenting

skills, and reductions in harsh parenting practices have been found, based on both parent report and independent assessment.

Studies quoting evidence on effectiveness of parenting programmes often refer to maintenance of effects a year or more later (e.g. Carr, 2014). However, follow-ups tend to lack control groups (sometimes because control groups were given the intervention at a later date) or any comparison with natural recovery rates (e.g.Webster-Stratton, Rinaldi, & Reid, 2011). Review authors concur that further research is needed to discover whether any longer-term outcomes are reliably found (Furlong et al., 2012).

In the UK it is not known whether those most in need of help are those who receive the interventions or will benefit. Trials have shown that there are many children who do not improve following parenting programmes and that those whose parents do not complete the course are likely to have more serious antisocial behaviour and aggression than those who do (Capaldi & Patterson, 1987; Lundahl et al., 2006). Drop-out rates reported in systematic reviews of parenting programme trials range up to 44% (Barlow et al., 2004). A re-analysis of data from Dretzke's systematic review (2009), including additional data supplied by the author, estimated that on average the included parenting programme trials reduced clinical cases of conduct disorders by 34% (range 20% to 68%) over and above the reduction found for the control groups (D'Amico and Bonin, 2010, unpublished data). These percentages are for those who did not drop out so, while the programmes may be worthwhile and cost-effective, there are clearly many families who fail to benefit, and it is likely to be those most at risk of having major difficulties in the future. Although reviews of parenting programme trials have suggested that those with the most serious conduct problems will benefit most from the intervention (de Graaf et al., 2008; Lundahl et al., 2006), socioeconomically deprived families, while they may still benefit, appear to experience smaller effects than those less disadvantaged (Scott et al., 2006).

A thematic synthesis of high-quality qualitative research investigating barriers to access to and engagement in parenting programmes highlighted a series of delivery-related factors and recommended raising awareness, providing flexible, individually-tailored support and using highly skilled, trained and knowledgeable therapists (Koerting et al., 2013). Meanwhile, a quantitative meta-analytic review, after controlling for differences

attributable to research design, found programme components consistently associated with larger effects included increasing positive parent-child interactions and emotional communication skills; teaching parents to use time out and the importance of parenting consistency; and requiring parents to practice new skills with their children during parent training sessions. Programme components consistently associated with smaller effects included teaching parents problem solving; teaching parents to promote children's cognitive, academic or social skills; and providing other, additional services (Wyatt Kaminski et al., 2008).

Other family-based approaches with some evidence of effectiveness in preventing or reducing children's antisocial and criminal behaviour (Ross et al., 2011) are Multi-systemic therapy (MST) (Henggeler et al., 2009), Functional family therapy (FFT) (Sexton & Alexander, 2000) and Multidimensional Treatment Foster Care (MTFC) (Chamberlain & Patricia, 2003), although these are generally aimed at older young people already involved in offending and so will be only briefly mentioned. MST is a home-based, intensive therapeutic intervention involving tailored components relating to child skills training, parent training and intervention with peers and school. A 2005 Campbell systematic review found insufficient evidence to show effectiveness, and no UK studies met their inclusion criteria (Littell et al., 2005) although a more recent trial has shown a positive effect over controls receiving usual services (Butler et al., 2011). FFT involves mainly clinic-based family therapy, but applies skills learnt to other contexts such as school and the wider community; a UK trial did not show any evidence of effect although this may have been due to the quality of the trial (Humayun et al., 2012). In MTFC young people spend a period of time in specialised foster care while both they and their parents receive individual and family therapy; a Cochrane review tentatively concluded from five RCTs that the intervention may be effective (Macdonald & Turner, 2008) but a UK trial did not find any evidence of effect (Green et al., 2014). All these programmes show greater effect sizes in trials conducted by the programme developers (Ross et al., 2011).

Intervening in communities

Although qualitative research has suggested that community development programmes might be important in providing informal support to families (Hansen, 2005), community-oriented interventions for antisocial behaviour have not generally been

evaluated with robust, controlled evaluation designs (O'Connor & Waddell, 2015; Ross et al., 2011).

Young people at risk of, or who have engaged in, antisocial behaviour may be offered diversionary activities, sometimes as an alternative to becoming involved in the criminal justice system which has been shown to be associated with poor outcomes (Curtis, 2016). Evidence from programmes such as the UK's Youth Inclusion Panels, providing recreational opportunities for young people after school is considered 'promising' if the recreational opportunities are structured and supervised (Ross et al., 2011). Sport and leisure opportunities were also considered promising in preventing antisocial behaviour in an Audit Commission report (2009) which highlighted the benefits of approachable project staff who take an interest in young people and offer advice and support. Supervision and structure are recommended because of the potential for negative outcomes from encouraging antisocial youth to associate together, a suggested reason for negative outcomes in 'scared straight'–type interventions (Petrosino et al., 2013). Sports-based programmes offer prosocial rewards, as well as diversion, and evaluations reported positive, as well as some negative outcomes, but with small samples and no control groups, effectiveness reviews are unable to conclude that positive outcomes were due to the programmes (McMahon & Belur, 2013).

<u>Intervening in schools</u>

A role for schools in prevention of antisocial behaviour has long been posited, given the associations discussed in section 2.2. It has been argued that schools could contribute to coordinating service delivery between families and other services as well as intervening directly with children to reduce risk factors and enhance protective factors (Walker et al., 1996). Rutter's 1977 study famously highlighted the potential of schools to use the 15,000 hours pupils spend there to bring about change (Rutter et al., 1982). Based on 12 inner-London schools, the study was reported as showing that schools' ethos affected children's outcomes, though the authors conceded that the study design was not one which could demonstrate causality. Although school ethos cannot easily be randomised, there is evidence that schools with more consistent enforcement of accepted and fair rules, and schools with high expectations of pupil achievement, have fewer disciplinary problems (Reinke & Herman, 2002).

Curtis argues that school-based programmes aimed at changing the school environment, rather than the young person independently, have best evidence of effectiveness (Curtis, 2016) and Reinke (2002) has summarised the evidence supporting this view. Approaches which seem to be effective include reorganisation of classes, so that disruptive pupils are taught separately at certain times, with alternative materials and using cognitive behavioural techniques; changing classroom management and teaching techniques to emphasise interactive methods, increase student participation and the use rewards and punishments contingent on behaviour; and changing school discipline or management, with greater involvement of pupils and the wider community. The research supporting these approaches is from the US but does include evaluation with control groups (Gottfredson, 2002; Ross et al., 2011; Wilson et al., 2001). Similar programmes in the UK, the Safer Schools Partnerships, forged collaborations with police and wider communities and seemed to show decreases in truancy and school exclusions compared to similar schools according to the national evaluation (Bowles et al., 2005). However, the process evaluation indicated that some staff and parents were unhappy having police in schools (Sherbert Research, 2009). Ross and colleagues suggest that UK schools' ability to intervene is restricted by not being allowed to hold pupils back a year as happens in the US.

Research showing positive effects of teaching social and emotional skills was mentioned above regarding intervening directly with the child. Schools are often the sites for such intervention and a number of reviews specifically regarding school-based life skills–teaching have shown overall evidence of effects on disruptive behaviour and/or violence (Mytton et al., 2009; Wilson & Lipsey, 2007) including in universal whole-class approaches (Hahn et al., 2007). In a high-quality systematic review Mytton and colleagues found intervention for children displaying, or at risk of displaying, aggressive behaviours reduced those behaviours immediately following the intervention, and for a subset of studies, one year later. Their subgroup analyses suggested that interventions which aimed to improve relationships or social skills may be more effective than those teaching non-response skills. However, both primary and secondary school pupils benefitted.

Bullying is a form of antisocial behaviour and those involved in bullying as perpetrators, and also, to a lesser extent, as victims, are more likely to be aggressive and

violent in later life (Ttofi et al., 2012). Systematic reviews and meta-analyses have evaluated the evidence for the efficacy of anti-bullying interventions and found overall positive effects on bullying behaviour, although some studies showed no effect and this was more common for curriculum-based interventions (Vreeman et al., 2007). Other types of anti-bullying intervention include multidisciplinary 'whole-school' approaches, social skills groups, mentoring and social worker support. Ttofi and Farrington (2011) found features of more effective programmes included parent meetings, firm discipline and improved playground supervision. However, they found work with peers was associated with an increase in being bullied (see also Dodge, Dishion, & Lansford, 2006). This review was updated by Evans and colleagues (2014), who found only half the relevant studies showed an effect on bullying perpetration whereas 67% of studies which looked at victimisation (being bullied) showed a positive effect. Additional features of successful programmes were parent and teacher training; strict, school-wide anti-bullying rules; and use of instructional videos.

As well as the school-based interventions mentioned above, the World Health Organisation (2015) recommends academic enrichment programmes and financial incentives for adolescents to attend school as likely to have an effect on reducing violent behaviour. Although there is an absence of evidence linking these directly to violence, programmes have shown effects on academic achievement and school attendance and engagement, known to be inversely related to antisocial behaviour, as shown above.

However, the potential for schools to make a contribution is constrained by available resources, including time and money (Pearson et al., 2015; Qureshi, 2015). Because of the overwhelming evidence of the childhood precursors of a wide range of serious difficulties which are costly for society, schools are considered the ideal location for intervening with an ever-growing list of issues including mental and physical health, obesity, suicide and radicalisation at a time when they are evaluated almost exclusively on academic outcomes (Arbesman et al., 2013; Brown & Summerbell, 2009; DiCenso et al., 2002; Ttofi & Farrington, 2011; Wells et al., 2003; Wyman, 2014).

Intervening at a societal level

Curtis writes that programmes addressing broader social issues in relation to prevention of antisocial behaviour are 'conspicuous by their absence'. The risk/resilience paradigm

through which prevention of antisocial and criminal behaviour is generally viewed can lead to overlooking the structural and historical context, and giving insufficient attention to the socially-constructed nature of factors associated with risk and resilience (Curtis, 2016). Many factors affecting household wellbeing (e.g. income, neighbourhood, social capital) and life chances of the parent and child (e.g. through education or employment) might be brought about via individual, family, community or national-level intervention; Roberts has written that the most successful interventions in reducing inequalities in health are likely to be those at a national or even supra-national level (Roberts, 2012). National-level intervention could take action to increase incomes in high need families and there is some evidence from a systematic review that this might be effective; the review found positive effects on children's outcomes resulting from increases in income, for example from benefits changes (Cooper & Stewart, 2013). In the US a natural experiment of the opening of a casino on an Eastern Cherokee reservation during a longitudinal study of children's mental health showed significant decreases in psychiatric symptoms, particularly behavioural symptoms, for children in households which consequently moved across an income poverty threshold (Costello et al., 2003).

The NICE-SCIE (2013) guidance on intervention for antisocial behaviour and conduct disorders does refer to societal factors which could be improved to help avert poor outcomes for children with conduct disorder, highlighting problems of access to services and appropriate intervention. Based on a review of service users' experiences in 18 studies they conclude that barriers to service access include limited resources for service provision but also societal (as well as personal and familial) attitudes to both the problem and to use of services. Societal attitudes, or prevailing discourses, could potentially be altered with beneficial effects. For example, a survey of attitudes to antisocial behaviour found a common attitude among community safety practitioners was that the assumptions and exaggerations of others regarding young people's behaviour may be alienating and antagonising, exacerbating antisocial behaviours (Millie et al., 2005). A World Health Organisation report on the evidence-base for preventing youth violence, as well as reviewing policing policy, calls on governments to raise awareness and organise national policy discussion around causes and prevention of youth violence (World Health Organisation, 2015).

Many of the reviews quoted above conclude that multimodal interventions, incorporating a range of the approaches mentioned above, are the most effective, as long as there is a dedicated case worker to coordinate programme delivery (e.g. Liabo & Richardson, 2007; Ross et al., 2011). A review of research on poverty and education found that studies tended to focus on only one of the following: individuals, immediate social contexts or underlying structures and inequality (Raffo et al., 2007). Initiatives such as Excellence in Cities, Sure Start, the Educational Maintenance Allowance and Extended Schools, for example, focus on immediate social factors and the problems they cause directly for local communities and individuals, but, the authors say, as a piecemeal response these can only have a small impact on the link between poverty and attainment. Instead, the authors call for a set of integrated and multi-level interventions. Epstein (2015), however, reported that there was currently only weak evidence supporting multicomponent interventions, that is, intervention delivered to the parent and another person such as the child or a teacher.

2.3.3 Problems with the evidence

The evidence-based practice movement has emphasised the importance of evidence from trials, especially randomised, controlled trials (RCTs), in assessing what works, because of their ability to control for unobserved differences between groups and therefore provide the best evidence that any difference in outcomes was due to the intervention assessed. However, these designs have their limitations when addressing complex social problems: only one or two comparators are studied under RCT conditions, whereas many alternative interventions are sometimes available, and provided; RCTs rarely mirror what is happening in the real world; and treatment fidelity may not be maintained once an intervention is rolled out (Eames et al., 2009; Welsh et al., 2009). Positive effects found in the studies discussed above are mainly small and there is little evidence of long-term benefits (Barlow et al., 2014; Stewart-Brown, 2004); there are good reasons why such interventions may be insufficient without regular, ongoing support (Barlow, 2015). Surprisingly little attention is given to the possibility of negative effects, particularly for those who drop out of programmes. We know little about what may be effective for families experiencing multiple disadvantages in real life situations but one meta-analysis of predictors of parent training efficacy showed families with low incomes, or maternal mental health problems, experienced significantly smaller effects (Reyno & McGrath, 2006).

A high proportion of trials are conducted by programme developers or their 'intellectual descendants', leading to suggestions of unintended bias as well as unrealistic expectations of programme fidelity when rolled out (Epstein et al., 2015). A bias related to study quality has also been suggested, since poor quality studies tend to find larger effects (Ross et al., 2011). In Epstein's review of psychosocial and pharmacological interventions for children with disruptive behaviour, only one in eight studies had a low risk of bias. Only five out of 66 studies were from the UK and questions have been raised over the transferability of results to the UK's different service landscape (Moran et al., 2004).

Many types of intervention offering support to families do not easily lend themselves to assessment in randomised controlled trials and the emphasis on RCTs has tended to raise the profile of manualised, short-term interventions which are relatively amenable to testing in this way, such as parenting and home visiting programmes. Munro has voiced her 'horrible feeling' that we might end up with Family Nurse Partnership and parenting classes for everybody, regardless of their problems, with this being seen as a panacea (Higgs, 2012). The UK Youth Justice Board, at the time of its threatened abolition (later retracted), despite seeing reductions in the numbers of young people involved with the youth justice system, lacked evidence of which types of the interventions they used with children and families were most effective, and they feared this could lead to unknowing cutting of the services which were the ones making a difference (Committee of Public Accounts, 2011). A focus on the relatively well-evaluated parenting programmes may have restricted availability of alternative forms of family support (Featherstone et al., 2011).

<u>Supporting 'at-risk' families: a lower level of evidence?</u>

Family support has lacked a commonly agreed definition (Dolan et al., 2006) and it may be that these problems with definition are linked to the lack of representation in the evidence-based practice literature discussed above (section 2.3.2). In contrast to the literature on intervention effectiveness the family support literature, including a preponderance of opinion pieces, gives attention to thinking about the kinds of activities that are important to families (Dolan et al., 2006). A government review confirmed that the available evidence suggested that some 'troubled families' benefitted from

intervention but that evidence was of variable quality, with no evidence of long-term cost-effectiveness (Local Government Association, 2012). The review points out that costs could initially increase because of identification of unmet needs. International evidence reflects that of the UK, showing the difficulty providing effective preventative intervention to families in need (Morris et al., 2008).

Dolan and colleagues ground family support in a model drawing on social support theory, and, similarly to the conceptual model for the current research, within a set of levels: the children and family are given support from wider family, friends, school and the neighbourhood; more formally from community, voluntary and statutory agencies, services and organisations; and finally from national policy and legislation (Canavan et al., 2000; Dolan et al., 2006). While informal support is not stigmatising in the way that formal support can be, these authors acknowledge that families and friends are a potential source of additional stressors, including abuse, and that families without adequate informal support are going to need formal support at some point. These authors, not opposed to the use of RCTs, argue that such a theoretical grounding can help develop meaningful evaluation by building measures of success into practice (Bruner, 2006). However, Morris and colleagues (2008), in their Think Family review of the literature on ‘whole family’ intervention, found insufficient account taken of the complexities of families’ realities and needs. Practice did not always meet intentions to engage with multiple difficulties, build on families’ strengths, adopt whole-family approaches or develop community links and wider social engagement. They highlighted a lack of direct data about the lived experiences of families enduring multiple difficulties.

Mapping of the large literature relating to intervening with ‘problem families’ in the UK and Ireland shows a preponderance of non-empirical studies, and of the empirical studies, most are qualitative and most would not be included in reviews of intervention effectiveness (Buckley et al., 2010; Local Government Association, 2012; Tarara & Daniel, 2007; Taylor, Mackay, et al., 2015). There is relatively little quantitative social work research in the UK with rare use of multivariate statistical analysis and longitudinal designs (Maxwell et al., 2012). Little is known about the number of services and interventions that individual families receive or the extent to which service use is related to families’ willingness to engage. Survey evidence has highlighted

parents' wariness regarding formal services in health, education and social support, despite a wish for more support (Bradshaw et al., 2008). Predictors of low engagement include low socio-economic status and parent psychopathology, although longitudinal study in this area is lacking and could help explain the complex relations between parents and services (Nock & Ferriter, 2005).

While the Allen review recommended 19 named and manualised interventions, including several parenting programmes to develop 'Good parents, great kids, better citizens' (Allen & Smith, 2008), Munro's (2011) Review of Child Protection put more emphasis on practitioners' professionalism. It has been suggested, indeed, that the tenets of evidence-based practice undermine social workers' professional judgement and discretion (Webb, 2001). An alternative evidence-based approach involves identification of key elements of successful programmes, allowing flexibility in the use of techniques rather than the prevalent emphasis on fidelity to a whole programme (Barth et al., 2012). Features of intervention with high need families that have consistently been considered important are listed in Table 2.2. A few projects are mentioned as examples of each feature, but many other examples could have been given (Early Action Task Force, 2011).

Table 2.2 Helpful features of UK intervention with troubled families

Features of intervention	Example programmes citing as helpful feature
Good relationships between practitioners and service-recipients	About Turn; Dundee; FIPs
Intensive support at home	FSUs; Dundee; FNP; FIPs
Practical help in home and with financial management	FSUs; FIPs
Multiagency working	Dundee; Sure Start; FIPs; Family Pathfinders
Lead professional/key worker	FIPs; Family Pathfinders; TFP
Challenging approach in direct work	Dundee; FIPs; Family Pathfinders
Flexibility/range of approaches depending on needs	Dundee; About Turn; FIPs; Family Pathfinders
Support 'on call'/long term/as long as needed	About Turn; Dundee; FIPs; FNP
Highly skilled staff	FIPs
Small caseloads	FIPs
Good management	Dundee
Address housing issues	About Turn; Dundee
Improve parental relationships	Dundee

FIPs: Family Intervention Projects; FSU: Family Service Units; FNP: Family Nurse Partnership; TFP: Troubled Families Programme
Sources: Programme evaluations referred to in the text and in Crowther & Cowen, 2011; Dillane et al., 2001; Early Action Task Force, 2011; Lloyd et al., 2011; Local Government Association, 2012; Morris et al., 2008; Nixon, 2008; Nixon et al., 2006; Pilling et al., 2013; White & Day, 2016; York Consulting, 2011.

The quality of relationships between practitioners and family members is repeatedly cited as key to successful intervention (Table 2.2). Morris and colleagues (2008) listed key components of relationships which were crucial regardless of intervention type: trust, openness, respect and responsivity; these findings were reinforced by Morris's later work (Morris, 2013). Originally proposed in the 1930s in relation to psychological therapy, the Dodo conjecture ('Everybody has won and all shall have prizes') proposes that all intervention is equally effective, and it is the quality of the relationship between the helper and the helped that makes a difference, not the content of the intervention (Duncan, 2002; Little et al., 2015; Rosenzweig, 1936). However, it is also possible that

those who are more likely to benefit from intervention are also more likely to form productive relationships, and that this is not a causal relationship. Goldsmith and colleagues sought to isolate the contribution of therapeutic alliance by adjusting for a range of alternative predictors of treatment outcome. They found that with a good therapeutic alliance, attending more sessions led to better outcomes whereas for a bad therapeutic alliance more sessions led to detrimental effects (Goldsmith et al., 2015). Practice models which put greater emphasis on the way practitioners of all types interact with families could potentially be compared but may be less amenable to testing in trials (Davis et al., 2002).

The role of relationships is, then, key — in families, with peers and neighbours, at school, with services providers and with strangers and the wider society (Little et al., 2015). Broad intervention approaches like the Family Service Units, Family Intervention Projects, Family Nurse Partnerships and the Troubled Families Programme share a belief in the importance of key practitioners in building relationships and in coordinating responses from multiple agencies to address multiple problems. Family Nurse Partnerships and the Troubled Families Programme in the UK both failed to provide evidence of effects on pre-agreed primary outcomes, compared to control groups (for Family Nurse Partnership: A&E attendance, birthweight, smoking rates and time until next pregnancy; for the Troubled Families Programme: employment, benefit receipt, school attendance, safeguarding and child welfare). This was also the case with the Home Start family support evaluation, which found no evidence of effect on wellbeing (McAuley et al., 2004). However, mothers valued the service highly and it continues supporting families today. Both the Family Nurse Partnership and, to a lesser extent, the Troubled Families Programme reported promising differences in secondary outcomes (Day et al., 2016; Robling et al., 2016) such as, for Family Nurse Partnership, small differences in intention to breastfeed, levels of social support, partner-relationship quality and general self-efficacy (Barnes, 2016) and for the Troubled Families Programme managing well financially, knowing how to keep on the right track, being confident that their worst problems were behind them and feeling positive about the future. While the primary outcomes were felt to be those most likely to show long-term cost-effectiveness, it is possible that changes in these secondary, or more attitudinal, outcomes might lead to important differences in the future.

We have seen above that while local authorities set out to help troubled families and young people at risk of future antisocial behaviour, the government appeared to be setting out to demonise them, affecting the societal-level environment around families. Several of the reviews cited above refer to the negative impact of these discourses on the likelihood of families benefitting from intervention, particularly when programmes were insufficiently funded to address significant underlying problems, frequently poor maternal mental health (Gregg & Mcmahon, 2010; Local Government Association, 2012; Morris et al., 2008). Curtis (2016:75) argues similarly that targeting antisocial behaviour intervention at young people exhibiting stated 'risk factors' contributes to a discourse of blame which undermines effective relationships with practitioners and can be a 'self-fulfilling prophecy'. A focus on risks can lead to labelling which, it has been argued, based on UK cohort study evidence, can affect youth justice decisions and lead to increased involvement in the formal justice system, from which it becomes increasingly difficult to escape (McAra & McVie, 2007). 'Constructing intervention through the lens of risk' is criticised as 'likely to be incompatible with the effective engagement of children in trouble' (Bateman, 2011). Farrington has made the case, instead, for focussing on promotive/protective factors, and on terminology, rather than on risk and prevention, to encourage a more hopeful position about promoting a better society (Farrington & Welsh, 2007).

2.4 Chapter summary and conclusions

Intervention with families with the aim of improving outcomes for children has a long history although a specific focus on parenting practices is more recent. Some families, particularly those living in stressful circumstances, are subject to many influences that are relevant to the psychosocial development of children with conduct problems. These influences can include interactions with services and agencies in education, health, social care, criminal justice, housing, parenting, benefits, voluntary/community groups and the private sector (e.g. money-lenders and landlords) as well as relationships within the family and in the wider community, and potential causal factors such as health, emotional/psychological and environmental characteristics and lack of resources and skills (Batty & Flint, 2012). There is robust evidence of effectiveness for only a tiny proportion of interventions which might be expected to ultimately benefit children with conduct problems (parenting programmes and home visiting for example). Even for these the evidence is mixed and there is almost no evidence regarding long-term effects

(Dretzke et al., 2009; Lundahl et al., 2006). Evidence on high need families is particularly lacking, because they can be hard to recruit to, and are more likely to drop out of, interventions, trials and surveys. Investigating effectiveness in 'real world' situations, as opposed to single-intervention research trials, is challenging, given the complex web of intervention and influence on family and child wellbeing.

By primary school-age many of the risk factors for antisocial behaviour, including conduct problems, are apparent, but although some families are involved with many services, we know very little about their long-term impact (Munro, 2012). There is a clear relationship between childhood risk factors and later anti-social and criminal behaviour. However, the causal pathways are varied and complex and many children are resilient to the presence of risk factors, not experiencing negative outcomes (Frick & Dickens, 2006; Rutter, 1999). The importance of the early years is clear but there is a difference between finding associations and knowing factors can be successfully changed. It is hard to say how helpful research is that leads to headlines such as 'Well-rounded children set for happiest futures' (Centre for Longitudinal Studies, 2015).

2.4.1 The contribution of this thesis

Existing research does not meet practitioners' and policy-makers' needs regarding families with children at high risk of future antisocial and criminal behaviour for three reasons that this thesis seeks to address: 1) Existing intervention research tends to look at single interventions, rather than holistically at what help might be useful to families; 2) There is little evidence of long-term effects, estimates of which form the bases of long-term savings projections; and 3) The most hard-to-help families are missing from research examining effectiveness of interventions and little is known about their use of services (Stevens, 2011; Stevens et al., 2005, 2007, 2009, 2010). To begin to address these difficulties this thesis takes a mixed methods approach, which will be described in the next chapter.

Most studies showing positive effects of interventions measure effects immediately following completion, or perhaps six months to a year later. The Troubled Families Programme is couched in terms of 'turning around' families within two years. In reality it is unlikely that a single short-term intervention would move a child definitively onto a

different trajectory. This study follows families over five years to capture interactions between families, services and other events and influences on their lives, to see what support they find helpful at different points, taking a longer-term perspective. The research is also original in its way of looking at intervention in that it captures families, and practitioners who work with them, in a ‘natural’, ‘real world’ setting, not with optimised ‘maximum fidelity’ versions of intervention but asking about all and any intervention they come into contact with and what aspects of interactions with services are helpful, and what barriers there are to help being effective. Factors which appear important to families’ experiences are distinguished and, where data allow, a much larger cohort of families are examined to see if any of these school-age factors, or *changes* in these factors during the school years, may be associated with a lower likelihood of involvement in criminal and antisocial behaviour in the long term. By including this long-term view the research attempts to contribute to the field by taking a ‘holistic perspective which preserves the complexities of human behaviour’ (Black, 1994).

Chapter 3

Methods

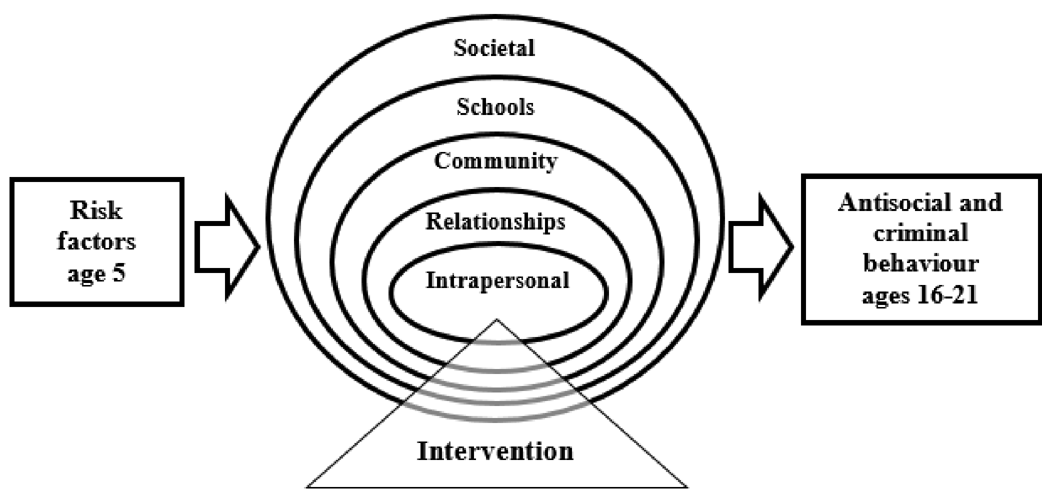


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> I always say this to my colleagues. I would like to have a ten-year reunion with all my students, just informally. I know it won't happen, but just to know where they are, how they're doing. Just to see whether or not it has made any difference. *Nominated practitioner at school for excluded pupils*

This study looks across possible levels of influence to see what works in helping avoid antisocial behaviour for at-risk children. The primary part of the research is a qualitative interview study following eleven families for five years. Although this main phase of the research is referred to as the *interview study*, some underpinning documentary data about the eleven families were also collected and analysed. Where appropriate, and where data allowed, findings from the interview study's qualitative analysis were used to develop hypotheses for quantitative investigation in a larger sample over a longer period of time using the Avon Longitudinal Study of Parents and Children (ALSPAC).

The specific research questions addressed by the study were presented in the introduction to the thesis, and both these and the conceptual framework were derived from the literature described in Chapter 2. The conceptual framework, illustrated in Figure 1, sees children's trajectories through life as influenced on a number of different levels where intervention from services, and society more broadly, is possible. In this chapter the methods used to address the research questions are explained. The reasons the qualitative and quantitative components were chosen and how they interrelate are explained in section 3.1, including how the design fits with typologies of mixed methods research. The methods for the collection and analysis of data for the interview study are described in section 3.2; the methods for the secondary phase of the research, the *ALSPAC study,* are described in section 3.3.

3.1 Mixed methods research design

The research is designed to look at service use, attitudes to services, child behaviour and family functioning and how these change, and are related to each other, over time. The research starts from the perspective of families, with an interest in all services families have contact with, and the perceived benefits or drawbacks of the approaches experienced, as well as considering the context of participants' lives and environments. The research seeks to understand how services, interventions and policy can affect the trajectory of a child and family, looking at all levels of influence. A mixed methods longitudinal research design, using primarily qualitative but also quantitative

approaches, is needed to study not just *which* interventions, services or other factors make a difference to families but *how* they do.

A one-to-one interview approach is needed to engage with the parent in a way that may uncover a fuller picture; keeping the sample small allows the necessary effort to recruit and retain hard-to-engage families. Getting the perspective of a practitioner working with the family provides useful triangulation to reinforce or challenge the view from parents, as does returning to participants at different timepoints. Qualitative analysis of interview data allows in-depth investigation of families' experiences with services and their wider community and how these seem to affect their parenting and their child's behaviour.

However, as there is a dearth of longitudinal studies looking at intervention and change within high need families it is valuable to get a longer-term picture by making use of previously collected cohort data, which will allow longitudinal examination of statistical associations in larger samples. Prospective longitudinal data allow examination of factors which pre-date children's antisocial behaviour and may moderate the relationship with childhood behaviour problems. In some studies of mechanisms of change, proposed mediators are measured at the same time as outcomes. Gardner and colleagues, for example, suggest that increases in observed positive parenting may mediate the effect of a parenting intervention in reducing negative child behaviours. However, since both behaviours were measured at the same timepoint it could be improvements in children's behaviour which caused more positive parenting rather than vice versa (Gardner et al., 2006).

Figure 3 shows the data collection timetable, illustrating the two main phases, distinguished by their different data sets and different methodological approaches. The first phase, the *interview study*, involves qualitative interviews with the primary caregiver and a key practitioner working with the family, as well as the collection of quantitative data on service use and child behaviour. In terms of Figure 1, the interview study is concerned with the middle section of the diagram, the school years, and potential influences on trajectories occurring at all the different levels. Pre-existing baseline measurement of services used by a sample of families involved in an intervention pilot, the Helping Families Programme (HFP), and of their child's

behaviour problems, provided the opportunity, with two further follow-ups in the current research, to assess changes in services used, feelings about services and children's behaviour over five years. This formed the primary data collection for the PhD thesis and provided evidence for the way the families are supported and the apparent effectiveness of this support in addressing children's conduct problems.

The second phase, the *ALSPAC study,* concerns the longer-term trajectory between risk factors and criminal and antisocial behaviour outcomes, the relationship between the risk factors and outcomes depicted on either side of Figure 1. This secondary phase involved quantitative analysis of potential modifiers of the relationship between risks and outcomes using existing cohort data. Children with behaviour problems at primary school age were identified and associations explored between factors hypothesised as important in the interview study, and later antisocial and criminal behaviour.

Longitudinal studies often have a problem with attrition which is typically non-random and can affect study conclusions. As discussed further below, families may well drop out of the study for reasons that are connected to the outcome of interest, in this case antisocial behaviour. And while some predictors of study dropout can be measured, it is likely that there are other, non-measured, reasons. As the section on recruitment of the interview study families makes clear, families of interest to the study may be 'hard to reach' and families with similar problems are thus more likely to have dropped out of ALSPAC. Trials face the same issue and the existing evidence base for intervention research tends to favour 'average' experiences. Families in difficulties, however, may respond differently to social pressures, and may interpret similar interactions in different ways. Hence, for the current investigation a qualitative approach looking at processes is needed in tandem with the longitudinal analysis of existing cohort data.

The first phase uses qualitative longitudinal research which can point to the possible mechanisms by which change takes place (Pawson & Tilley, 1997). Qualitative longitudinal research allows the exploration of contexts, mechanisms and outcomes at the individual level (Farral, 2006) and the understanding of transitions, adaptations and trajectories (Millar, 2017). Findings from the interview study can therefore be used to inform theories about how change occurs. Some of the findings are used to develop hypotheses for investigation in ALSPAC so as well as contributing to theories of

change, the qualitative findings form the basis for interrogation of the existing ALSPAC longitudinal data, aiding interpretation of study findings. Each phase of this study is designed to be valid in its own right. However, the two are linked in a way which aims to counteract the biases in each (Ragin, 1987).

While in previous decades an 'epistemological chasm' was felt to lie between qualitative and quantitative research, a more pragmatic, or realist, view is possible (Olsen, 2004). Here, mixed methods are not adopted in an 'illusory search for the full picture' (Silverman, 2013: 139). Rather, acknowledging the weaknesses of all methods, the aim is to combine types of data and method in such a way that the weaknesses of each approach are not overlapping, and the strengths are complementary (Johnson & Turner, 2003).

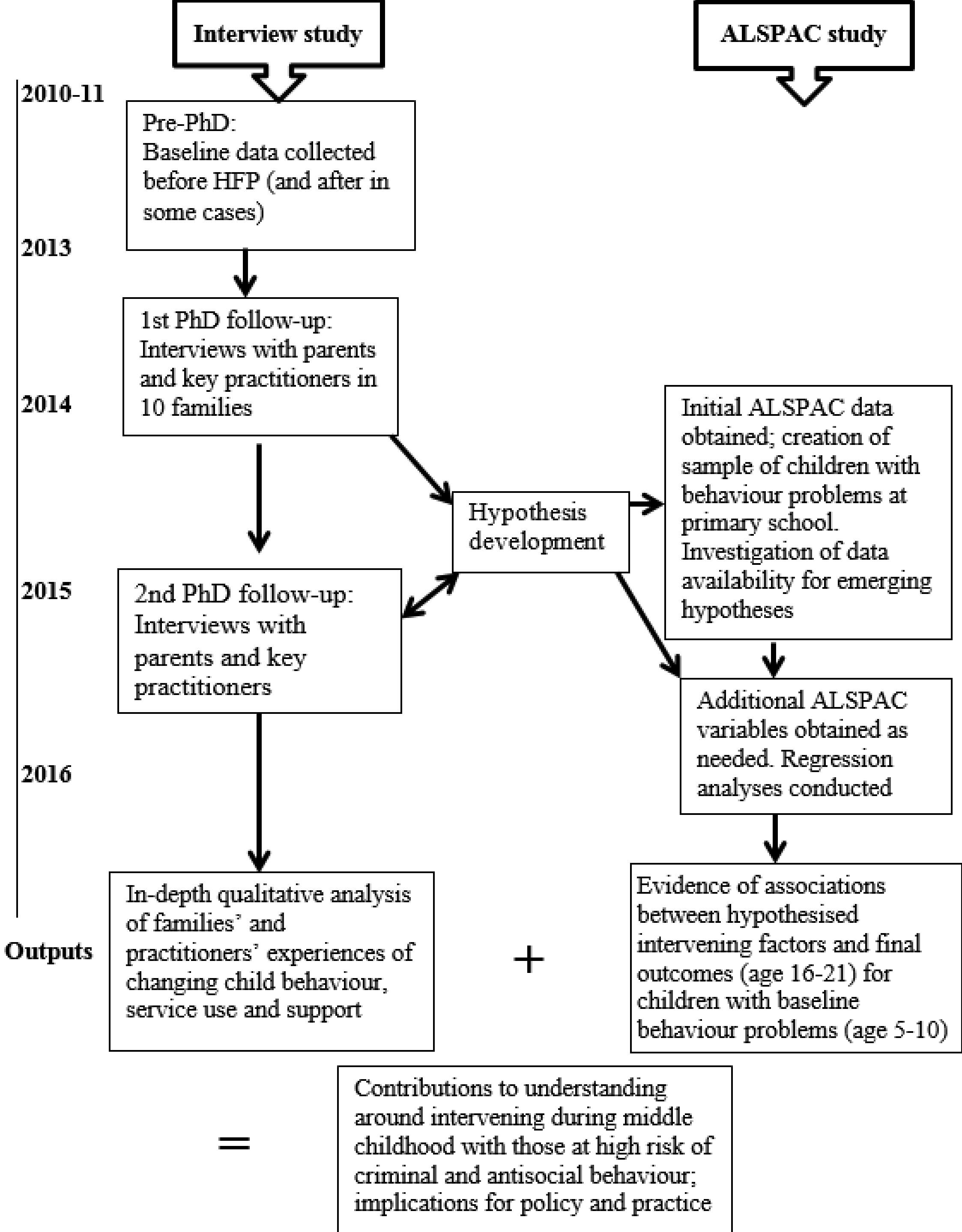
The function of integrating the methods is partly triangulation, to test wider applicability of conclusions from analysis of the interviews, but also exploration (Creswell, 2013); while the qualitative analysis explores processes and opinions, the longer-term quantitative analysis explores whether there is evidence of longer-term associations hypothesised from the five-year interview study. While the phases are mainly sequential, the qualitative analysis can also help to illuminate the meaning of the quantitative findings (Morgan, 1998). As the review of the literature implies, both quantitative and qualitative research led to the formulation of the research questions. As explained below, data collection, analysis and interpretation all involved both qualitative and quantitative approaches, since the study is multi-stranded, involving separate data sets, analysed separately (Tashakkori & Teddlie, 1998).

In Bryman's typology of mixed methods types, the approach to the inclusion of the quantitative data used here most closely fits the 'confirm and discover' model, by using qualitative data first to generate hypotheses, and then quantitative research to test them (Bryman, 2006: 106). However, the qualitative research goes beyond raising hypotheses to investigate questions of process, explanation and context which were not possible to investigate in the quantitative data set.

In Figure 3 the arrows indicate the direction of influence; in summary, the qualitative analysis of interviews influences the choice of factors to be investigated in the

quantitative analysis of ALSPAC data. As initial ALSPAC analyses looking at background factors took place before the final follow-up interviews, there was also some influence the other way. In addition the literature on existing ALSPAC findings formed part of the background work undertaken to develop the interview guides, so there is some influence of each type of data on the other. The initial hypothesis development, based on the first set of follow-up interviews, influenced both the emerging ALSPAC approach, and the content of the second set of interviews, which in turn influenced the final hypotheses for investigation in ALSPAC.

Figure 3 Research design and data collection timetable



3.2 First Phase: The Interview Study, Qualitative Longitudinal Research

3.2.1 Sample

The aim was to recruit parents in families where there was a child with serious behaviour problems and additional problems in the family which were risk factors for long-term antisocial behaviour in the child. Use was made of an existing sample of families meeting the criteria, who had been recruited to a previous study conducted in 2010–11, a pilot, uncontrolled evaluation of a one-to-one therapeutic parenting intervention, the Helping Families Programme (HFP) (Stevens et al., 2014). The use of this existing sample allowed a valuable and unusual five-year follow-up. All families in this original sample had a ‘target’ child with serious behaviour problems at the start of the study and the parent had been offered a newly-devised intervention. Some of the sample had been considered successes in the programme while others had not, and several had dropped out. Baseline (pre-HFP) data consisted of a full record of their service use at the time, and a measure of child behaviour. For many of the families there was also in-depth interview data. Families’ initial referral to the programme may have been at a time of crisis and going back to them three years later would provide a range of more ‘naturalistic’ experiences about their lives, and services responses, since then. This original sample consisted of 14 families living in two inner-London boroughs, and the aim was to recruit ten for the current research. The sample size of ten was chosen, after consultation with the original study’s clinicians, to be large enough to reflect a range of views, attitudes and experiences, while being achievable within the study’s timeframe.

<u>Inclusion and Exclusion criteria</u>

Parents recruited to the HFP study met the following inclusion and exclusion criteria, which remain the inclusion criteria for the current study. The criteria were chosen to indicate presence of behaviour problems, risk of school exclusion and additional family-level risk factors identified in the literature (Day et al., 2011).

Inclusion criteria:

1. Child aged 5–11 years

2. Child displaying behaviour meeting American Psychiatric Association definitions of Oppositional Defiant Disorder or Conduct Disorder (DSM-IV-TR, APA, 2000). The following guideline was given to recruiting practitioners:

The child has displayed four or more of the following characteristics over the last six months:

- Often loses temper
- Often argues with adults
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehaviour
- Is often touchy or easily annoyed by others
- Is often angry and resentful
- Is often spiteful or vindictive

3. Child currently excluded from school, has been in the past three months, or is at risk of being excluded. ‘At risk’ of school exclusion is defined as the identified child having been asked to leave the classroom at least three times in the last fortnight.
4. Child lives with participant parent/carer.
5. Participant parent/carer is subject to at least one of the following risk factors as measured by the Parental Risk Indices with a score of 2 or above:

Parental Risk Indices:

- Harmful substance use
- Interpersonal conflict with their child, partner, close family and/or school
- Inability to maintain a tolerant, stable and regulated mood
- Lack of supportive family/social networks
- Frequent crises

Exclusion criteria:
1. Principal presenting problem of sexual abuse, pervasive developmental disorder or severe mental disability

2. Acute parent/carer mental illness
3. Insufficient parent/carer spoken English[1]

Recruiting families

Recruiting the families was expected to be challenging given the well-documented difficulty of engaging and retaining vulnerable mothers in research (Barlow et al., 2005). However, the 14 families from the HFP pilot had already been engaged once by research practitioners (Day et al., 2012), so recruitment began with a list of 14 names, addresses and telephone numbers from the last HFP contact, between May 2010 and March 2011. The clinical team on the HFP trial, as well as other advisors, suspected it would be difficult to find and recruit ten families from this sample. Therefore, before approaching the original families, additional families were sought, not from the original sample, with a dual aim of piloting study materials and potentially providing additional families if too few families from the original sample could be located and recruited. A group of practitioners who were being trained in the Helping Families Programme in a different London borough were asked to refer families matching the inclusion criteria. Negotiations over access to the practitioners, information meetings and follow-up contact with practitioners took several months but resulted in the recruitment of only one additional family to the study. This family had been referred to the HFP but received only the initial session as the trained practitioner left the post. The ethical issues which emerged during both the recruitment and data collection periods are discussed in section 3.2.3.

Efforts to contact families from the original HFP pilot took place over seven months, beginning with letters with stamped addressed envelopes to return and multiple telephone calls and texts. For families who had moved and/or changed their telephone number additional attempts to locate them included: directory enquiries, speculative visits to all the addresses, chats to neighbours, lengthy negotiations with the original referring services for any updated contact details, talks with practitioners who had worked with the family and a look through clinician records for additional contact details. Similarly to previous studies, services were reluctant to approach families regarding the research (Morris, 2013). When all other avenues had been explored, and following ethical guidance, I contacted the original schools attended by the target

[1] An additional exclusion criterion in the original study was "Consent for school attendance records and teacher-rated SDQ refused" but this was not a criterion in the current study.

children. Schools had their own individual policies regarding passing on information and this approach resulted in two additional participants.

Only one parent declined to participate. For all the other ten families with whom any contact was achieved it was eventually possible to either interview the baseline primary carer or (in one case) receive information on how the child was doing from another person in close contact with the child. Table 3.1 shows the method by which each family was eventually contacted. Families are listed in the table in the order they were recruited to the PhD study, but their identification numbers in the later tables reflect the order they were recruited to the original HFP pilot study.

Table 3.1 Successful methods of contacting and recruiting participants

	2012	October-November 2013*		February-March 2014				Contact details, change over time		
ID	New recruit via HFP practitioner	Contact form returned	Made contact with original phone no.	In person by going to address	Multiple phone calls/ conversations	Referring agency put me in touch	Contacted via original school	Same address?	Same phone number?	Child resident with same parent/carer?
i	R									
ii		R						Y	N	Y
iii			R					Y	Y	Y
iv			R					N	Y	Y
v			R					Y	Y	Y
vi				R				Y	N	Y
vii					R			N	Y	Y
viii					R			N	Y	N
ix						R		Y-t	N	Y
x							R-c	N	N	N
xi							R	N	N	Y
NR			Y		D			N	Y	DK
NC								N	N	DK
NC								N	N	DK
NC								N	N	DK

R: Contacted and recruited via this method D: Contact made but declined to participate Y: Yes N: No DK: Don't know
Y-t: Yes but in temporary accommodation when I first tried to get in touch HFP: Helping Families Programme
R-c: Recruited for information regarding child only, no contact with parent or primary carer
*None of the recruitment efforts made in December and January were successful NC: no contact made NR: not recruited

To encourage retention in the study between timepoints all participants were sent greetings cards and study information at Christmas. Efforts to get back in touch with parents for the second PhD follow-up began at the beginning of May 2015 and all had been interviewed by mid-June, except for one who was not contacted until October, in order to wait for the child, the youngest in the sample, to transfer to secondary school.

Sample description

Ten families were followed up from the HFP pilot and one additional family was recruited in December 2012 as described above so that there are eleven study families in total. Ten parent/carers were interviewed. For the remaining family, where it had proved impossible to trace the mother, the child's school explained that the child had been taken into care three years previously and was now moving to a permanent foster placement. The school agreed to complete questionnaires about the child, and services provided via school, so the child was kept in the study. Another target child had also been taken into care three years previously; both events happened shortly after withdrawal from the HFP intervention, although HFP practitioners were not involved in, or aware of, either move. This mother still had occasional contact with the child, and was interviewed twice. All other primary carer interviewees were mothers resident with the child except for one who was the grandmother with parental responsibility. The terms 'parents' and 'mothers' will be used for ease.

3.2.2 Data collection

At each of the two PhD timepoints data were collected from parents, practitioners nominated by parents, and the target child's school, as described below. Additional data from the HFP pilot study were available for some families at two earlier timepoints, before and after receipt of HFP. The types of data available for each family at each timepoint are shown in Table 3.2 and Table 3.3. The main focus of interviews was in-depth discussion of participants' experiences and impressions but two instruments, one standardised, the SDQ, and one adapted from the CSRI, were completed during the interviews and these are described first.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a widely-used questionnaire of 25 items measuring psychological well-being covering emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour (Goodman, 1997) (see Appendix 3). For

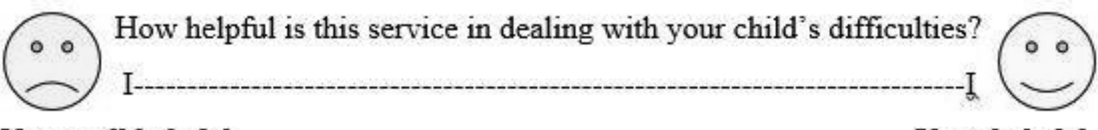
this study SDQs were collected from parents and teachers. The use of multiple informants has been shown to increase the sensitivity of the SDQ, that is, its ability to identify children with conduct disorders (Goodman et al., 2000; Stone et al., 2010) (also see section 3.3.2). An impact supplement to the questionnaire includes questions about the young person's level of distress and social impairment, and burden to others, which are used to weight predictions of psychiatric problems. The questionnaire's authors particularly recommend use of the impact supplement for investigating determinants of service use (Goodman, 1999). Combined scores taking account of parent and teacher questionnaire responses and incorporating impact scores were computed and are presented in Chapter 4.

<u>Adapted Client Service Receipt Inventory (CSRI)</u>

The CSRI was originally designed for costing psychiatric interventions by collecting service use information, for example for use in economic evaluations (Beecham & Knapp, 2001). An adaption of the CSRI was developed for use in the HFP pilot study (Stevens et al., 2014) (Appendix 3). Because of the complexity of the families' service use, and the need to simplify form-filling in the interviews, the adaptation did not use pre-specified service types. Instead a separate checklist listed services known to be available to families in the area. This was used as an aid to prompt respondents about any additional services they might have received (as described in the next section). The CSRI form was used to record each service discussed, the quantity of contact, a rating of the service's usefulness and the degree of choice they had in seeing the service. For each service, following discussion, respondents were asked to mark a visual analogue scale to indicate how helpful the service was (Figure 4). The definition of 'helpful' formed part of the in-depth discussion and was analysed qualitatively, while the scale also provided a quantitative measure. This quantitative rating had also been collected during the HFP pilot study and this information was used in the follow-up interviews to ask questions such as,

> 'You gave this service a very high rating last time, what changed?'

Figure 4 Visual analogue rating scale used in CSRI



Where data were available, it was also possible to refer back to previous changes, for example,

> 'After you took part in the HFP you were much more positive about your social worker – why do you think that was? What happened after that?'

In a departure from the instrument's usual purpose (quantifying resource use), the CSRI was principally used as a springboard for in-depth discussion of service use, although it also allowed summary tables of service use and opinions to be prepared (see Chapter 4).

The visual analogue scales were also used in interviews with practitioners for rating helpfulness of services and a further adaptation was prepared (Appendix 3) for self-completion electronically by school staff.

Table 3.2 Data collected during Helping Families Programme (HFP) Pilot 2010-2011

Pre-HFP				**Completed HFP?**
ID	**CSRI**	**SDQ**	**TSDQ**	
1	✓	✓	✓	No
2	✓	✓	✓	Yes
3	✓	✓	✓	No
4	✓	✓	✓	No
5	✓	✓	✓	Yes
6	✓	✓	✓	Yes
7	✓	✓	✓	Yes
8	✓	✓	✓	No
9	✓	✓	✓	Yes
10	✓	✓	✓	Yes
11	n/a	n/a	n/a	No

Post-HFP								
ID	**CSRI**	**SDQ**	**TSDQ**	**HFP Case Summary**	**School feed-back**	**Interview with parent**	**Records of HFP sessions**	**Documents from other agencies**
1	X	X	X	X	X	X	✓	✓
2	✓	✓	✓	✓	✓	✓	✓	✓
3	X	X	X	X	X	X	✓	✓
4	X	X	X	X	X	X	✓	X
5	✓	✓	✓	X	✓	✓	✓	X
6	✓	✓	✓	✓	✓	✓	✓	✓
7	✓	✓	✓	✓	✓	✓	✓	X
8	X	X	X	X	X	X	✓	X
9	✓	✓	✓	✓	✓	✓	✓	✓
10	X	✓	✓	X	✓	✓	✓	X
11	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓

SDQ: Parent-completed Strengths and Difficulties Questionnaire; TSDQ: SDQ completed by teacher or other school staff; CSRI: Client Service Receipt Inventory; ✓: Collected; X: Not collected

Table 3.3 Data collected during PhD interview study

PhD Time One data collection, 2014							
	Parent			**Nominated practitioner**	**Teacher/ school staff**		
ID	**Interview**	**CSRI**	**SDQ**	**Interview(n)**	**CSRI**	**TSDQ**	
1	✓	✓	✓	X	✓*	✓	
2	✓	✓	✓	✓		✓	
3	X	X	X	X	✓*	✓	
4	✓	✓	✓	✓		✓	
5	✓	✓	✓	✓	✓	✓	
6	✓	✓	✓	✓(2)	✓	✓	
7	✓	✓	✓	✓	✓	✓	
8	✓	✓	✓	✓(2)	✓	✓	
9	✓	✓	✓	✓(2)	✓	✓	
10	✓	✓	✓	✓	✓	✓	
11	✓	✓	✓	✓	✓	✓	
Total	10	10	10	12	2	11	
PhD Time Two data collection, 2015-16							**Total number of face-to-face interviews conducted for PhD; both timepoints, all respondents**
	Parent			**Nominated practitioner**	**Teacher/ school staff**		
ID	**Interview**	**CSRI**	**SDQ**	**Interview**	**CSRI(n)**	**TSDQ**	
1	✓	✓	✓	X	✓(2)*	✓	2
2	✓	✓	✓	✓	✓	✓	4
3	X	X	X	X	X	X	0
4	✓	✓	✓	✓	✓	✓	4
5	✓	✓	✓	✓	✓	✓	4
6	✓	✓	✓	✓	X	X	5
7	✓	✓	✓	✓	✓	✓	4
8	✓	✓	✓	✓	✓	✓	5
9	✓	✓	✓	✓	✓	✓	5
10	✓	✓	✓	✓	✓*	✓	4
11	✓	✓	✓	✓	✓*	✓	4
Total	10	10	10	9	3	9	41

SDQ: Strengths and Difficulties Questionnaire; CSRI: Client Service Receipt Inventory completed with parent; SRI: Service Receipt Inventory completed by school; *self-completion, the remainder were completed in person with the researcher; ✓: Collected; X: Not collected; n: number of practitioners interviewed where more than 1

Parent/carer interviews

Parents were interviewed in their own home except one mother with whom I met both times in a café near her home. In four interviews the target child was in the house, and on two occasions was present (if not attending) during much of the interview. Siblings were also sometimes present, most often a baby. On two occasions a friend was also present and, in one case, participated in the interview. Most interviews with parents lasted about two hours. The study aims, implications of involvement and consent to

participate were discussed at the beginning of each interview and all interviews were audio-recorded.

The interview procedure contained the following components:
1. Completion of the Strengths and Difficulties Questionnaire (SDQ). This was completed in a discursive manner so that the discussion around completion of the items formed part of the transcript and the analysis.
2. Main interview with in-depth discussion of parents' experiences of services and their perception of their child's experiences of services. Use of topic guide to ensure all areas covered. The interview included discussion of parenting, what other help parents might like to receive and what aspects of families' lives and surroundings make it more difficult, or easier, to parent the child.
3. (Partially incorporated into above) Completion of the adapted CSRI including respondents' rating of each service on a visual analogue scale, with reference to the checklist.
4. Nomination of key practitioner for interview.
5. Consent sought to contact child's school and for future follow-up.
See Appendix 3 for interview materials referred to above.

The process developed somewhat over the course of the study, and also differed depending on the circumstances. Usually the best approach, rather than using the checklist of services at the beginning, as I had at first, was to allow a more natural discussion about services. I noted the names of services mentioned on the CSRI form as they came up in conversation. The checklist was used later to check for any services respondents might receive but not have mentioned. Towards the end of the interview we returned to the CSRI form and the list of services and the respondent rated each service. Rather than rating each service as it was discussed, this allowed reflection after the discussion of all services, and also a more explicit comparison of different services' contributions.

The interview topic guide (see Appendix 3) was used, when needed, to guide the interview. The guide included open-ended questions to probe further into the relationship with services, and to explore what helps participants manage their lives and their children's behaviour, and what factors make this more difficult. The discussion

therefore went beyond provision of services to other factors in families' lives, living circumstances, employment and neighbourhoods.

Within the framework of the topic guide, and the procedures outlined above, the interviews were structured quite loosely and participants were encouraged to describe experiences in their own way. The questionnaires provided a basis for in-depth exploration of experiences, probing for the interpretations participants put on interactions with their children, with services, and in their wider experience. The order in which things were discussed was modified and substantially reordered to follow the natural flow of the conversation, with additional questions following up on participants' responses (Robson, 2011). The interview included elements of oral history as respondents were encouraged to recall and reflect on past experiences. However, the use of schedules helped to ensure all important topics were covered and to focus the interview around the issues of the child's behaviour problems and family members' interactions with services. Having the structure of the SDQ and CSRI, as well as conversation, worked well; it allowed a shared focus so the participant and interviewer were not face to face all the time, but the questionnaires could be diverted from as suited the flow of the conversation. The interviewing style used was not passive; general issues about services were raised, along with the suggestion that there could be positive and negative aspects of service involvement. In this way the aim was to signal that any type of opinion was legitimate.

The second follow-up interviews differed from the first because part of the aim was to investigate hypotheses arising from the first interviews. Emerging findings from the analysis were explicitly discussed towards the end of the interview, and participants' feedback sought on tentative conclusions; also, participants were encouraged to consider whether they thought there were important themes in their own story which had not been picked up. Discussion was extended to encompass the experiences of other people they knew and the extent to which emerging findings might apply to them also. Names were avoided to ensure anonymity.

To a degree therefore, participants were directly involved in the analysis; indeed, they appeared engaged with this process and had some clear ideas of their own, leading to co-constructionist or 'collaborative meaning-making' (Daly, 2007).

Recruiting and interviewing nominated practitioners

At the end of the interviews with parents they were asked to nominate a practitioner who was important or helpful for them. This was done using a variation of the following words:

> 'I am asking all the parents in the study if they can nominate a practitioner for me to interview. Can you suggest someone that has been helpful, somebody who knows the family, who I can interview about services, and about the sort of help they provide (a professional person, not friends or family, but they can be from any service)?'

Most parents found it easy to think of someone to nominate, although two found it difficult and one of these nominated someone who had been helpful in the past. The parent whose child had been taken into care did not want me to interview any practitioner involved with her family. Some parents nominated two practitioners, and I interviewed both if possible. The job roles of all practitioners nominated are shown in Table 3.4. All were interviewed except where indicated. Family identities are not given to preserve confidentiality.

Table 3.4 Nominated practitioners

	Nominated practitioners 2014		Nominated practitioners 2015/16	
ID	**Practitioner type**	**Currently seeing**	**Practitioner type**	**Currently seeing**
A	Family worker	No	1. CAMHS consultant (did not consent to interview) *2. Class/SEN teacher*	Yes Yes
B	*Learning Support Assistant*	Yes	*Class/SEN teacher*	
C	*1. Head of year* 2. Family support worker	Yes No	Social worker	Yes
D	*Class teacher (special school)*	Yes	1. Private sports coach (not approached for interview) *2. Teacher, special school*	Yes Yes
E	1. CAMHS family support worker *2. Learning mentor at secondary school*	Yes Yes	*Assistant Principal & Head of Year*	Yes
F	*1. Teaching Assistant at primary school* *2. Learning mentor at secondary school*	No Yes	*One-to-one teacher (special school)*	Yes
G	*Learning Support Assistant*	Yes	CAMHS consultant	
H	1. Social worker (had left so could not be interviewed) *2. Vulnerable student and family support*	Yes Yes	Social worker	Yes
I	Social worker	Yes	*Special school Headteacher*	Yes

School-based practitioners are in italics
CAMHS: Child and Adolescent Mental Health Services
SEN: Special Educational Needs

Interviewing practitioners

Before the practitioner interview, the recording of the parent interview was listened to and partly or wholly transcribed. Notes were taken about particular services or other issues that would be useful to discuss. The practitioner interview topic guide is in Appendix 3. The interview explored practitioners' own contact with the family and their views on other types of support received, the family's needs, any issues with accessing appropriate services and perceived barriers to improved family functioning and child behaviour. Their role in general was discussed as well as how experiences with this family related to their experiences with other families. As with the parent interview, the topic guide was a springboard for in-depth discussion, with interesting leads being followed where this seemed fruitful. Practitioners were also asked to rate services

involved with the family on a visual analogue scale, as above, being told that the parent had done the same. This encouraged the practitioner to think about what helpful meant and what any contribution may have been.

When invited to be interviewed, practitioners were told interviews would take between 30 and 45 minutes. However, with participants' agreement, most interviews were subsequently around 50 minutes long (range 25–80 minutes). As with the parent interviews, these were audio-recorded which in most cases caused no problems, and it was made clear that the recording was for the researcher's own use only and would only be listened to by the researcher and a transcriber. However, two practitioners did seem uncomfortable being recorded. One of these relaxed after I reiterated that this was merely for my own use and so that I did not need to take too many notes. The other, a social worker, appeared to moderate what she said on the recording and asked for the recorder to be switched off at one point before making more confidential comments about her colleagues.

Data from schools

All schools were approached to complete SDQs and attendance data with respect to each study child at each timepoint (Table 3.2 and Table 3.3). Consent to approach schools for attendance and child behaviour data was sought from parents during interviews and in some cases schools did ask to see confirmation of consent. Where the nominated practitioner was from a school, they were asked to complete the SDQ and attendance data. In other cases the headteacher of the child's school was contacted to ask for the class teacher to complete the questionnaire.

For the two children who had been taken into care, authorisation had not been obtained to interview a key practitioner about their view of families' involvement with services. Therefore schools were asked, in addition to completing the SDQ, to complete the self-report Client Service Receipt Inventory (Appendix 3) about the services the child had received at school, and any other services the school was aware of. The information provided by these proved useful, therefore at the final follow-up CSRIs were requested and received from all children's schools where the nominated practitioner was not school-based.

Additional sources of data

Additional data were available for the families from the original HFP pilot study, dating from 2010–11. Parents' consent was sought for the use of this material in the research with the proviso that no identifying information would be used. The material could include the following for the families who had completed HFP:

- Case summaries – HFP practitioners' brief reflections on the family and their experience with HFP
- School feedback forms – information given to schools informing them of the outcomes of the HFP for the family with a child at that school
- Transcripts of post-HFP interviews about participants' views of the programme and anything they had gained from it
- HFP files, recruitment and baseline data plus post-session reflections from HFP practitioners
- Documentation from referring agencies
- Correspondence between HFP practitioners and other agencies

In the case of the family who had not been involved in the HFP pilot, with the mother's and the head of service's consent, a recent assessment of the family situation was shared. The data available differed for each family and is shown in Table 3.2 and Table 3.3. In addition there were field notes, and, for some families who had dropped out of HFP, a discharge letter and reflection from HFP clinicians.

3.2.3 Ethical issues

A key contribution of this study is in-depth information received from a relatively hard-to-reach group. However, there were ethical difficulties around the tension between wishing to engage potentially vulnerable participants and ensuring participation and information-sharing was truly voluntary and informed.

Engaging families and informed consent

I decided early on that the parents should not be expected to give me their time for a long interview without compensation, so it was agreed with the ethics committee that parents would be given £20 as a thank you at each interview and that I would mention this while recruiting.

The amount of chasing it was reasonable to do, and the extent to which parents would feel able to say no, was discussed with supervisors and the ethics committee. While most families were quick to agree to meet once contact was made, some families were spoken to many times. At each conversation it was stressed that taking part was entirely voluntary but that participation would be a great help to the research and the research team would be grateful for their participation. When one mother expressed the wish to 'opt out' this was immediately accepted.

Contacting schools to ask about children was potentially concerning, in case this could raise a child's profile, and perhaps reinforce a label which might have lapsed. However, these concerns were not shared by the ethics committee and so I contacted schools; no parent indicated any concern with this process. There were issues of consent with the two cases where the child had been taken into care. In one case it was eventually possible to speak to the social worker with parental responsibility and obtain permission to collect data about the child from their school, but in the other case I only spoke to the school and complied with their approach to data sharing.

<u>Ethical issues in interviewing parent/carers and practitioners</u>

Sometimes parents asked for advice in interviews, for example regarding school choice, sources of additional benefits and interactions with school personnel. Some feminist scholars have argued that one should intervene in these situations if it is possible to help (Oakley, 1982; Reinharz & Davidman, 1992:74-5). However, intervening could also cause harm and so, on the whole, comments which might be taken as advice were not made, although there were occasionally carefully worded suggestions. The possibility that interview discussion could affect future events had to be taken seriously. For example, it was sometimes necessary to schedule interviews with practitioners so as to avoid the possibility of influencing decision-making, for example I avoided meeting practitioners just prior to a child protection conference.

In the cases where the target child was present for much of the interview, decisions had to be made about the degree to which he would be involved, as it seemed disrespectful to discuss certain issues without involving him. The approach taken was to ask the child (and the mother) whether he minded us talking about him, and to offer a children's version of the SDQ questionnaire in case he would like to provide his own responses,

although neither child did so. In both cases the child interjected into the discussion at times and this data has been included in the analysis.

In interviews with both parents and practitioners I was in possession of information which should not be shared with the other party. All participants were assured that no identifiable information would be used in reports, but practitioners were being asked to divulge what could be considered confidential information; although some practitioners were very open, particularly those in schools, others were more reserved. In these cases some indication that I was already in possession of the facts they were concerned about revealing was helpful in overcoming reserve. This raised issues around a) the extent to which it was reasonable to divulge information given in the parent interview and b) whether the practitioner's response might be influenced by my input. Care had to be taken even with non-verbal communication in these cases; a raised eyebrow, for example, could indicate that the story did not concur with the parent's version. The solution was to demonstrate awareness of key events that the practitioner would obviously know about, but with the smallest amount of verbal communication necessary and using non-verbal communication where possible, so as not to repeat the parent's words.

Ethical issues in reporting

I had explained to participants that no identifiable information would be used in reports, but that participants were likely to be able to recognise themselves when I quoted their words and experiences. My aim was that others would not be able to recognise them. There was a risk, however, that parent/practitioner dyads would be able to identify what their nominated practitioner said about them. I reflected a great deal on the extent to which I could report particular incidents and views, and discussed the issues with experts in qualitative research ethics. Many characteristics, incidents and opinions have not been linked to pseudonyms. Others have, but in these cases the risk of parents accessing the material and then identifying themselves was felt to be tiny, and the risk of possible resulting harm extremely small. It was felt that in many cases the link to pseudonyms was needed in order to present the evidence effectively, rather than asking the reader to take too much on trust. I hope I have struck a balance in retaining anonymity as far as possible without compromising the evidence. Although there is

perhaps more chance of interviewed practitioners accessing the material I believe the precautions taken have minimised any risk of harm.

3.2.4 Data analysis

All interviews were transcribed and entered into NVivo 10 (QSR International, 2012) along with field notes and the other available data. Although the number of cases (families) was small, there was a great deal of data because of having multiple informants and timepoints. The interview data from the first set of follow-up interviews was analysed before the second set of interviews was conducted so that these could draw on the analysis to date.

The qualitative analysis approach was largely an inductive thematic analysis (Braun & Clarke, 2006). Within the broad aim of finding out what helped families and what hindered families from benefitting from services, the narrower themes were drawn from the data in the manner described below.

First I familiarised myself with the data by close readings of transcripts and listening to recordings. I read through and corrected all the transcripts while noting key themes and coding categories (or ‘nodes’). For the first few transcripts the coding scheme was kept completely flat (that is, no tree/folder structure). I initially coded sparsely, noting new ideas and themes, so as to not be overly influenced by the order of choosing the transcripts. I noted when particular phenomena were repeated in different cases, and returned to previous instances to compare (a constant comparison approach (Fram, 2013)). At this early stage, following Bazeley and Jackson (2013: 71) I did not code the documents into broad topic areas. Analytical notes on suggested themes were written as the ideas came up.

After a few transcripts the shape of a useful coding scheme became apparent, with the main broad headings, into which the nodes could be organised, as follows:

Child behaviour
Interventions
Other factors affecting child behaviour and family functioning
Reasons for intervention being helpful or unhelpful
School

The codes under ‘Other Factors’ and ‘Reasons’ were primarily analytical whereas under ‘Child behaviour’ and ‘Interventions’ they were mainly descriptive. I coded everything to do with intervention in schools under the ‘School’ heading, rather than the ‘Intervention’ heading – although there was some crossover, for example regarding some therapeutic intervention delivered in school. The ‘School’ heading included descriptive codes but also some analytical codes where they contained specifically school-related ‘reasons’ for intervention being helpful or unhelpful, or specifically school-related ‘other factors’ affecting child behaviour and family functioning.

The initial qualitative analysis was case-based in order to uncover processes and links for each family and I wrote a summary of each family’s story. However, events and ideas which were shared between accounts were also noted and the next stage further developed cross-case thematic analysis. Codes continued to arise from analysis of interviewees’ accounts; codes were developed and refined following an iterative process. At this stage I was careful to code *all* the material, to ensure that I did not inadvertently leave out material that did not suit my codes, but, rather, that I made my coding scheme fit my material. In my analytic codes I included within the same code data that both did and did not support the implied hypothesis.

When half the transcripts had been coded in detail I considered the themes emerging at that point. A preliminary analysis was produced, and discussed, based on 1) my impressions about what was coming out as important, 2) re-analysing the quotes I had coded as ‘key quotes’, 3) considering answers to my research questions and 4) exploring the coding framework which had emerged so far. A new classification chart cross-tabulated the themes that had emerged so far with the individual families and investigated any gaps. Where relevant, note was made of themes that would be worth addressing in follow-up interviews. The coding scheme was reorganised to be closer to the emerging thematic framework which was continually revised following re-examination of the material.

The quality of the analysis in terms of internal and external validity was considered (Flick, 2009). Lincoln and Guba (1985) suggest the following criteria for evaluating interpretative research work: credibility, transferability, dependability and confirmability. In this study credibility was sought through triangulation of accounts,

both between primary carers and practitioners and between the same individual's accounts at different timepoints. Further, views of services raised in discussions with respondents were compared with the ratings given for the services on the CSRI and my interpretations of accounts were checked with participants on return visits. I shared with participants my findings so far and asked for their feedback. Credibility checking also involved, as alluded to above, negative case analysis, seeking out instances that do not support emerging theories, and adapting those theories as necessary (Patton, 1999: 1191). Regarding transferability, the inductive analytical approach involved looking at commonalities among separate instances of the same phenomenon with an assumption that gaining understanding of aspects of families' experiences is likely to be fruitful in gaining understanding of aspects of other, different, families' experiences (Braun & Clarke, 2006).

Dependability and confirmability are similar concepts to *reliability*, referring to the extent to which the analysis is conducted in a way which could be repeated by others. An attempt to consider dependability and confirmability here involves close examination of my presentation of research data and methods by my supervisors and discussion with them around how I have applied the coding scheme and how the conclusions were reached. Although space considerations mean it is not possible to include a full audit trail in the written thesis, I have made the raw qualitative data and full notes and details of analytical steps taken available to my supervisors. Intracoder reliability was considered by returning to the first set of transcripts a year after the initial coding. The effects of any inconsistency in the application of codes were considered and the content of particular nodes re-examined where necessary.

3.2.5 Hypothesis development from the interview study for investigation in the ALSPAC study

In addition to addressing Research Question 1, the qualitative analysis of interview data aimed to generate hypotheses for investigation using ALSPAC data in the second phase of the research (to address Research Question 2). Themes emerging from the analysis were examined for feasibility of investigation in ALSPAC. This involved identifying themes where factors could be hypothesised as potentially related to longer-term

antisocial and criminal behaviour in the child, factors which were, or could be, subject to intervention and which could be represented by variables available in ALSPAC.

3.3 Second phase: The ALSPAC study, a Secondary Cohort Data Longitudinal Analysis

A number of hypotheses about how families can be helped emerged from the interview study, suggesting school-age ‘modifying factors’ which might affect children’s likelihood of future antisocial and criminal behaviour. Where possible these hypotheses were investigated using data from the Avon Longitudinal Study of Parents and Children (ALSPAC) which follows children from mother’s pregnancy, through childhood and adolescence into young adulthood. The aim was to identify a sample of children with behaviour problems at primary school age and compare those who do and do not experience the ‘modifying factor’ to compare rates of antisocial or criminal behaviour in late adolescence and early adulthood. Rather than aiming to identify pre-existing protective factors, the ALSPAC analyses look at where changes or family experiences *during the school years* appear to indicate a more positive trajectory. Given the high risk of bias inherent in a study design not involving randomisation to conditions, analyses control for childhood behaviour problems at the beginning of primary school and, where possible, family background characteristics related to the outcome under investigation.

In this study the quantitative analysis comes second because the aims of the research include taking a broad definition of help; if a broad, exploratory approach was taken using the survey (ALSPAC) data there would be a risk of spurious associations, because of multiple testing. Therefore a limited number of analyses based closely on the theoretical work deriving from the qualitative analysis were conducted. Because of the nature of some of the factors to be investigated (for example, they may be likely to have no impact on many families but a large impact on a few; or the sample sizes may be fairly small when the factors investigated are relatively rare) it was recognised from the outset that significance levels may be low.

3.3.1 Data selection and missing data

ALSPAC was chosen as the best match to the needs of the study in comparison with other available data sets, being the most recent data set covering the age range of interest with sufficient detail and sample size. ALSPAC follows a general population sample of over 14,000 families with a child born in 1990–92. Data is currently available on the trajectories of young people from birth to age 21 and there is extensive detail on life events, parent and offspring's mental health, and social variables, including housing, neighbourhood and social networks (Boyd et al., 2013). Maxwell and colleagues concluded that ALSPAC was one of only seven UK studies big enough to look at associations with social work contact (Maxwell, 2012). The data set has advantages and limitations as discussed below.

Data collection in ALSPAC includes multiple survey questionnaires completed by parent/carers, the young people themselves and teachers; 'Children in Focus' clinics attended by a randomly chosen 10% of the sample; and linkages to the National Pupil Database (NPD) and the Pupil Level Annual Schools Census (PLASC) including indicators for receipt of free school meals (FSM) and special educational needs (SEN) status (Boyd et al., 2013). Questionnaires aimed at primary carers are directed to, and nearly always completed by, mothers, for example when children were age 4, 98% of respondents to 'Mother's New Questionnaire' were mothers.

There is a high degree of non-response to questionnaires and this is 'non-monotone', that is, respondents respond to some questionnaires but not others. For example, the average rate of response to 12 different measures in the adolescent phase was 48.2% but 75% of the sample responded to at least one questionnaire during adolescence (Boyd et al., 2013) and 82% of mothers remained engaged with the study by 2013 (Fraser et al., 2013). The ALSPAC sample is not representative of the UK population as a whole in some aspects, both because of the characteristics of the Avon population, and because of the non-random nature of the missing data (Fraser et al., 2013). For example, those in the Avon area are more likely than the national average to own a car, be white and be an owner-occupier of their home, and those in the ALSPAC sample are even more likely than the Avon population as a whole to have these characteristics. ALSPAC children are more likely to have married parents and are less likely to be on free school meals; their mothers have higher educational attainment scores than both the Avon eligible

sample as a whole and the national average, and those who were lost to follow-up had lower attainment on average. Although in general ALSPAC mothers have higher socio-economic indicators than equivalent women in both Avon and the UK, overcrowding is slightly more likely in the ALSPAC sample (Fraser et al., 2013).

ALSPAC attrition, then, is systematic and not random, being more common in lower social classes (Wolke et al., 2009). There is a direct relationship between socioeconomic status and the number of questionnaires returned (Boyd et al., 2013). Rates of teacher-reported oppositional and conduct disorders in school year three (age 7–8) are twice as high for children whose parents did not respond to the age 7 questionnaire than for those who did respond (4.9% versus 2.4%; $p<0.001$) (Herrick et al., 2004:379). Wolke and colleagues examined the impact of this selective drop-out on predictions of behaviour problems. Children who dropped out were more likely to suffer from behaviour disorders than those who did not. However, while ALSPAC, along with other longitudinal studies, is likely to underestimate prevalence of problems, regression models were only marginally affected; in other words, the usefulness of the sample for looking at predictors of antisocial behaviour did not appear to be impaired by the non-random nature of the attrition (Wolke et al., 2009).

The intention here is not to make generalisations about prevalence but about factors related to future antisocial behaviour, and Wolke's study gives some reassurance that the study is not undermined by the missing data. Some studies use methods such as multiple imputation to estimate values for cases with missing data, requiring detailed modelling and specialist statistical advice if it is to enhance study validity (Hayati Rezvan et al., 2015; Sterne et al., 2009). In order for multiple imputation to be appropriate, data should be assumed to be missing completely at random (not the case in ALSPAC) or missing at random after taking into account the background factors known to be related to missingness (Little & Rubin, 2002). It is not appropriate to make such an assumption in this case; it is highly likely that there are unrecorded reasons for mothers to drop out of the study, or not respond to questionnaires, that are related to the antisocial behaviour outcome, such as particular crises or attitudes which lead to respondents failing to return, or perhaps receive, questionnaires. In addition, assumptions for multiple imputation are harder to justify where more than 20% of the data is missing (Little & Rubin, 2002).

Given Wolke's findings, and the non-monotone nature of missing data (Boyd et al., 2013), I concluded that for this study, multiple imputations would not be helpful and instead I sought to maximise the available sample by using multiple measures of both behaviour problems and antisocial behaviour, so that a child needed an available measure on only one of each to be included in the analysis. Regression analyses were conducted to compare characteristics of those with and without available outcome data (Appendix 5). However, in some cases where respondents provided data, but did not complete all items needed to compute a score, if fewer than half the responses were missing, prorating was used to estimate scores so that the cases could be included, that is, the overall score was computed using existing items only and adjusting for the number of items.

3.3.2 Identifying ALSPAC families with children with primary school-age behaviour problems and an available measure of later antisocial behaviour

Two binary variables were constructed: a 'presence of behaviour problems' variable, to identify children with problematic levels of behaviour at any point between ages 5 and 11; and a 'presence of antisocial behaviour' variable to identify presence or absence of antisocial and criminal behaviour between ages 16 and 21, the outcome variable for the analyses. The core sample consisted of children with behaviour problems at primary school, and for whom there were outcome data available.

Presence of behaviour problems measure

For the analyses, children were identified as having primary school age behaviour problems if they scored positive for conduct problems on *any* of eight ALSPAC measures taken between ages 5 and 11 (Table 3.5). Five ALSPAC SDQ measurements were available, completed by primary carers at average ages of 6.7, 8 and 8.7, and by teachers in school years 3 (age 7–8) and 6 (age 10–11). Goodman and colleagues (2000) have shown a reasonable sensitivity (over 70%) in the ability of the SDQ to identify those with conduct problems. Goodman and colleagues advise that children have a high and substantial risk of clinically significant behaviour problems if they score at least 4 on the SDQ conduct problems scale, and this cut-off is used to identify 'problem' cases here (Table 3.5).

Three additional variables recorded at primary school age were also used to identify children with difficult behaviour who might not have been identified by the SDQ:

i) DAWBA (Development and Well-Being Assessment) clinical diagnosis of oppositional or conduct disorder, using combined clinic, parent and teacher reports at age 7.7 (Goodman, Heiervang, et al., 2011).

ii) Child identified as having disciplinary problems at school, according to parent-report at age 9.

iii) Expelled from school, by age 8.5, according to parent report.

These three measures added 136 additional children to the behaviour problems sample who had not been identified by the SDQ. Of these, 13 children were missing all six SDQ scores and the remainder had at least one SDQ score in the normal range.
Table 3.5 shows the number and percentage of ALSPAC children who were reported as having behaviour problems according to each measure.

Table 3.5 ALSPAC children with behaviour problems, according to each measure

Measure of behaviour problems		Has problem behaviour	
		n	% of non-missing ALSPAC children
SDQ conduct problems parent-rated, age 6.7		884	10.5
SDQ conduct problems parent-rated, age 8		744	9.6
SDQ conduct problems parent-rated, age 8.7		618	7.7
SDQ conduct problems teacher-rated, age 7-8		402	6.4
SDQ conduct problems teacher-rated, age 10-11		616	8.0
DAWBA clinical diagnosis, age 7.7.	Any	261	3.17
	Oppositional defiant	170	2.07
	Conduct	48	0.58
	Disruptive behaviour, no other symptoms	43	0.52
Child identified as having disciplinary problems at school by age 9		232	2.82
Expelled by age 8.5		51	0.62
Child has primary school age behaviour problems according to at least one of the above measures		**2440**	**19.10**

Note: The total number of participants with non-missing values is different at each timepoint as explained at the beginning of section 3.3.1.

The table shows 3808 scores indicating problematic behaviour, referring to 2440 different children who are considered to have behaviour problems for the purposes of the analyses. Those included in the ‘no behaviour problems’ group have no abnormal scores on any of these measures and at least one ‘no problems’ SDQ score, although they may have several missing scores. At least one SDQ ‘no problems’ score was needed for inclusion in the ‘no behaviour problems’ group because the three non-SDQ measures used indicate a higher level of problems than the SDQ and so a ‘no problems’ score on these variables, if SDQ scores were all missing, was not sufficient evidence of the absence of SDQ-level problems. All other cases were excluded from the analyses. According to the binary ‘presence of behaviour problems’ measure 2440 children had

behaviour problems between ages 6 and 10, 19% of the valid sample. However, for the regression analyses it was also necessary for the cases to have an available measure of later antisocial and criminal behaviour.

Antisocial and criminal behaviour outcome measure

For the antisocial and criminal behaviour outcome measure (referred to as ASB) I constructed five scales from five sets of questions asking either parents or the young people themselves about antisocial and criminal activities, between the ages of 16 and 21. From these I constructed a single summary binary variable to indicate whether the young people had displayed antisocial behaviour at *any* of these timepoints.

At age 16 parents reported on their child's behaviour, while the other four question sets were answered by the young people themselves, usually by postal questionnaire, but, at age 17, by computer during a clinic session. In four question sets, respondents were asked the 'Number of times' the young person had done each thing in the past year e.g. stolen something from a shop, threatened to hurt someone, actually hurt someone, deliberately damaged property. There were four possible responses which were recoded as follows:

0 'Not at all'

1 'Just once'

2 '2-5 times'

3 '6 or more times'.

For each question set response values were summed to create an antisocial behaviour scale with a potential range of 0–75 (age 16 parent report); 0–50 (age 17 in-clinic self-report); 0–36 (age 18 and age 21 self-reports). The more trivial misdemeanours were excluded from later questionnaires (see Appendix 5). A similar scale was used by Salt who carried out a factor analysis of the items showing them to load onto a single factor (Salt, 2013). The scale is based on that used in the Edinburgh Study of Youth Transitions and Crime, and I have used the frequency items in line with the approach of Smith and McVie's *volume of offending* measure (2003).

The questions in the remaining set were worded differently. At the age 17 clinic, 3949 young people were asked about their contact with police and the criminal justice

system. The items I used to create a criminal involvement scale are shown in Table 3.6. Most of the questions were yes/no questions, those that were not were recoded, and scores were summed to create a scale of 0–8. A score of one or more on this scale was used to indicate criminal involvement (as used by Kretschmer and colleagues (2014)). Table 3.6 compares the rates of reported criminal involvement for those with and without primary school age behaviour problems.

Table 3.6 Self-reported criminal involvement of young person (YP) by age 6 to 10 behaviour problems (max n=3815)

	Behaviour problems		**No behaviour problems**	
	n	**%**	**n**	**%**
YP was given a fixed penalty notice by the police	16	2.66	49	1.52
YP was charged by the police for committing a crime	22	3.66	40	1.24
YP received an official police caution	31	5.19	85	2.64
YP received a fine from the Court	11	1.84	20	0.62
YP was given a Community Service Order	6	1.01	7	0.22
YP was given an ASBO	5	0.84	6	0.19
YP spent some time in a Secure Unit	2	0.34	5	0.16
YP spent some time in a Young Offenders Institution or in prison	2	0.34	1	0.03
Any	45	7.48	127	3.93

ASBO: Antisocial Behaviour Order

A summary binary variable was created for use in analyses by assigning 1 to cases who scored in the top 10% of the full ALSPAC sample for any of the 4 antisocial behaviour scores, or scored one or more on the criminal involvement scale. A 10% cut-off has been used by others to indicate problematic levels of behaviour (Goodman, 2001; Hanington et al., 2012; Ramchandani et al., 2005). The approach to dichotomisation is similar to that of others using this data, although they did not combine timepoints, and Salt used a cut-off of 15% on a single scale (Kretschmer et al., 2014; Salt, 2013). Table 3.7 shows the numbers and percentage of the full sample scoring above the cut-off point on each measure, and that 15% of young people scored above the cut-off on at least one measure.

Table 3.7 Antisocial and criminal behaviour scales, full ALSPAC sample

Measure	Cut off for inclusion in ASB variable	N with ASB	% of valid n with ASB
ASB Parent report age 16	Top 10%. Cut off >5	526	9.3
ASB Self report age 17	Top 10%. Cut off > 6	103	10.5
ASB Self report age 18	Top 10%. Cut off > 2	252	7.5
ASB Self report age 21	Top 10%. Cut off > 2	272	6.4
Criminal involvement age 17	Said yes to one or more items	117	4.5
Antisocial behaviour ages 16-21	**Included in any of the above**	**1126**	**15.0**

Combining the five scales significantly increases the available sample size as illustrated in Table 3.8, showing the number of cases with data on each scale that also have data on presence or absence of primary school age behaviour problems.

Table 3.8 Available sample sizes for each measure of antisocial behaviour (ASB) or criminal involvement for those with an available measure of behaviour at ages 6 to 10

Comparison	Available sample size
ASB Parent report age 16	5605
ASB Self report age 17	952
ASB Self report age 18	3269
ASB Self report age 21	4122
Criminal behaviour age 17	3831
Antisocial behaviour ages 16-21 (any of the above)	7253

Sample for ALSPAC regression analyses

Table 3.9 shows the full sample for whom there is the necessary data at both baseline (ages 6 to 10) and outcome (ages 16 to 21) timepoints.

Table 3.9 Behaviour problems over time; antisocial and criminal behaviour (ASB) at ages 16-21 for those with or without behaviour problems at ages 6-10.

		n (%)	Of these, n (%) with ASB at 16-21
Behaviour Problems at 6-10	**No**	6004 (83%)	753 (13%)
	Yes	1249 (17%)	338 (27%)
	All	7253 (100%)	1091 (15%)

There were 1249 children with behaviour problems at primary school age and who had data available on their antisocial behaviour between the ages of 16 and 21 (Table 3.9). These form the core sample for the ALSPAC analyses in Chapter 7. Further information and discussion of the characteristics of this sample are in Appendix 5.

3.3.3 Predictor variables: 'modifying factors'

As discussed above, hypotheses about which modifying factors, or 'exposures', may influence the later antisocial behaviour of children with behaviour problems were developed from the qualitative analysis, and linked to ALSPAC variables where possible. To avoid repetition, how these variables were derived will be explained where they are used in Chapter 7. For use in the logistic regressions, to simplify interpretation, some scales were dichotomised. Where no cut-off value was available from the existing literature, cut-offs were made to identify the 15% of individuals with the lowest scores, for example, the 15% with the lowest levels of social support. The 15% cut-off was used for consistency with the approach taken above. As before, where fewer than half the items on individual scales were missing, prorating was used to compute scores.

3.3.4 Data analysis

In the following explanation, and in future chapters discussing the ALSPAC analysis, 'behaviour problems' refers to age 6 to 10 problems as described above, and 'antisocial behaviour' (ASB) refers to antisocial and criminal behaviour at ages 16–21 as also described above. 'Predictor' or 'exposure' variable refers to the operationalisation, using ALSPAC data, of the modifying factor hypothesised following the qualitative interview study analysis.

Data analysis was carried out using Stata 14 (StataCorp, 2015). Relationships between predictor variables and antisocial behaviour in the behaviour problems group were first examined visually and then compared with simple two-variable analyses, prior to running multivariate regressions to control for potential confounders. Categorical predictor variables were cross-tabulated with the ASB outcome variable. Ordinal predictor variables were recoded as binary variables, and differences between cases with and without ASB at ages 16–21 were assessed using chi-square tests. For scale, predictor variables distributions were compared using means and standard deviations, and differences in means were tested using unpaired t tests.

Because the designation of antisocial behaviour (ASB) was a binary variable, logistic regression was used to examine relationships with potentially modifying factors, first in univariate analyses, and then adjusted for key covariates (Domínguez-Almendros et al., 2011).

Confounders/covariates

A number of factors could potentially confound the relationship between the school-age predictor variables and later antisocial behaviour. A large number of family and child background factors, for which there are data in ALSPAC, are risk factors for antisocial behaviour, as discussed in Chapter 2. If these pre-existing risk factors are also related to the predictor variables it is possible that any associations between a predictor and ASB are in fact explained by these pre-existing risk factors. The relationships between these potentially confounding background factors and ASB, were examined and these analyses are presented in Chapter 7, with additional investigation in Appendix 5.

Potential covariates were chosen based on existing knowledge about factors associated with antisocial behaviour in order to control, as far as possible, for confounding background factors, and focus on the impact of later occurrences (see for example Bowen et al., 2008). For each individual analysis, covariates were initially chosen for theoretical reasons, from those identified in the literature, and then retained if the covariate had statistically significant associations with both the predictor variable and the outcome variable (ASB). However, not all potential covariates could be included. As a general guideline for logistic regression it is recommended that there should be at least ten of each type of outcome for each predictor/independent variable (Agresti,

2007; Peduzzi et al., 1996). As the proportion of cases with the ASB outcome was low (around 15%) it was therefore usually not possible to include more than two or three predictors. In addition many of the potential covariates were highly correlated with each other (multicollinear) and so could not be included together. The aim was therefore to achieve a parsimonious model using a minimal number of covariates to explain the outcome.

3.4 Summary and conclusions: Strengths and limitations of the methodological approach

This chapter has explained the need for an in-depth qualitative analysis of families' experiences over time to identify what factors associated with services' intervention efforts appear helpful. This is referred to as *the interview study*. The relationships between some of these factors and young people's antisocial behaviour further in the future (at ages 16–21) are investigated quantitatively using ALSPAC data and reported in Chapter 7. This is referred to as *the ALSPAC study*. However, the major focus of the thesis is the qualitative analysis of interview and documentary data connected with the eleven families.

The interview study sample is not intended to be representative, in a statistical sense, of families meeting the inclusion criteria, although it is implicit that what appears to be true for a family in this study may be true for other families. The study sample is small but varied in terms of age, ethnicity and family history, and an excellent sample for studying a range of experiences, and allowing the rare opportunity to follow families and their use of services over five years. The families have in common that they were all referred to the Helping Families Programme in 2010–2011, which meant not only that they met the inclusion criteria but that they were willing, at least in principle, to participate in the programme. As a result, although nearly half the families did not complete the programme, the sample may nevertheless be more open to service intervention than an average sample of families meeting the inclusion criteria. Chapters 4, 5, 6 and 8 illustrate the variety in the experiences and attitudes of these families. Interviews with practitioners nominated as helpful by parents, provide another perspective on the families' experiences, and the possibility of examining how practitioners are able to provide useful support as well as any constraints on their intervention.

The interview and ALSPAC study samples are not perfectly matched, as the interview study families all face risk factors additional to the child's behaviour problems. The ALSPAC sample would have become too small if the same criteria were used, however ALSPAC family-level risk factors are included as covariates where possible in the analyses presented in Chapter 7 and are further examined in Appendix 5. In addition, the interview study families come from two inner and one outer London boroughs, while the ALSPAC families are from the Avon area around Bristol, more diverse in terms of urban or rural location, but less ethnically diverse.

The data available from the ALSPAC cohort study are very rich and it was possible to find variables corresponding to many of the themes arising from the qualitative work. The underlying question of interest in looking at the relationship between school-age factors and later antisocial behaviour is, of course, one of causality. However, because ALSPAC participants are not randomised, or even assigned, to exposure to the factor or not, it is impossible to say whether the associations observed are due to a causal relationship or whether both result from a third factor. For this reason, the quantitative ALSPAC study is secondary to, and rooted in, the in-depth qualitative analysis of families' experiences over five years. While randomised controlled trials do provide a way to account for unmeasured differences between groups which may explain different outcomes, they face other constraints which can limit their usefulness for understanding processes of cause and effect in complex, multifactorial real world situations. Despite the limitations of the current study's approach for looking at effectiveness of intervention, it would also be problematic to rely only on evidence from trials because of the danger of prioritising interventions which are easier to research. The current mixed methods study is designed to provide an examination, both in-depth and broad, of what families find useful in bringing about change in the longer term.

Chapter 4

Children, parents and sources of support: description of interview study families and change over time

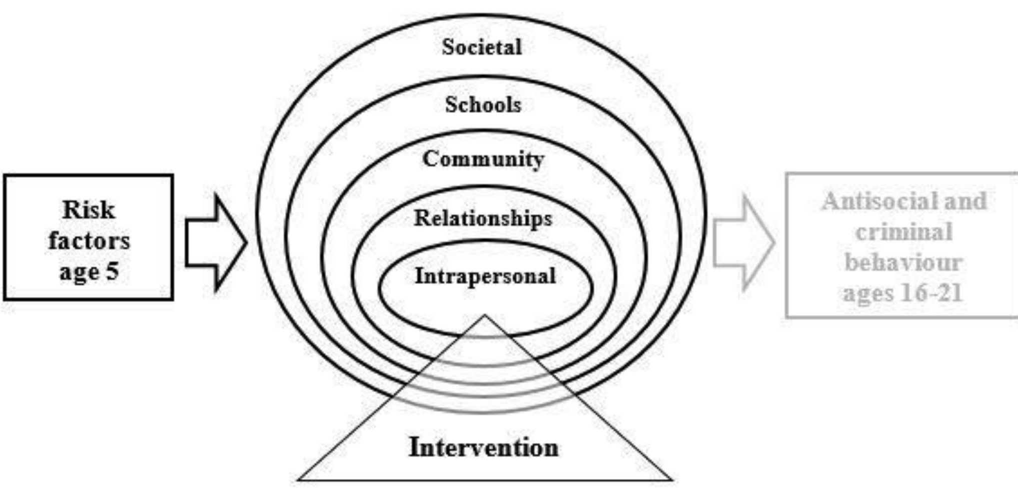


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> When she first started working with Jamie, I couldn't stand him basically. I was just like 'take him away, take him!' She built the relationship back up, like, through working with her, so it was really good. *Linda*

This is the first of the thesis's five empirical chapters, four of which relate to the interview study. In this chapter the eleven interview study families are introduced, with an overview of their trajectories over five years, particularly in terms of children's behaviour and services' involvement. The chapter mainly presents quantitative data on the families, collected from interviews and from questionnaires completed with parents, and collected from practitioners and schools. Characteristics of the families, summaries of their histories and measures of the children's behaviour problems over the five years are presented in section 4.1. Summary information about families' service involvements, and their views of services, are presented in section 4.2. The UK's child protection framework is briefly explained, alongside study children's changing child protection status over the years. Two main points are drawn from the service use data presented: Firstly, that despite many changes, including improvements, in family situations and relationships, children's behaviour problems continue over time; and secondly, that levels of service involvement are uneven over time. Elements of the qualitative analysis are brought in to help illustrate the importance of these points for families.

4.1 Characteristics of the families in the interview study

As explained in Chapter 3, families in the interview study were recruited because they had been referred to the Helping Families Programme (HFP). They were referred to HFP because criteria had been met which indicated risk of future antisocial behaviour in the child, in terms of both the child's behaviour and additional family-level risk factors. The families recruited to the current study had already taken part in at least one research interview prior to starting HFP, in which information on child behaviour, service use and opinions of services was collected, with further data collected post-intervention for those families that completed HFP. Two rounds of follow-up interviews were later conducted as primary data collection for the current study. Table 4.1 is a summary of the more detailed information given in Tables 3.2 and 3.3 in Chapter 3, to give an overview of the chronology. For some families the documentation collected as part of

multiagency involvement in HFP covered additional years prior to 2010. The table shows the number of families from whom data were collected at each timepoint. The table also shows how the timepoints will be referred to in subsequent tables and text.

Table 4.1 Chronology: Number of families with data at each timepoint, 11 families

<table>
<tr><th>Timepoint</th><th>Pre-HFP</th><th>Post-HFP</th><th colspan="2">Time 1 (T1)</th><th>Time 2 (T2)</th></tr>
<tr><td></td><td colspan="2">Data collected prior to PhD</td><td colspan="3">PhD data collection</td></tr>
<tr><td>Year</td><td>2010</td><td>2011</td><td>2012</td><td>2014</td><td>2015/16</td></tr>
<tr><td rowspan="2">Number of families from whom data were collected at each timepoint. Total n=11</td><td rowspan="2">10</td><td rowspan="2">6</td><td>1*</td><td>10</td><td rowspan="2">10</td></tr>
<tr><td colspan="2">11</td></tr>
</table>

* One mother, Paula, was not part of the original Helping Families Programme (HFP) trial but was recruited to HFP later from a different borough. She did not in the end receive the programme because the HFP practitioner left her post, but she was re-interviewed in 2015.

The first interviews for the current study were carried out three to four years after parents had been offered the Helping Families Programme, and the second interviews, 12 to18 months later. At each interview parents were asked to nominate a practitioner to be interviewed, someone who had worked with them and been helpful. Participants were interviewed about the role of services and other factors in their lives, in helping the family to manage as the child grew up. Tables 3.2 and 3.3 in Chapter 3 show the sources of data for each family over the four possible timepoints: Pre-HFP (2010, baseline), post-HFP (2011), PhD time one (T1; first follow-up, 2014) and PhD time two (T2; second follow-up, 2015/16). Although the first interview with Paula was not a follow-up interview (as she was newly recruited), because the two interviews with her were conducted for the PhD and the content was similar to the other interviews, they are included with the other PhD time one and time two interviews.

The families had been offered HFP often at a crisis point in their lives, at a time when services noticed that there was a problem with a child and with their family and as a result were putting additional services in place. Three years later the children and their families had developed in different ways, and in many cases the service use profile had altered dramatically.

4.1.1 Parent and child characteristics

Demographic characteristics of the families were first collected at the start of the Helping Families Programme in 2010–11 (2012 for Paula) and are shown in Table 4.2 (anonymised family characteristics) and Table 4.3 (pseudonyms and additional family characteristics). Pseudonyms are not included in Table 4.2, to maintain anonymity. All parent-figures were female, and all were the mother of the target child except for one who was the grandmother and in her sixties. Three mothers were in their twenties, three in their thirties and four in their forties at the time of the HFP intervention.

Table 4.2 Family characteristics

Child’s age at baseline	Child's ethnicity	Number of siblings by final follow-up	Mother’s ethnicity	Father
10	White European	3	White European	Absent
6	Black British	3	Black British	Absent
7	White British	5	White British	In home
5	White British	0	White British	On probation/no contact
9	White British	4	White British	Absent
9	White British	2	White Irish	In prison
11	Black African	2	Black African	Lives locally
8	Mixed race British	3	Mixed race British	Occasional contact
9	Mixed race British	2	White British	In prison
6	Black British	1	Black British	Absent
8	White British	2	White British	Involved, outside home

Table 4.3 Baseline (except *) characteristics of interview study mothers and children

Pseudonyms	Mother's details 2011				Child's details 2011		
Mother & Child	Employment status	Age at school leaving	Qualifications	Relationship status	Completed HFP	School exclusion ever	Diagnosis, if any, by *final follow-up
Esther & Shaun	Not employed	16	<5 GCSEs	Single	No	Yes	
Linda & Jamie	Not employed	15	None, expelled age 11	In relationship	Yes	Yes	ADHD, full-time medication
Jenny & Tyler	Not employed	16	Not known	In relationship	No	No	ADHD
Donna & Joe	Not employed	<16	None	Single	No	Yes	ADHD, part-time medication
Mary & Ryan	Not employed	16	None	Married	Yes	Yes	ADHD, full-time medication
Kathleen & Michael	Student	<15	Taking NVQ	Single	Yes	Yes	
Sue & Aaron	Employed part-time	15	English & Maths (adult education)	Single	Yes	No[1]	Autism spectrum
Bella & Palani	Not employed	<16	None	Single	No	Yes	ADHD, medication stopped
Nicole & Ben	Employed full-time	Post-16	Diploma	In relationship	Yes	Yes	
Amana & Darius	Employed full-time	18	A levels	In relationship	Yes	Yes	ADHD, full-time medication
Paula & Harriet	Not employed	15	<5 GCSEs	Separated	No	No[1]	Learning difficulties

HFP: Helping Families Programme; NVQ: National Vocational Qualification; GCSE: General Certificate of Secondary Education; ADHD: Attention Deficit Hyperactivity Disorder. [1]No exclusions at baseline but excluded by end of study. For more information on school type and exclusions see Chapter 6.

As shown in Table 4.3, by the time of the follow-up, six children had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and four of these were taking medication for the condition. Three mothers said they only gave their child the medication to help them through school, and sometimes had breaks from the medication at weekends or in the holidays. Being on medication meant that the child had continued contact with child and adolescent mental health services (CAMHS), and in two cases this had meant consistent contact with a single psychiatrist throughout the 5 years.

Table 4.2 shows the characteristics of the parent/carers. At the first follow-up interviews in 2014, two of the target children had been taken into care during the intervening three years, and were not living with their mother, who was therefore no longer the primary carer. One of these mothers remained in contact with the child and was interviewed at both PhD timepoints; the other could not be traced, although information was collected from the child's school at the first PhD timepoint. All other primary carers were interviewed at both PhD timepoints. For ease, the group of primary carers as a whole will be referred to as parents, or mothers.

As shown in Table 4.2, only one child had a live-in father-figure. Three fathers and an older brother in a fourth family were in prison or on probation at the final follow-up, and another older brother had recently been released from prison. This question was not asked directly so only those instances mentioned in conversation were recorded. Primary carers were of varied ages and ethnicities and most had little in the way of educational qualifications. All children were primary-school-age at baseline but age varied between 5 and 11 years old. Being at risk of exclusion from school was one of the inclusion criteria for HFP and all but three had already been excluded, at least temporarily, at baseline, with two of the others excluded later. At baseline two mothers were employed full-time, one was employed part-time, one was a student and the remainder were not employed. At the final follow-up one mother was on maternity leave and the remainder were not working. Most mothers said they were not working because of the demands of their child (see Chapter 5).

Summaries of families' stories are given in Table 4.4.

Table 4.4 Family story summaries

Family story
Esther and Shaun Shaun's violent and uncooperative behaviour was flagged up by his school at the age of 5. Esther had problems with alcohol, depression and low self-esteem. Services suspected she and Shaun had been victims of domestic violence. Services felt she was unable to implement change and Shaun was taken into care. At the final follow-up Esther was about to be evicted for non-payment of rent. Shaun was in stable foster care but wished to return to his mother.
Linda and Jamie A practitioner commented that Linda needed a lot of pushing to get things done, for example, completing paperwork for special needs assessments, or getting medication. There was a family history of antisocial behaviour, and a sibling with ADHD was excluded from mainstream education. Linda enjoyed HFP, and felt it had transformed her relationship with Jamie, but was less positive about other intervention they'd received.
Jenny and Tyler Jenny and Tyler's home life was described as chaotic and services felt that Tyler was exposed to inappropriate behaviours at home from other adults, some of which he acted out at school. Professionals commented on the warmth between mother and son. However, Jenny did not comply with targets set as part of a child protection plan, and did not engage meaningfully with HFP. Tyler was taken into care. Three years later his school reported that, with a lot of support, he was doing well and was due to move to a permanent adoptive home.
Donna and Joe Donna was often angry and had been banned from some premises, but she was prepared to give services a try, and often actively sought out help. However, she was usually disappointed; she dropped out of HFP feeling it had nothing to offer her. The HFP practitioner noted that she did not try out any of the suggested strategies. She and Joe had a loving bond. Joe was seen as very vulnerable by some practitioners, easily influenced by trouble-makers he associated with.
Mary and Ryan Ryan had a difficult beginning in life, moving before primary school to live with his grandparents. Mary gave up her job to care for him. Mary was wary of service involvement and keen to report that they were coping well. There were additional stresses on Ryan's grandparents and Ryan worried about his gran's wellbeing. There were serious concerns about his behaviour in the neighbourhood and his susceptibility to negative influences from older peers. He seemingly found it difficult to tell right from wrong and responded to plaudits from peers, for example for his fighting prowess.
Kathleen and Michael Kathleen and Michael had been receiving many services at baseline, when Kathleen's ability to parent her children safely was questioned and Michael was in trouble at school. They were receiving almost no service contact at the first follow-up, when things seemed to be going well. A year later, however, Michael was excluded from school, and had been involved in crime as both a witness and a perpetrator. Although Kathleen had been very positive about previous support she had received, the number of services involved at the final follow-up was overwhelming. Child protection proceedings were due to take place to oblige Kathleen and Michael to be seen by services.

Sue and Aaron Before HFP Sue felt that Aaron made her family's life a misery with his destructive behaviour. As Aaron's behaviour was satisfactory at primary school, services did not believe her stories until a sympathetic social worker experienced his behaviour. Sue formed useful relationships with this social worker, and with the HFP worker, and dramatically improved her relationship with Aaron. However, following the transfer to secondary school he was excluded and was having a difficult time in his special school, where Sue was belligerent in his defence (see comic story, Appendix 1).
Bella and Palani Bella's children all had special needs. Bella had little social support and had not been able to complete her education. She fought for services for her children and for a bigger home. She had refused to become involved with social workers, but had long-term support from CAMHS which she valued highly. She became more confident over the years at dealing with services and at the final follow-up was delighted to have won a tribunal case regarding services for one child. Her children remained challenging, but were now all in school and she had plans to return to her own education.
Nicole and Ben Nicole's family had links to criminal activity which put them in danger. Ben's behaviour had been challenging since beginning primary school. Nicole wished for a housing move to a new neighbourhood but did not want to risk a less secure tenancy. Nicole felt children's services took a surveillance role, and did not offer useful support. By the final follow-up Ben was excluded from mainstream school and was being taught in a one-to-one setting. Nicole was embarking on psychotherapy, partly, she said, to address her poor life choices.
Amana and Darius Amana was a young mother and had faced much criticism of her parenting from services, as well as from her own family. She had been told she was too harsh with her child, and too busy, working full-time, to give him the attention he needed. Darius had very difficult behaviour to the point that he had been hospitalised after being unable to calm down. Amana responded positively to the strength-based approach of both HFP and a CAMHS psychiatrist who remained involved with the family from the time of Darius's ADHD diagnosis. Amana was now a great advocate of parents seeking support from services.
Paula and Harriet Paula was referred to HFP at a time of great crisis for the family. The father had recently left the home, which was in danger of repossession, and she had suffered several recent bereavements in her extended family. Paula spent a lot of time in an alternative online world. All her children had behaviour that was challenging in different ways. Paula was receiving a great many visits from services, and felt these to be an additional burden rather than a support. The family's situation seemed to have improved by the final follow-up but this did not seem to be due to services received.

This table focusses on family issues; child and school issues are summarised in Chapter 6.
Details have been changed or omitted to preserve confidentiality.
ADHD: Attention Deficit Hyperactivity Disorder; HFP: Helping Families Programme; CAMHS: Child and Adolescent Mental Health Services

4.1.2 Children's behaviour over time

All the study children met the criteria for behaviour problems set out in Chapter 3 when they were referred to HFP. The Strengths and Difficulties Questionnaire (SDQ) provides an alternative measure, a prediction of conduct problems using responses from both the child's primary carer and teacher, including ratings of the impact of the child's behaviour (Figure 5).

Figure 5 Conduct problems prediction for each child by timepoint (Strengths and Difficulties Questionnaire scores)

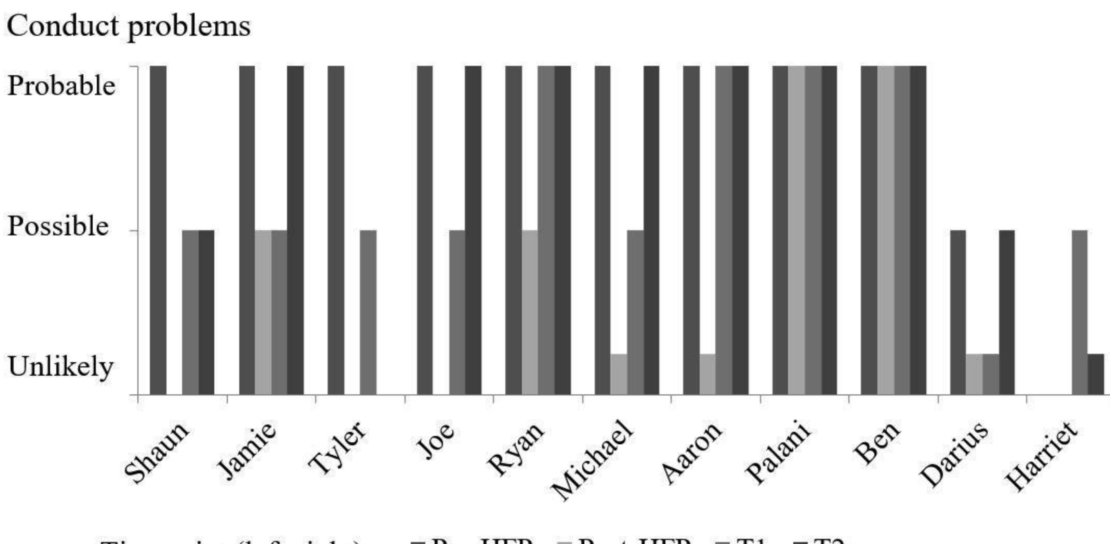
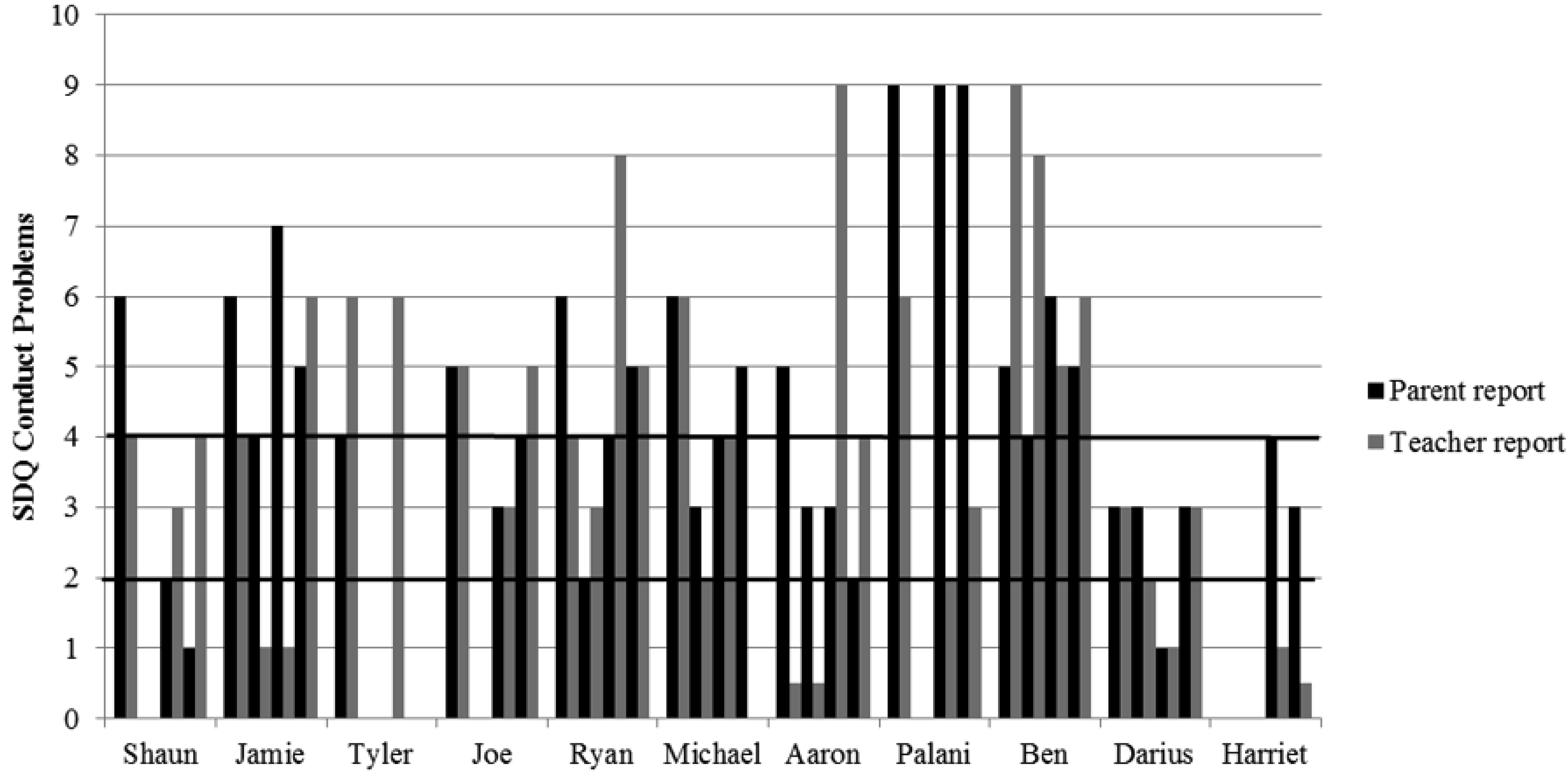


Figure 5 shows that at baseline, prior to the HFP intervention, all the children's SDQ scores put them in the 'probable' conduct problems range, except for Darius and Harriet who were predicted to have 'possible' conduct problems. Only six of the families completed the HFP intervention, and had therefore completed a further SDQ at the end of the programme. All these had improved behaviour scores following the intervention, with conduct problems less likely, except for Ben. However, of the original ten families referred to HFP, nine had probable conduct problems at baseline, four at the first PhD follow-up, and seven at the final follow-up, according to the SDQ. All the conduct scores for the children whose parents completed HFP returned to the original pre-HFP levels by the final follow-up. The two children who were taken into care showed improved behaviour scores, but these should be interpreted with caution. For Shaun, the parent behaviour report was completed by Esther, his biological mother, who was not his primary carer at the time of the follow-up interviews. Indeed, the breakdown of separate parent and teacher raw scores (Figure 6) shows that Shaun's behaviour had not changed much according to teachers' reports (shown in grey). Equally, Tyler's conduct problems prediction was based on teacher report only at follow-up, but on both parent and teacher reports at baseline (Figure 5); teacher score alone showed little change (Figure 6).

Figure 6 Separate parent and teacher-rated conduct problems score at 4 timepoints (Strengths and Difficulties Questionnaire (SDQ))



SDQ Conduct problems 0-2=normal range of behaviour, 3=slightly raised, 4=high levels of problems

Note: where SDQ scores were available, but were zero, they are represented by a small line to distinguish from missing data.

Figure 6 is included to show the differences in parent (in black) and teacher (in grey) reports of children's behaviour in some cases, particularly for Aaron and Palani. On the whole, the SDQ scores support the qualitative analysis of interviews in this regard. Aaron's mother Sue described the discrepancy in his behaviour at school and at home, and the change in these between primary and secondary:

> Back home he was smashing the windows and doors... in school he was brilliant they said, he couldn't do nothing wrong…and then [after the transition to secondary school] he was being good at home, nightmare at school! And I was thinking oh god it's reversed! *Sue*

All the children retained problem levels of behaviour at the final follow-up according to at least one informant, although for Darius and Harriet the scores were only slightly above normal.

As well as the predictions of conduct problems, additional subscales in the Strengths and Difficulties Questionnaire identify the likelihood of hyperactive and emotional disorders (see Appendix 4). None of the children had SDQ-predicted emotional disorders at any timepoint. However, at baseline, five children had predictions of probable hyperactivity disorder. At the final follow-up only one of these five were predicted to have hyperactivity disorder by the SDQ, as well as an additional three children.

4.2 Services received by families in the interview study and change over time

As argued in Chapter 3 detailed information on experiences of, and attitudes towards, services received is key to understanding what helps – or hinders – positive change for families of children with behaviour problems. These data were collected during in-depth interviews with primary carers and practitioners and the main themes arising from the qualitative analysis are reported in Chapters 5, 6 and 8. Here a summary of quantitative service-use data is given, including participants' quantitative ratings of services, as well as the introduction of some themes from the qualitative analysis that relate to families' overall service use profiles.

Many practitioners saw families in their homes, while others did so at clinics, neighbourhood centres or schools. Social worker contacts usually took place in parents' homes, or in schools or children's services' premises for meetings that were not solely

with the family. CAMHS contacts usually took place at CAMHS offices, but sometimes at schools. Family support services could be received either in the home or in a centre. These might consist of an individual worker regularly visiting to discuss household management and parenting issues, or could be more of a drop-in service, where parents could go for support. Children, as well as mothers, would sometimes meet practitioners elsewhere in the neighbourhood, for example a café or park. Respondents did not always know which service a visiting practitioner represented, why they were there or what job role a practitioner had. For example, they might not know whether a CAMHS representative was a psychiatrist, psychologist, counsellor, or other support worker. While much relevant detail was teased out in interviews the categorisations in the following tables are necessarily broad and represent a rough outline of the types and quantities of services received.

The types of services used, and broad classification, are shown in Table 4.5. For the reasons given, social and mental health services are grouped together:

Table 4.5 Types of services used by study participants

School-related services

Teaching and Learning Support assistants, Teaching staff, Speech and language therapist, Educational psychologist, Special Educational Needs Coordinator, Learning mentor, Welfare officer, Special needs advocacy, Counselling, Transition support, Extra-curricular activities, Family liaison, Art/music/drama therapist, Attendance officer, School nurse, School police

Social/community/mental health services

Early intervention team, Youth offending team, Police, Mentor, Youth worker, Social worker, Psychologist, Psychiatrist, Other CAMHS worker, Parenting programme, Parent support group, Family support intervention, Domestic violence support group, Counselling, Housing officer, Religious support, Foster care

Activities

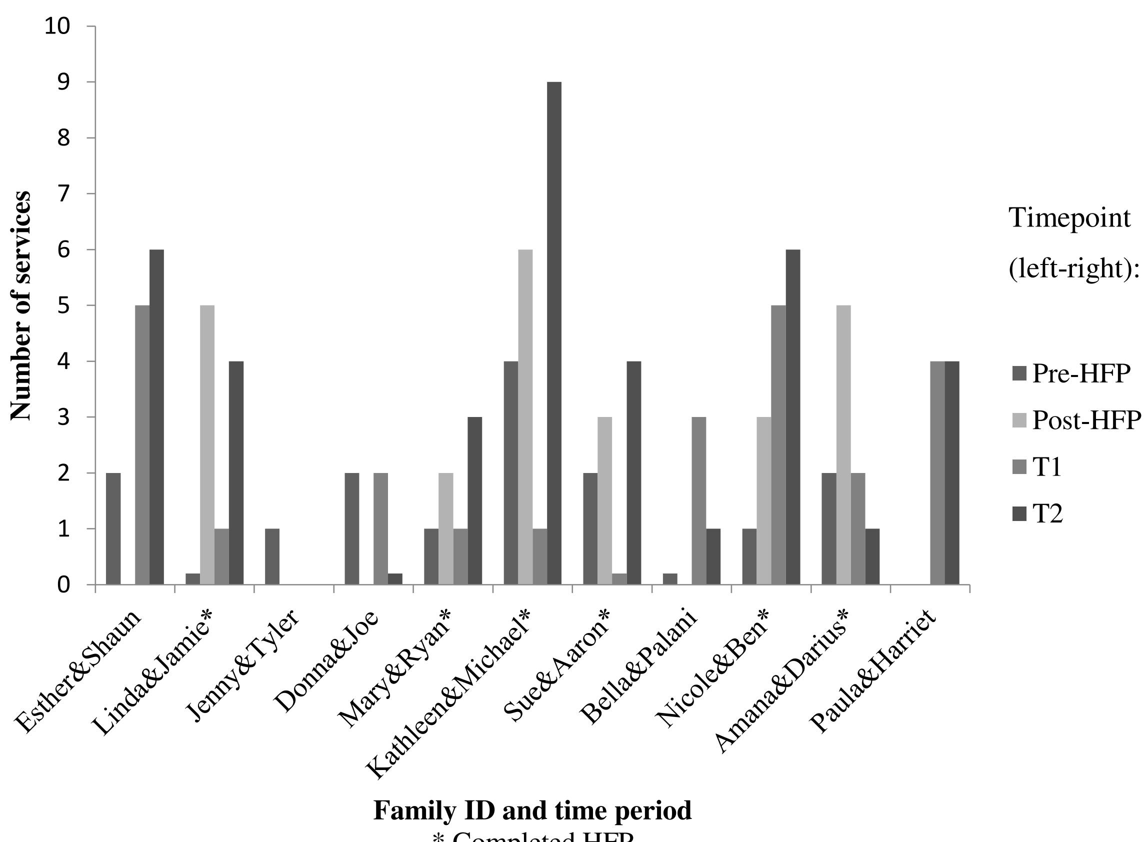
Sports clubs, Youth club, Playgroups

Health services

General Practitioner, Accident and Emergency, Health visitor, Hospital inpatient

Information on which services were received is most easily compared between families for services received outside school, and where the parent was involved. The social, community and mental health services category represents most of these; the number of these services involved with each family at each timepoint is shown in Figure 7.

Figure 7 Number of social, community and mental health services received at each timepoint, according to parent report



In Figure 7 the families who completed HFP are indicated with an asterisk. The figure suggests that additional services were put in place during or following the Helping Families Programme, but three years later fewer services were involved. However, at the final follow-up the number of services is higher again.

Although parents were also asked about services received at school, their knowledge of these was inconsistent, with some parents knowing more about school provision than others. For the current study, but not for the HFP pilot, information on service use was also collected from practitioners, but as these represented different services, they too had varying amounts of knowledge regarding other services the family received. Information on additional services children received at school was asked of all schools only at the final follow-up. With these caveats, Table 4.6 shows the total number of services families reported seeing at each timepoint. Services reported by practitioners and schools are also included where they were not already mentioned by parents. School-based services included are targeted interventions, additional to what all

children receive. A more detailed breakdown by the service categories in Table 4.5 is given in Appendix 4.

Table 4.6 gives an overview of the numbers of services families are involved with and the variation between study families. However, these numbers do not necessarily reflect the amount of support received. For example, Darius and Ben received very intensive support from a single individual at primary school, and so did Bella and her son Palani from their CAMHS worker. The qualitative analysis of interviews indicated that these single relationships might be more beneficial, at least while they lasted, than having a wider range of services involved (see Chapter 8).

Table 4.6 Number of services families are in contact with at each timepoint

Mother **Child**	Esther Shaun	Linda Jamie	Jenny Tyler	Donna Joe	Mary Ryan	Kathleen Michael	Sue Aaron	Bella Palani	Nicole Ben	Amana Darius	Paula Harriet
Pre-HFP											
Total parent-reported services	4	2	2	2	2	9	4	0	8	6	
Post-HFP											
Total parent-reported services		8			5	10	7		5	10	
T1											
Total parent-reported services	7	6	0	3	3	4	9	5	13	6	7
Additional school-reported services	6		4		9	3		2			
Additional practitioner-reported services	1		3					1			
Total including school/practitioner-reported	14	6	7	3	12	7	9	8	13	6	7
T2											
Total parent-reported services	1	2	3	4	5	6	7	8	9	10	11
Additional school-reported services	7	5		6	10	11	10	4	13	6	7
Additional practitioner-reported services	4[a]	[b]		5	2	1	3		1		1
Total including school/practitioner-reported	11	5	0	11	12	12	13	4	14	6	8

[a] Reports were received from both Shaun's primary and secondary schools at T2, this is secondary school response (primary n=5)
[b] Four specific teachers were mentioned as being a particular help at Jamie's special school, but not mentioned as additional services

Table 4.7 illustrates children's access to one-to-one support at school, the most intensive type of support received (other than foster care). These practitioners usually had a job title of Teaching Assistant or Learning Support Assistant (both referred to below as TA) and were sometimes providing significant support to parents as well as the child. Sometimes children shared a TA with other children with special needs, as indicated in the table.

Table 4.7 Child's one-to-one support in school

Mother	Child	Pre-HFP	Post-HFP	T1	T2
Esther	Shaun			Shared	Shared
Linda	Jamie		Full-time	Outside school[1]	
Jenny	Tyler			Shared	
Donna	Joe			Full-time[2]	Full-time
Mary	Ryan		Full-time	Part-time	
Kathleen	Michael		Part-time	Part-time	
Sue	Aaron	Part-time	Part-time		Part-time
Bella	Palani				
Nicole	Ben	Full-time	Full-time	Full-time	Full-time
Amana	Darius		Full-time	Full-time	Shared between 2
Paula	Harriet				Part-time

[1] Jamie was excluded from school at this timepoint but receiving one-to-one teaching
[2] Joe's statement allocated him full-time support but Donna doubted this was happening

As shown in Table 4.7, following the HFP intervention four children had full-time TAs whose job was solely to support the child in school at all times, including playtimes. Other children had such support part-time, which could be, for example, an hour per day, or all morning, or shared with others. More detail and analysis of support at school is given in Chapter 6.

The tables and figure above illustrate the unevenness of service provision over time and the qualitative analysis of interviews pointed to this unevenness as a significant issue for parents in the study, as will be explained in section 4.2.2. First, the children's child protection status at each timepoint is shown.

4.2.1 Child protection status

Table 4.8 shows the changing child protection status of the target children in the study.

Table 4.8 Child protection status and school type

Parent&Child	**Child Protection Status**			**School type at final follow-up**
	2010/11	**2014**	**2015**	**2015/16**
Esther&Shaun	Child Protection	Looked After	Looked After	Mainstream
Linda&Jamie	Child Protection	Child in Need	None	Special
Jenny&Tyler	Child Protection	Looked After	Not known	Mainstream[1]
Donna&Joe	Referred	None	None	Special
Mary&Ryan	Child in Need	Child in Need	Child in Need	Special
Kathleen&Michael	Child in Need	None	Child in Need /Child Protection	Excluded
Sue&Aaron	Child in Need	None	None	Special
Bella&Palani	Referred	None	None	Mainstream
Nicole&Ben	Referred	Child Protection	Child in Need	Special
Amana&Darius	Child in Need	None	None	Mainstream
Paula&Harriet		Child in Need (2012)	Child Protection	Special

[1]Final follow-up was in 2014 prior to transfer to secondary school, all others are at secondary by final follow-up

Although five of the families were no longer involved with social services by the final follow-up, all the children continued to have difficulties with their behaviour over the five years. Three of the children in these five cases were excluded from mainstream education and the other two were both struggling with issues around their behaviour in mainstream schools. Children’s school histories are presented and explored in Chapter 6.

In England children can be designated a Child in Need if children’s services (previously known, and generally referred to by study parents, as ‘social services’) assess them as being in need of extra support for their safety, health and/or development. This can include children with significant emotional and behavioural difficulties, including those

at risk of exclusion from school. Such a designation can lead to extra support being provided, although thresholds for support are locally determined.

If children's services believe that a child is at risk of significant harm they are legally obliged to investigate. If concerns remain, a child protection conference will be arranged to see whether the child needs a child protection plan because of professional concern about risk of harm due to neglect or physical, sexual or emotional abuse (Family Rights Group, 2015; see also http://protectingchildren.org.uk/cp-system/initial-assessment/child-protection-plan). The plan sets out what needs to be done, why, and by whom, to keep the child safe and to promote the child's health and development. It specifies what outcomes need to be achieved and how. It will also set out how often the child and family must be seen by the social worker and when the plan will be discussed and reviewed.

In Table 4.8 Child Protection means that the child is on a child protection plan, the highest designation of risk before a child is taken into care, at which point she or he becomes a Looked After Child. At the time of the Helping Families Programme, two of the children, Esther's son Shaun and Jenny's son Tyler, were subject to child protection plans; both these children had been taken into foster care by the first follow-up in 2014, and Tyler was later adopted and moved to a new area. Two other families moved to higher risk designations during the study period. Kathleen and Michael's social worker said she was about to 'step up' their case, to the Child Protection level, so that she could oblige the family to accept visits, and Paula's daughter Harriet also became subject to a child protection plan, although their social worker felt that this would be downgraded soon. Nicole's son Ben was also given a child protection plan due, Nicole said, not because of concerns about her parenting, but because of dangerous situations occurring around him, connected to other members of the family.

Donna and Bella had both been seen by social services (referred by their schools) and, according to the mothers' accounts, the social workers had been more-or-less sent away. Intervention was voluntary at that stage, as social workers found no reason to suspect risk of significant harm, and both had refused to be involved with children's social services, although both became involved with child and adolescent mental health services (CAMHS).

4.2.2 Feast or famine in service provision

A theme from the qualitative analysis is the sense from some parents that service provision was a case of feast or famine, with many services involved or none. Kathleen and her children were involved with many services at the time of HFP, and Kathleen had been very positive about the help she had received. At the first follow-up interview for the current study the family stood out for Kathleen's wholly positive reports of previous services and for how well her son Michael seemed to be doing. However, she missed the support of services:

> I'm happy when I see people – when I see community helping me and seeing… big changes, because otherwise with this problem I would have gone already. I went days and days without having a bath because I was like, what's going on? What am I going to do? And until they start coming and they start giving me that hope – oh no, we're gonna call this person that's gonna help you, we're gonna do this, this, and that – you're not alone on these problems. *Kathleen*

Kathleen thought it was better for her to have some service involvement but she could see that there were others whose needs were higher. However, at the final follow-up things had changed dramatically. Michael had been excluded from school and was involved in local crime. A great many services got involved again and Kathleen felt overwhelmed. Michael initially refused professional emotional support for a serious trauma he had witnessed, which his mother said was because he was seeing so many professionals at the time including social workers, police, lawyers and youth justice workers. Kathleen's social worker felt that duplication of efforts from different services getting involved could be linked to Michael's lack of engagement. Kathleen and Michael's story demonstrates the possible problems of many services only being available short-term, at times of crisis.

Sue and her son Aaron had received a lot of services at the time of HFP, a crisis point, and Sue, like Kathleen, missed the support when it was no longer there (see comic in Appendix 1). At the final follow-up she had recently been refused help after approaching children's services. The family had not been considered high enough risk to warrant the support. Other families also experienced periods when too many services were involved. Bella felt overwhelmed by service appointments at baseline, so that they became a burden rather than a support and she felt unable to continue with HFP; for Nicole, too, social services had suggested she had too many services involved to also

take on HFP, and Paula felt she did not have a choice about the very high level of service involvement she was given, and did not see that it benefitted her, or was even designed to benefit her (see discussion of the surveillance role of services in Chapter 8).

One aspect of Kathleen and Michael's case was common to most of the families, that being on the Child Protection or Child in Need register is a passport to services. As Sue explained:

> When I had Aaron in Child in Need, I got every kind of help I could get.
> The minute he'd come off, it was like 'bye'. *Sue*

This was the experience of most of the families in the study. Sue and Kathleen both presented this as a negative thing, whereas Paula and Linda were relieved to be left alone, even though Linda, particularly, had appreciated some of the support she had received. Nicole had mixed feelings; she had wanted more support but felt that the support given was not very useful, and did not come at the right time.

Nevertheless, while Bella and Donna both refused to engage with social workers they had been able to access some support from elsewhere. Bella suggested, however, that support was hard to come by for those who were not directly harming their children:

> There was that family social support worker, but y'know, they couldn't, just because, I don't know, maybe it's because I didn't smoke drugs, or drink alcohol, they wouldn't help me. *Bella*

The following chapters present themes arising from the interviews about what aspects of intervention and support, and other features of families' lives, are helpful in addressing the risks facing children and families. The next section presents a summary of parents' views and quantitative ratings of services.

4.2.3 Parents' view of services

Table 4.9 summarises parents' positive and negative views of services, ordered by number of positive views.

Table 4.9 Primary carers' positive, neutral and negative views of services over all four timepoints

Non-school services	Positive	Neutral	Negative	Total
GP (General Practitioner)	12	3	1	16
Social Worker	12	4	10	26
CAMHS (Child and adolescent mental health services)	10	3	2	15
Activities/sports provided	7	4	0	11
Family support	8	2	2	12
Parenting group	3	2	2	7
Mentor to child	3	0	2	5
Police	2	0	3	5
Total	57	18	22	97
School-based services	**Positive**	**Neutral**	**Negative**	**Total**
Mainstream Primary School	16	4	5	25
LSA/TA/Mentor (Learning Support/Teaching Assistant)	13	7	1	21
SENCO (Special Educational Needs Coordinator)	6	1	5	12
Special Secondary School	4	0	2	6
Class Teacher	4	1	3	8
Mainstream Secondary School	3	1	6	10
Total	46	14	22	82

For the two PhD interview timepoints the information in Table 4.9 was taken from the qualitative analysis of interviews with parents, reinforced by the ratings of services given by parents on the Client Service Receipt Inventory (CSRI), completed during interviews (see Chapter 3). For the earlier two timepoints, only the ratings given by parents on the CSRI, and any recorded comments, could be used. When using the CSRI ratings, views were categorised as negative if a service was rated less than 4/10 and as

positive if rated above 6/10. Ratings in-between were categorised as neutral. Only services with five or more positive or negative views are included in the table but in total views on 32 different categories of service were recorded.

Table 4.9 shows that positive views of services were much more common than negative views. The services with the most positive ratings were mainstream primary schools, school teaching/learning support assistants, GPs, child and adolescent mental health services (CAMHS) and social workers; however, social workers also had a high number of negative ratings. Social workers have the most negative ratings, followed by mainstream secondary schools and primary schools, and school special educational needs coordinators (SENCOs).

Although GPs had the most positive ratings, their contribution was only significant in a minority of cases. Kathleen, for example, at the second follow-up, said she was seeing her GP every couple of weeks:

> Every time when I go to see my doctor, she always, always say to me, 'I'm there, if there's ANYthing, if you feel like killing yourself', because in the past I used to think like that… she always tell me, 'If there's ANYthing I'm here, call me, this is my number, call me, we'll talk'.

Sue also had the same GP for more than 15 years and found him very supportive. However, by the final follow-up, GP practice boundary enforcement had meant she was no longer allowed to see that GP and she had yet to register with a new one. Nevertheless for most of the families, although they had positive opinions of their GP, they were not of great importance in their lives.

Table 4.9 showed that parents' views of primary schools were more positive than their views of secondary schools. The disjuncture between primary and secondary school experiences was a major theme in the qualitative analysis and is discussed in detail in Chapter 6. Here, Figure 8 shows parents' quantitative ratings of the helpfulness of their child's school at each timepoint, as marked on visual analogue scales with ten as the maximum score. The figure also illustrates how ratings differ for different types of school. Primary schools are shown in grey and secondary schools in black, with pupil referral units, and the other special schools the children attended after being excluded from mainstream school, shown as striped.

Figure 8 Primary carer’s ratings of how helpful they found the child's schools at each timepoint

Primary carer's rating of school

10
8
6
4
2
0

Shaun Jamie Tyler Joe Ryan Michael Aaron Palani Ben Darius Harriet

Up to six school ratings for each child.
Timepoints left-right: Pre-HFP, Post-HFP, T1 (regarding previous school), T1 (current school), T2 (previous school), T2 (current school)

Note: When zero or negative rating is given, a small line is shown to distinguish from missing data.

Parents' ratings of schools (Figure 8) could have any value between zero and ten. In fact, parents sometimes wanted to give ratings off the bottom of the scale ('minus ten') or off the top of the scale ('ten plus plus plus'). The figure shows that ratings for mainstream secondary schools tended to be low, with more mixed ratings for special schools, while several primary schools, including primary pupil referral units, were given top marks. The chronology in Figure 8 reflects when the ratings are given, so for example at the T2 interview, the parents might have been looking back to how helpful the earlier primary school was, so in some cases primary school ratings are shown later than secondary school ratings (for Joe and Palani). The figure does not reflect the full complexity of children's schooling histories. Although primary school ratings shown here are mainly positive, four of the children (Joe, Ryan, Ben and Darius) had moved early in their school careers from primary schools that could not deal with their behaviour. These moves pre-dated the HFP referral and ratings were not collected but the issues with these negative early experiences are discussed in Chapter 6.

Table 4.9 and Figure 8 illustrate polarised opinions on some of the principal services discussed in interviews with parents. In the interviews with practitioners, ratings were also collected about the usefulness of particular services to the study family. Services most likely to be rated positively by practitioners were social workers, CAMHS and literacy interventions. Social workers and CAMHS were also those most likely to have negative ratings, along with family support projects. The qualitative analysis, presented in Chapters 5, 6 and 8, explores the reasons behind parents' and practitioners' views about what services were helpful. On the whole, whether parents found services helpful or not came down to the behaviour of individuals, but individuals' behaviour was also circumscribed by features of organisations (Chapters 5, 6 and 8).

4.3 Chapter summary and conclusions

This chapter has introduced the eleven families in the interview study and some aspects of the families' stories over the five years of the study. The chapter has presented mainly the quantitative data collected during interviews with parents and from schools and practitioners, as well as some information collected during the HFP pilot study. The data are quite complex, involving different timepoints and informants, as well as multiple types of service. The summary underlines the importance of the qualitative interview approach for uncovering the meaning behind these figures. Some elements of

the qualitative analysis were introduced in this chapter to set the context for the findings. Subsequent chapters will look in depth at what aspects of service provision help or hinder the family in improving their situation.

The eleven children in the interview study all continued to have behaviour problems five years after their referral to the Helping Families Programme, and in addition several had diagnoses of ADHD by the final interview, most of them controlling their condition with medication. The children had varying degrees of involvement with child protection services, ranging from being referred to safeguarding officers, but no further action taken, to two children being taken into care. Families are more likely to receive support services when a child has been designated as ‘in need’ or is subject to a child protection plan. The families were involved with many different services, but the number of services and amount of contact fluctuated over time. For the six families who completed HFP, more services had been put in place to support them by the end of the intervention. Some of the children had intensive one-to-one support at school.

Families expressed a range of views about services they had contact with, which are analysed qualitatively in the following chapters. Here, parents’ ratings of services’ helpfulness were presented. Parents tended to have fairly polarised views but although very negative opinions were expressed in relation to some services, positive views were more common. Parents’ ratings of schools their child had attended were presented in more detail suggesting a wide range of experiences, which are explained and discussed in Chapter 6.

The data presented in this chapter on the range of services received, and the variety of views expressed, confirm that the sample offers original material for studying experiences of service intervention and how such intervention might be helpful, or how and why efforts to intervene with families might fail to be helpful. The data also support the value of looking at change over time, and the importance of longer-term follow-ups for reflecting on effectiveness of interventions. If families are only studied at times of crisis, periods where parents are looking for support but not finding it will be missed. The HFP pilot trial data, in contrast to this thesis, illustrates only a period of intense support, particularly if those mothers who drop out of the intervention are not studied (Stevens et al., 2014). While children in those families who completed the HFP showed

initial improvement in behaviour, the longer-term SDQ scores suggested that these improvements may have been short-lived.

The next chapter shows the value of a qualitative interview approach for investigating what is behind these shifts, and reveals that important improvements occurred which are not necessarily reflected in behaviour scores (Chapter 5). There were for most of the families periods of intense intervention followed by very little; a cliff edge of support, with an apparent lack of preventative on-call support in between crises. Chapters 5, 6 and 8 present the qualitative analysis of data from the interview study, which suggests factors that may be important for longer-term improvements in family functioning and child behaviour. For some of these factors hypotheses are developed for investigation in the ALSPAC analysis (Chapter 7), to see whether there is any evidence, from that larger sample, of associations with longer-term antisocial behaviour as the cohort children become adults.

Chapter 5

Parenting children with difficult behaviour: families, communities and social support

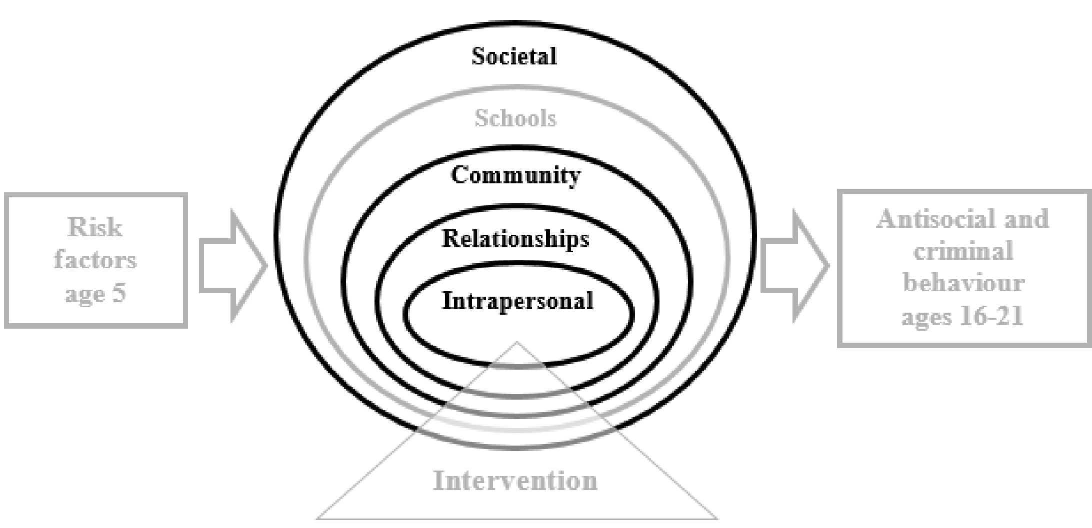


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> It's bloody hard work. And it's challenging, very challenging, I know that. Very challenging. *Donna*

> [I need] somebody – especially somebody to help me manage the children, mainly. That's the most hard, hard job ever. *Kathleen*

It is clear from the in-depth interviews with ten parents that all the families continued to face significant difficulties five years after their initial invitation to the Helping Families Programme. As indicated in the previous chapter, children's behaviour remained challenging, although there had been some important improvements. The range of experiences allowed the analysis to identify what factors seemed to help and what factors hindered improvements in child behaviour and family functioning. Services often played a part in bringing about changes.

This chapter covers the themes arising from qualitative analysis of the interview study data concerning influences on parenting, including in the home, neighbourhood, community and society. The aim, responding to Research Question 1, is to examine what helps bring about positive change, or creates barriers to change in children's behaviour and family functioning, with a focus on the role of intrapersonal factors for the mother, relationship factors between the child and the mother and broader environmental community and societal factors. These areas correspond to four of the spheres of influence included in the conceptual framework (summarised in Figure 1). The analysis particularly addresses part a) of Research Question 1: *What factors amenable to intervention influence family functioning and child behaviour?* Where possible factors identified in this chapter are further investigated using ALSPAC data in Chapter 7. The fifth sphere of influence is schools; school-related issues are discussed in Chapter 6. While the current chapter looks at the role of services in helping bring about change in parenting through intrapersonal, relationship, community and societal factors influencing parents and children, Chapter 8 examines the levers and barriers within services, which have an impact on how well parents and children are supported.

The chapter argues that parents improve relationships with their children in different ways. The first part of the chapter (5.1) presents themes related to mothers' roles in addressing their children's behaviour problems, and the role of services in generating change: Firstly, how getting mothers to see their child's behaviour differently, for example attaching less blame to the child, can lead to changes in the relationship and the

child's behaviour; secondly, how learning strategies to address difficult behaviours can help; and thirdly, how parents' own wellbeing cannot be ignored and services need to recognise the impact of parents' mental health problems and personal histories.

The context in which families live, including wider relationships and experiences in the neighbourhood, adds to the layers of influence on outcomes, and may be shaped by services or policy. The second section (5.2) presents themes related to the role of social and environmental factors in supporting or undermining parenting and better child behaviour. These factors include the influence of local peers, and the neighbourhood more generally, and issues to do with housing, informal social support, employment and state benefits. Given the sensitivity of reporting parents' and practitioners' comments about each other it has sometimes been necessary to omit pseudonyms.

5.1 Changing parenting to improve children's behaviour

This section discusses firstly how getting parents to see their child's behaviour in a different light can affect parenting behaviour. This can involve challenging parents' views about their child, or increasing parents' understanding about what scenes should be kept from the child's view. Following this, two important areas of parenting practice which parents (and practitioners) felt could be helpful are presented: strategies for managing children's behaviour, and strategies to help parents remain calm in the face of sometimes extreme provocation. This may well be a necessary first step to implementing behaviour management strategies successfully but is difficult for all parents, who are, as Donna said, only human.

5.1.1 Addressing mothers' unhelpful ideas about their child's behaviour

The Family Partnership Model, which informs the HFP, refers to parents' 'constructions' of their children's behaviour; that is, how parents interpret and put meaning on their child's behaviour (Davis & Day, 2010). It is felt that negative constructions of children's behaviour need at some point to be addressed. This concept influenced the analysis of the interviews, and two broad types of construction emerged. In the first type, the blame was put on the child, for their behaviour, and often for the family's wider difficulties; there was a belief that there was something wrong with the child, even that the child was evil (particularly true for Sue and Linda). A second type was where none of the behaviour was the child's fault, that it was beyond their control

and they should be treated accordingly and not blamed (particularly true for Donna and Nicole).

Linda and Sue stood out as having radically altered their attitudes towards blaming their child, improving their relationship as a result. Both credited service involvement, in particular the Helping Families Programme, as being instrumental in bringing about this change. At the time of her first involvement with HFP Linda had been asking for Jamie to be taken away, feeling he was destroying her family. She explained how she had been able to change the way she parented Jamie:

> I think it's just the support of people, sort of look at the positive rather than the negative all the time, you know? Not to look at the bad points, look at the good points he's got and things like that, which I would never have--if I had not had met people, I would never have assumed that. *Linda*

Linda pointed to this as the main bit of advice she would want to pass on to others.

Sue had always thought there was something wrong with Aaron, who blamed an imaginary friend for his bad behaviour. At the beginning of the HFP intervention Sue felt that she had tried everything and that it was Aaron who needed to change. But she transformed this conceptualisation during the programme. By the first follow-up, three years later, she was a great supporter of her son, as with Linda, and when asked whether his difficulties put a burden on her and her family said no, it was the school, not the child, that put a burden on her. Sue had been ‘blinded by stress’, she said, which meant she could not see Aaron's good behaviours and was overly negative with him. Despite her initial resistance to the idea of any change needed other than by the child himself, Sue came round to say ‘I will change if this needs to happen’ (Sue and Aaron’s story is represented in the comic in Appendix 1).

Conversely, one nominated practitioner commented on the impossibility of getting a study mother to accept that any change on her part might improve her daughter’s behaviour. The family worker felt she and the mother did not make progress because:

> It was just always this thing of going back to ‘But she’s got to do it – what can I do? She’s got to do it.’
>
> ‘But do you remember when we said you could do this?’ *Former family worker*

While Linda had turned around her behaviour towards Jamie it seemed as though these lessons had not transferred to her feelings towards her younger daughter. Even though Linda recognised that her change in attitude towards Jamie's behaviour had been key, when asked about her younger daughter her attitude to the 8-year-old seemed similar to her original one towards Jamie: 'She's a Bitch. Bitch!' She even described her as being 'the new Jamie', explaining her negative impact on the family, as she had previously with Jamie.

HFP practitioners' case notes showed where they had looked for evidence of parents' unhelpful constructions (possibly revealing the practitioners' own constructions) which they would then try to address. For example, a mother (and others made similar comments) was noted as saying her children 'have an agenda' and 'do it on purpose'. Practitioners said another mother needed to see her son more as a child in order to have more appropriate expectations of him. Both these mothers were seen by HFP as having unrealistic expectations of their child.

Some parents did not blame their child at all and had perhaps gone too far with the idea that the child was not responsible for their actions. Donna, for example, though she had a very different attitude towards her daughter, and while acknowledging the great burden of Joe's behaviour on her and her family, saw his behaviour as beyond his control and not his fault. One consequence was that she expected Joe's school to treat his difficulties the same way, whereas the school encouraged Joe to take responsibility for his actions. This seemed a key problem in Donna's relationship with schools, a clash of constructions, meaning she was not always supportive of punishments or calls from school about Joe's behaviour (see Chapter 6).

Parents sometimes normalised the child's behaviour. This might be an essential coping mechanism, could simply reflect the reality of the lives they have become used to or could represent a barrier to change. For example Esther, two of whose children had been in prison, said 'they never really play up'; Donna, who felt services were overly critical of Joe's behaviour, would say, 'Everyone has their off days, do you know what I mean? It's ridiculous!'

Ryan’s stoical grandmother played down the impact of his very difficult behaviour on her:

> My main concern is the support in the school. At home it’s manageable but in the school it’s very important. *Mary*

Her account differed markedly from that of a school-based practitioner who said the summer holidays had been ‘horrific’ for Mary, because of Ryan’s behaviour.

It had to be borne in mind when analysing these interviews, that the parents had told their stories, and been questioned about their parenting, many times. Most had had some involvement with social services over the question of adequate parenting for the child. It may have been important to their story to assert that they were coping and that the difficulties were manageable, and this may have affected the narratives they presented in interviews.

The way parents talked about their child’s behaviour was related to how they saw their own role, for example as coping, or as over-burdened. There sometimes seemed to be tension between wanting to show they were coping well, and wanting recognition of just how difficult their situation was. One mother, for example, reacted to wanting to show she was coping with her difficult children by being what the HFP practitioner considered overly harsh, in response to behaviour the practitioner considered ‘within the normal range’. A teaching assistant (TA) similarly worried about another mother being overly harsh sometimes, and Amana commented that her own parents, Darius’s grandparents, had been resistant to Darius’s ADHD diagnosis, suggesting that it was her behaviour which was the problem:

> They were like, we think it's because maybe you put him in the naughty corner too much, so maybe you need to be a bit more understanding and stuff, and not discipline him as much. *Amana*

Parents’ constructions of their child’s behaviour were inevitably affected by the child having been given a diagnosis of ADHD or autistic spectrum disorder. Parents whose child had a diagnosis were pleased to have this. It made them feel to an extent vindicated in having noticed something wrong, and made them feel that it was not their fault. It also seemed to help parents have compassion for their child, and to see that a child with a diagnosis needed to be treated in a different way to other children.

However, in Linda's case it did not seem to have helped her feel more empathetic towards her daughter in whom she suspected ADHD. Amana, who felt she had been blamed for all Darius's extreme behaviour, took the details of the eventual ADHD diagnosis very seriously, and was at pains not to let Darius blame behaviours on the condition that were not a recognised part of the description. She would telephone the psychiatrist, for example, to ask if not going to bed on time, or being rude, was part of ADHD.

Practitioners also sought to enlighten parents regarding the effects of the child being exposed to aspects of parents', and others', behaviours. When I first interviewed Kathleen she had recently been to a parenting workshop which she said had opened her eyes to the influence of her own behaviour on her children's behaviour, although she also recalled that she had learnt the same lessons on HFP three years previously. Unusually in this small sample, Kathleen blamed herself to a large degree for her children's difficulties, stating that she had not been able to keep her deep sadness from them:

> How can I change my children's behaviour? I myself have to change first for my children to change, because children they act what they see in me, that's what they're going to act outside of the house. If I scream a lot, or if I cry a lot, like [daughter] she's crying only because she sees me cry and she's taking that to school, and Michael sometimes... So I need to change myself, the way I speak, the way I talk to them, I need to change it for them to change. *Kathleen*

Part of the reason that Jenny and Esther's children were taken into care was because they had not been able to protect their child from exposure to seriously inappropriate behaviours.

So changing parents' understanding of the reasons for their child's behaviour could have a beneficial effect. New understandings could lead to different methods of communicating, and new behaviour management strategies. But parents could also make good use of new strategies without having fundamentally altered their view of the child. We now look at parents' experiences of learning strategies to address both their child's behaviour, and their own emotional responses.

5.1.2 Learning strategies to help manage children's behaviour

Parents reported that having fun together, keeping calm and applying consistent rules and boundaries could improve their child's behaviour. In the final interview parents were specifically asked to reflect on what they thought they had learnt over the years, what they had found worked well with their children and what advice they would give to others struggling with children's difficult behaviour. Linda, for example, who had several children and was described as an obsessive cleaner of her home, had come to see that Jamie's difficult behaviours were an attempt to get her attention, and noted that when she gave him undivided attention his behaviour was at its best.

The main points made are summarised in Table 5.1. Table 5.1 also summarises where parents said they learned these strategies. Amana felt very strongly that formal support, such as from CAMHS (Child and adolescent mental health services), was essential in working out the most successful ways to parent, and setting up realistic routines: 'You need professional help I think'. Amana sought, received and implemented detailed parenting advice and was passionate about wanting her story to be used as an example to others about how utilising the right support could make parenting easier. Bella, in contrast, felt she had learned purely through experience. She did not really connect help she had received with any parenting practicalities. When a practitioner (at baseline) questioned the impact of shouting at her younger children, Bella's response was that she had to shout enough to get the message through; that she did not believe the softer approach worked. The messages she was being given simply did not accord with how she saw her experience, and Bella dropped out of HFP. Nevertheless, several years later she had learned similar strategies, through trial and error, and with support from her long-term CAMHS worker. Several parents pointed out at the final follow-up that they had realised from experience that shouting did not work, but instead escalated arguments. Most parents felt they had learned what worked through a combination of experience and advice from practitioners. Sue had learnt, through trial and error, as well as service support, that she needed to respond in different ways to different children, speaking to Aaron in a certain calm tone, for example.

Nicole said the best advice she had been given, by a school-based practitioner, was to overtly put the choice in the child's hands, explaining the choices available regarding the particular behaviour. Witnessing a practitioner using this technique with Ben had

made an impression on her. These data suggest that for something to really click it needs to be learned from experience; the original idea may come from advice, then the person tries it out and if it is effective they will use it, when they feel able, although sometimes in the short term it often seems the easier option to give in. Several parents commented on the need to follow through with threatened consequences and to make sure those consequences were realistic (Table 5.1 Mothers' parenting strategies). It may be that for some parents repeat visits and practical demonstrations might be needed to make the strategies look credible:

> I never thought that the strategies would work but they do and I have seen the benefits of them. *Linda*

Table 5.1 Mothers' parenting strategies

Family	Tips for parenting	Learnt from people or experience	Quotes
Esther and Shaun	Just go along with it (second follow-up)		*I'm sort of like a laid back person, you see, I just let them get on with it. But no, it's no good being laid back, trust me.* (second follow-up)
Linda and Jamie	Be more accepting of the child, do fun things together, positive attention; boundary rule; star chart; not giving in	A bit of both; try things out	*Mainly, it's just not giving in. Which was my biggest downfall, you know? I'd just give in all the time.*
Jenny and Tyler	Not interviewed		
Donna and Joe	Pick other parents' brains; try advice to see if it works; set boundaries and see through consequences	Experience, others' ideas, TV	*I told the school…'I ain't one of these parents like if they've been bad at school, right, okay, you can go out now'. I said, 'If they've been naughty, there's a consequence, and he knows that'. He either don't get no money after school or take the computer out of his room.*
Mary and Ryan	Boundaries and rewards; be very clear about punishments; say no and mean no; don't scream and shout; deescalate, put him outside or leave when he's having a tantrum; consequences: taking something away; when younger just hold him, restraining; have patience, let a lot go over your head; naughty step is rubbish	Experience, although example given from parenting programme video	*Not letting it escalate. That is the worst one, if you let it go like that then he absolutely goes mental. So you've got to get it in the beginning. I've put him out in the fresh air for that a couple of times. Open the back door and I said go outside and calm down.*
Kathleen and Michael	Don't scream and shout; punishments like taking away computer; get other adult to speak to him; teens don't like to talk to you on phone in front of friends, send a message instead; more talking, don't say it was bad, show the impact of what they did, e.g. on their future; talk while engaged in another activity	Both together	*I say okay, this is what I used to do with [HFP practitioner], I'll calm myself. I'll go and do my meditation and everything, just to ease up my mood and everything.*

Family	Tips for parenting	Learnt from people or experience	Quotes
Sue and Aaron	Talk; trial and error; leave scene during tantrum	Both together	*You just have to find ways of doing it. If speaking to him this way doesn't work, try a different way…It's just trial and error…I think bits from everything and maybe put it all together my own way.*
Bella and Palani	Routine; time out; choices; consequences, have a chart e.g. rewards for siblings playing nicely. Quality time with each child; involve the kids in what you're doing	Chart from practitioner, the rest from own experience	*Involve all your kids in what you're doing, that's what it is…And you ask them all for advice, like if I want to watch a film today we've all got to agree on the one film to watch, so we all know what we're watching, no-one's going to be arguing, things like that, silly things, it makes a difference.*
Nicole and Ben	Clear boundaries, be consistent. Best tip: give them a choice, the behaviour is their decision, they can make a different decision, explain consequences; sanctions e.g. no PlayStation, no going out. Leave room if tantrum; don't get involved in arguments	Both	*Walking away. Yeah. Don't get involved in the argument. Just say, 'I'm not arguing now, I've said my piece, that's it'. Just don't fall to their level, got to rise above it, really. It's very easy to get into that trap and you find yourself then arguing back and you're thinking, 'Hang on a minute, I'm arguing with a 13-year-old'.*
Amana and Darius	Baseline: Taught restraint techniques by hospital; setting aside more one-to-one time; T1: praising child; warnings, and seeing through realistic consequences. T2: patience, boundaries, routine, persevere	Practitioner	*And just always keep the same thing so he knows that like this is your first warning, this is your second warning. And it should be something that is kind of straight away.*
Paula and Harriet	Would prefer to use physical punishment but has been told cannot; doesn't believe other methods work		*My ex has realised they're walking over me, because I'm trying to talk to them, we end up in this house full of shouting because I can't hit 'em.*

Group-based Parenting Programmes

Many of the parents had attended group-based parenting programmes. These were not necessarily well-targeted. Paula, for example, was sent on a programme with parents of much younger, and less challenging, children than hers, so she felt it was not helpful. Esther said she was not referred to a parenting programme until after her child had been taken away. Mary was scathing about a programme she had been to where the videos were all of Americans:

> The naughty step, well that's the biggest load of rubbish I've ever seen in all my life, it can work for some kids but I used to say to Ryan, 'You sit there, don't move, three minutes,' I'd walk away, he's behind me. *Mary*

The intended benefits of the group programmes, generally to teach parenting strategies and thereby improve child behaviour, were not necessarily the benefits experienced by parents. Esther, who attended two ongoing parenting groups, valued them as a way to get her out of the house, and into a social environment. Several parents (Mary, Donna, Bella, Esther) mentioned feeling better when they found there were others with worse problems:

> They're having trouble with their kids, this and that. And I said boy, I thought I was alone! I thought I was the only one! *Esther*

Parents often turned down offers of programmes. Neither Donna nor Bella could see the point given their experience as a parent. Donna said, 'Oh I've got five kids I don't need a parenting thingy'; Bella had given a programme a try:

> They did offer… I only went to one for one day. And I sat there, and I was like, everything she was saying, I already knew, I've been there and I've done that. I said, not to be rude, I don't need to be here, 'cause everything you're saying, I know. I thought they were just flinging me in any course they could. But not really thinking of how much experience I already have. *Bella*

A family worker who delivered programmes, was familiar with these feelings:

> Parents think, 'Well, why? I've got two children, I've got an older one, he's okay, this one's not but this one is, so why do I need to do a parenting programme?'

But he felt they were valuable:

> I actually believe everybody should do one but they're not the be all and end all, no. No, you don't do a parenting programme for [a few weeks] and all of a sudden you get sent away and you're going to fix everything at home 'cause that isn't going to happen. *Family worker*

Another family worker felt the group approach can sometimes help where one-to-one cannot:

> I think – when you're in a group – when people around you are getting it – it kind of forces you to get it a bit more, but sometimes when you're one-on-one and you're talking about – and you're suggesting these things – it's just one person saying that – but that group process can be much more powerful. *Family worker*

She described a woman in her current group who ridiculed the suggested strategies, saying they would not work for her son. Group members had responded by giving their own experiences and suggesting news ways of addressing the problem: 'Did you try doing it like this?' and 'Did you try doing it like that?'

However, Bella's CAMHS worker seemed to concur with Bella that a parenting programme was not appropriate for her:

> I think it's quite insulting for people who are basically intelligent and have good parenting skills and are not cruel or nasty to their children to be sent on a parenting course.

Bella and Paula both objected to programmes just focussing on the needs of the child:

> 'Cause you're human, yeah, so when you go to these little courses and things, they don't go into depth of how the parent feels, it's like the parent is just there to be the parent to the child and you have to learn about your child's feelings, what about everybody else's? And they don't pick up on none of that, to me it was just boring, it was nothing, nothing useful. *Bella*

Bella pointed out the need to make parents feel that they could manage rather than that they were failing:

> They're maybe like some parents won't need it but what about if there's a percentage of mums that are really down and are depressed because they feel that they're not doing good enough, there is that percentage of parents that do need that advice… they need that little shove, they need that little confidence, they need that advice to know that they're not the only ones going through it and that's all it is. *Bella*

As with one-to-one support, intervention can be counter-productive if a parent feels blamed and perceives negative feedback. Amana had been offered parenting programmes but did not react well to having her parenting criticised. She had found the HFP much more positive about her efforts, and more useful.

Kathleen had been on different types of parenting programmes. She distinguished between interventions such as, on the one hand, HFP and the recent parenting session at her daughter's school, where parents discussed their own needs, and on the other, programmes like Triple P which were framed around the child and strategies to improve their behaviour directly. Kathleen obviously enjoyed these programmes but despite having ‘graduated’ from several she still felt at sea when it came to dealing with her teenage son. Kathleen’s social worker had delivered parenting programmes herself and felt they could be useful where parenting knowledge was the key issue, but a potential waste of time when the key issues concerned parental mental health. She had known parents who had been on ten programmes with 100% attendance but were still referred back to social services, and had attended sessions where she felt parents were not taking it in.

Jamie’s headteacher commented on the inadequacy of parenting programmes for dealing with entrenched real-life difficulties. Parents attending programmes were presented with strategies for dealing with children’s behaviour but found implementing the strategies in real life very difficult. One sample mother was reported as finding it nearly impossible to impose boundaries, and Paula said the suggested strategies did not work with her children because they did not care about the consequences.

5.1.3 Addressing parents’ own wellbeing

All the parents interviewed recognised at some point, if not initially, that their own wellbeing was important for the wellbeing of their children. Regulating their own responses to stress and their child’s behaviour was often a stated goal, a goal sometimes developed in conjunction with a practitioner. Some parents commented on the importance of ‘giving yourself a break’:

> At the end of the evening if I’ve had a stressful day I will pour myself a brandy and coke and sit down and have a drink, you know, so I don’t care, it’s like yeah [laughs] I’ve taught myself, which I think it’s a good thing…I

> would love to let other parents know like and try and give them a bit of enlightening. *Bella*

As with parenting strategies, there is a question around how much stress- and self-management can be taught and how much can only be learned from experience. Practitioners and parents both noted the connection between stress levels and harsh parenting. Seven parents commented on learning to walk away from arguments, and/or calming techniques, such as mindfulness and breathing exercises, and some were very positive about such techniques and still used them. HFP practitioners specifically taught such techniques and could be frustrated when related 'homework' tasks were not followed through. Nevertheless, five years after the programme, some of these techniques seemed to be in use, while parents also worked out their own strategies for keeping calm, including time out, exercise and 'not being too hard on yourself'.

The limits to how helpful addressing parenting can be

Parents found some parenting techniques that are regularly taught had a limited shelf life; star charts, for instance, stopped being effective for some children when the novelty wore off and sticking to boundaries became harder when children stopped caring about threatened consequences. It is hard to maintain routines, even where parents found good routines that helped them. Sue and Aaron, for example, had found doing meditation together helpful, despite being sceptical when the HFP practitioner initially suggested it. Recalling these sessions, Sue wondered why they did not do it anymore, saying it might be beneficial. At the next follow-up, she still recalled the sessions fondly but had not started doing them again.

Four cases in this sample seemed not to instigate change in response to services' efforts. In Jenny and Esther's cases, child protection services concluded that the parent was not able to prioritise the child's needs and instigate change to address serious risks to which the child was exposed, and the child was taken into care. In the other two (Donna and Paula) services gave up trying to change the parent's behaviour. In these four families it seemed that some change was desirable in the interaction between mother and child, but to date, intervention had not managed to bring this about. Esther accepted that some of her parenting approach may have negative impacts on her children, but did not feel able to change. In other cases, the mother lay blame elsewhere — on services, on the child, or on other family members. Although not the focus of the research, it was clear that

there were some good reasons, to do with mothers' own life circumstances and personal histories, behind their difficulties with parenting. In these cases it might be concluded either that services need to direct their efforts at supporting the child without relying on changing the mother's behaviour and/or that intervention to help the mother needs to be much more intensive than learning strategies, possibly (as practitioners sometimes suggested) involving psychological therapy. Parents' reactions to services' attempts to alter their parenting are summarised in Table 5.2

Table 5.2 Summary of parents' reactions to services' attempts to change parenting

Parent	Reaction to services' attempts to change parenting
Esther	Unable to implement change; child taken into care; maintains supervised contact and encourages child to listen to foster carers and be good at school
Linda	Completely changed understanding of child's behaviour and became more empathetic to child, fighting his corner rather than blaming him
Jenny	Although always loving towards child, did not respond to services' attempts to make changes which would keep child safe. Child taken into care
Donna	Open to new ideas and parenting strategies but did not attempt suggested anger-regulation techniques. Little change in parenting. Services stop attempting change
Mary	Has learnt about the value of setting and enforcing consistent boundaries
Kathleen	Has absorbed much knowledge about parenting theory and techniques; has good idea about what she should be doing; services questioned extent to which this was implemented in practice
Sue	Completely changed view of child's behaviour, with help from key practitioners, stopped blaming him and became his defender. Came to see child needed different treatment from her other children
Bella	Learnt a lot about parenting techniques and became organised and proactive in arranging service support for her children
Nicole	Tended not to place blame with herself or her son, thought by services not to act on advice given. Services' suggestion of psychological help for mother has been accepted
Amana	Had close relationship and detailed advice from consistent CAMHS contact whose advice she implemented faithfully
Paula	Did not find parenting advice given useful or relevant to her situation and her children's difficulties. Services appear to be about to stop attempting major change

<u>Recognising the impact of parents' own mental health and personal histories</u>

All the mothers interviewed, except for stoical Mary, referred to the impact of their own mental state on the way they were able to parent their child.

> At that time I was sort of low, yeah, I was just low, I was just letting them get on with it, which I shouldn't have done anyway. That was my BIG mistake. *Esther*

> Yeah, I suffer depression, as well, and, was it vertigo? Anxiety? Just really pissed off at life. *Sue*

Some had received counselling, not always with positive results; others talked about seeking counselling and not getting it; and sometimes counselling had been offered and not accepted.

Of one of those who turned down counselling the former family worker said:

> At the end I tried to refer her for her own therapy – her own anger problems which she said she had – and it just felt like until they're really addressed she's not – everything is somebody else's fault. And the parenting stuff is not going to work. And she said 'I've tried all this stuff – it doesn't work'.

Many parents had difficult stories in their backgrounds, often with little in the way of role models of nurturing parenting. Intervention which fails to at least be aware of these issues was criticised by practitioners, and several parents stated their need for psychological support. One family worker discussed the challenges in breaking the cycle of intergenerational problems:

> You've got to get to the root of why they think the way they do, why they act – well, their thinking determines their actions anyway, you know? And a lot of it does stem from tradition, culture, cultural practices. *Family worker*

Some parents expressed their desire *not* to address deep-rooted trauma, for example from their own childhoods. In fact when interventions sought to address these background issues, which were seen as a barrier to change, some parents became disengaged. Bella felt that confronting her deeper issues at the time she started HFP would detract from her primary concern of caring for her children:

> Not for now, 'cause, urgh, no, I'm just too busy. I just, you know what, I'd just rather do it when everything's settled. For all I know, I could talk to someone, and it could open up a whole different, and I don't even wanna go there now, I got small kids! *Bella*

Jenny had not engaged with services that attempted to address her own emotional issues and stopped attending HFP sessions when the therapist began to address questions about her past. Similarly, two options for Esther had been suggested following psychological assessment: either she enter therapy to address underlying causes of her situation, or have a huge amount of support put in place. Referral to the Helping Families

Programme was aimed at the latter, focussing on parenting practice. However, Esther was unwilling to engage with the programme, saying she had no difficulties in any of the parenting areas targeted. Shaun was taken into care soon afterwards. By the second follow-up Esther had received therapy; although she found the therapist nice, the counselling was upsetting (‘No, this is not for me’) and she did not feel it had helped (‘Even though I’m smiling, I’m still hurting inside’). Esther’s extremely high external ‘locus of control’ had been noted; that is, her belief that she had little ability to affect the things which happened to her and her family, which was evident in the interviews.

In contrast to those who did not want to revisit their past Kathleen reflected a lot on the abuse she had faced:

> [A parenting practitioner] said to me yes, I know now what’s your problem – you’re holding onto the past. Can you let it go? I say I can’t. *Kathleen*

Another practitioner noted the challenges of working with her when she easily fell into ‘real despair’. Having previously turned down counselling, feeling she needed to concentrate on her son’s needs, Kathleen did later attend counselling, and was trying to protect her children from her emotional lows.

Parents’ histories, and their mental health, are significant factors which may affect how effective intervention can be. The degree to which underlying trauma should or can be addressed needs to be considered, and for some parents a coping strategy of not addressing these may work. For others it may be, as social services eventually decided in Jenny and Esther’s cases, that the problems cannot be addressed and affect the parent’s ability to look after their child adequately (Table 5.2).

We have seen in this section that sometimes parents’ ‘constructions’ of their child’s behaviour changed away from blaming the child but not necessarily to encompass blame on themselves. There was also evidence, however, that when mothers saw more of a role for themselves in the child’s behaviour difficulties, it could add to stress levels, without necessarily leading to improvements in child behaviour. Parents could feel blamed, and feel that services did not appreciate the difficulty of their lives, and the challenges of managing children’s needs alongside their other life struggles. Children’s behaviour could involve parents being permanently on call, being kept up at night, forgetting to eat, not being able to leave the house and dealing with violence towards

themselves and their home, and a variety of special needs from different children. Mary said:

> I do discipline him you know and of course you can't even smack a child now 'cause you're in trouble, but you can stand there and let them punch the lights out of you. Which is not right, is it? *Mary*

Parents could then see services as unsupportive. Practitioners that were aware of this put an emphasis on strength-based intervention and giving positive feedback. Features of effective practice with parents, and characteristics of effective practitioners, are discussed in Chapter 8. The next section looks at the wider environment surrounding the family, and how this can have an impact on family functioning and child behaviour.

5.2 The role of social and environmental factors which could be targeted by intervention

Up to this point the chapter has looked at parents' influence on their children's behaviour, how this could become more positive over time, and services' role in such change, according to the analysis of interviews with parents and practitioners. However, parents do not parent in a vacuum and increasingly, as the child ages, influences outside the family have an impact on the child's behaviour, as well as continuing to have an impact on parents' wellbeing and family functioning, which are likely to indirectly affect child behaviour. The thesis seeks to explore what type of intervention, and what factors which could be targeted by intervention, help ease families' difficulties. The above section about parents' wellbeing and their behaviour towards their child relates to the 'Intrapersonal' and 'Relationships' levels of the conceptual framework (Figure 1). In this section, themes which relate to the 'Community' and 'Societal' levels of the framework are presented.

There are aspects of the immediate and wider environments in which families live which affect how easy or hard it is for them to manage their lives, and that may influence children's behaviour. Some aspects of the local area were quite difficult to get respondents' reflections on, such as the built environment. The themes relevant to 'community' which emerged from the qualitative analysis of interviews are to do with people and places in the local area: neighbours and the influence of local peers, opportunities for recreation and social support. Issues to do with housing are also briefly

discussed; these concern both the immediate environment of the family and the neighbourhood where the family lives. The themes which fit with the 'Societal' level of the framework are those that are affected by, or could be affected by, government policies or societal norms; benefits and employment are considered here. Families with a study child at home, particularly where the child has a recognised disability, and where the family has discovered their entitlements, appeared to feel they were being reasonably well supported by the state. Money was still tight, however, and it was rare for families to take a holiday.

5.2.1 Peers and neighbourhood

A significant improvement in Linda's family's situation came when they were rehoused, removing Jamie from peers on the previous estate with whom he had been involved in persistent antisocial behaviour:

> Round here he's got a nice little group of children that he plays with… the kids that were on that old estate, a lot of them were a bit older than Jamie and obviously where they knew what Jamie was like, and he had no fear factor, they'd get him to do things, like throwing stones at people's windows, and he would do it and think oh look they're all liking me for doing all this, but round here you don't get kids like that. *Linda*

Practitioners blamed local peer influences for another study child's antisocial behaviour and while his mother did not report neighbourhood problems she made similar observations to Linda, as did Mary:

> They're like followers, they're not leaders really, they're followers… Any child can [get in trouble] can't they, even if they haven't got problems, but with ADHD, they're more likely to, because you know, they're very gullible. *Mary*

Many parents commented on the potential threat from other children and young people their child might have contact with. Nicole had wanted Ben to go to a different school, where he did not already have a reputation, partly inherited from his elder sibling, 'so he wouldn't feel that he had to live up to anything, you know?' and she had reservations about the influences he was exposed to at a local youth club:

> I know there's a lot of older children around, and what they're up to and the influence they have on him and, you know, I'm just a bit worried that he can get influenced and distracted and drawn in by these older children, asked to do things. *Nicole*

Issues around giving the young people independence in the local area as they got older, and the additional stresses due to their behaviour problems, came up in most interviews. Mary had clear ideas of where it was alright for Ryan to go; she did not want him attending one nearby community centre. Some parents said their children had difficulty working out who they should not be friends with and in some cases parents related this trait to ADHD. Aaron's brother kept an eye on him in the neighbourhood and advised him if he was talking to the wrong people. Jamie had received support in this regard from a local 'early intervention' policeman on the previous estate. Community mentors (assigned to at least three study children) were specifically tasked with helping children work out how to behave in public.

Amana resisted the idea of Darius going to an all-boys school because she thought it might increase the risk of gang involvement. Michael did attend a mainstream boys' school, until his exclusion, but it was peers in his neighbourhood that seemed to cause most problems. At the first follow-up, Kathleen explained her fear of postcode-based gang antagonism:

> Maybe because of his anger someone might just hit him or something…I do worry because we got like, gangs around here…It's like every time when we walk around and we see them, and he's like [whispering] 'Mummy – let's not pass over there let's just go around here.' I say, 'Are you scared of them?' He say, 'Of course! You have to be scared because some of them they are carrying a knife.' *Kathleen*

By the second follow-up, Kathleen's fears seemed to have been justified. Michael was involved with youth justice services in connection with a stabbing (as a witness) and a robbery (as an alleged perpetrator). The youth justice worker concluded that Michael was not directly connected with a gang, but that there were certain of his friends that it would be better not to be involved with. She took the attitude, and she encouraged Kathleen to do the same, that Michael, now aged 16, could not be told what to do, but only advised about his choices. The family's current social worker was impressed with the youth worker's knowledge of local gang activity and felt her involvement was crucial, 'I don't know how they get information… she knows all of them!' The youth worker would call Kathleen to warn her to keep Michael at home when there was gang activity, which Kathleen had managed to do at least once. Michael himself had expressed his wish to move to a new area:

> He says, ‘I just want to go away from my friends, I just want to go, come back, tired, sleep, and that’s it’. *Kathleen*

This sentiment was reported regarding other young people by Jamie’s headteacher:

> The sad thing is, they will do the things that they can do best. If it's hanging about with a gang and they do that well, and the gang is giving them a certain amount of you know… 'Oh you, you're a fast runner, you can hide this for me, you can hide that for me' .... When they get older, it's really sad because you often get young people and they say, 'I don't really want this lifestyle. I don't like the lifestyle I've got, but I don't know how to get out of it. There is nothing I can do.’ And a lot of them will say, 'I just wish you could put me somewhere far away, I can start again… I can't do it here, because too many people know me. I've got a life, I can't get out of that life. And I know there's only two roads for me. It's either death or prison'.
> *Special school headteacher*

In one borough children were given funds for local activities including sports activities. Those who were on disability payments, which in this sample were those with a diagnosis of ADHD, got a much larger fund. Two parents whose children received this were very positive about it, saying it gave the children places to go and activities to try. However, one of these parents commented on the closure of a local centre which had previously provided some respite during school holidays. In another borough what was on offer seemed to depend on where you lived. Bella felt that the provision of activities was not as good as it used to be. However, she did not really want activities that were open to all, because, similarly to Nicole’s concerns about the youth club, she was worried about negative peer influences.

5.2.2 Housing

Two main housing-related issues emerged from the interviews. Firstly, the appropriateness of the home itself for the family it contains – whether it is big enough or has the necessary number of rooms. And secondly, the location, where sometimes it seems that a solution to potential or actual antisocial behaviour might be a house move.

Both Linda and Amana’s families benefitted greatly from being rehoused in more suitable properties. Amana’s flat at baseline was very cramped and on a busy road. According to her HFP practitioner the environment put extra stress on them; the constrained surroundings seemed to exacerbate her son’s violent and destructive behaviour, and seeing through strategies for de-escalation was difficult in a one-

bedroom flat. Amana and the HFP practitioner both felt the busy road was a risk as, even at the age of six, Darius was difficult to physically restrain. Another HFP practitioner wrote a letter supporting Amana's request for re-housing. Amana's little family was moved to a more suitable flat, on a quiet road. Linda's large family was also moved to bigger accommodation. The moves seemed to make both families' lives a lot easier. Bella had also moved to a flat with an extra bedroom, and while this helped, she would ideally have wanted a further room so her constantly arguing sons would not have to share.

Two families, Nicole's and Kathleen's, sought different accommodation because of negative gang-related influences in the area. Both families had connections with serious violent crime which a move to a new area might have helped to sever. However, the families were not supported to move when they were motivated to do so; no one seemed to have taken responsibility for this, despite intensive service involvement. In one case police did not support a housing move because of the risk of moving antisocial behaviour to another area. It was also felt that their existing geographically wide networks of acquaintances meant it was unclear where would be safe for them to go. In the other case a move would have involved giving up a secure tenancy, a risk the mother was not prepared to take.

Although at the first follow-up Sue had been considering whether a move away from the local estates would be a good idea, by the second follow-up, the obvious importance of the supportive links Aaron had made locally had changed her mind. However, as her two adult children no longer lived at home Sue's housing benefits had been cut because of the 'bedroom tax' and she said of the council 'they want my house':

> And I am not moving. Because Aaron needs stability…If I moved him now, and he lost his [club], he wasn't across the road from it, lost his friends, I don't know what's going to happen to him. *Sue*

5.2.3 Social support

The families differed in the degree of support they received from friends and family, although this was mainly quite limited. Relationships usually considered part of social capital could in some cases constitute negative influences, for example having local

family was not necessarily seen as providing support. ‘They’re just there,’ said Esther, and Donna said, ‘I don’t ask my family – I get on with it myself’. Later, after several family members had passed by during the interview and I asked whether she got any help from them she replied, ‘Not really, everyone comes to me’. Practitioners sometimes indicated that wider family, as well as certain friends, were more problematic than supportive:

> More of a problem… Everyone was just blaming everyone. She’s getting blamed, and she’s blaming them, nobody’s taking responsibility… And that’s what the kids are doing now – obviously – because you would if that’s all you’ve seen. *Family worker*

Some families did have networks of support at certain timepoints. For example, local shopkeepers had backed Aaron and Sue in a case where a particular police woman had tried to gather evidence of Aaron’s antisocial behaviour (apparently a case of mistaken identity). Linda referred to useful ‘friends of the family’ and her younger daughter also regularly stayed with a relative, although she did not have anyone she could easily leave all the children with. At the second follow-up, when things seemed to be improving for the family, one practitioner commented on the crucial support Linda got from her friends and how several would have Jamie to stay overnight. Aaron, Jamie and Joe had all formed positive relationships with elderly neighbours who they visited regularly. Ryan’s grandmother praised her neighbours for their tolerance of Ryan’s outbursts and pointed out how important this was when trying to implement some of the recommended parenting strategies:

> [Ryan is] getting the message now that, you know, when I say no I mean no. And I don’t care whether he screams and hollers and shouts, because I’ve got good neighbours, they know what he’s like. *Mary*

Donna commented on her neighbours’ tolerance of her own shouting:

> My mum said, ‘I could be right on top of the tall block but I can hear you’. I don't care. I paid for the roof over me head, I don't care. If I want to shout, I'll shout. Simple as. I ain't had no police knocking on my door. I ain't had no social workers knocking on my door. Good job my neighbours know me! *Donna*

Conversely, Kathleen had a terrible relationship with her neighbours in the flat underneath, who she felt made her life a misery with constant complaints and racist abuse; they had brought a court case against her. The only sources of informal support

she mentioned, at the first follow-up, were one neighbour, and an aunt (though not living nearby) but by our next meeting she had fallen out with both because they had gossiped about her. She had also stopped attending church for similar reasons. This worsening informal support situation coincided with the collapse in her son's adult support network as will be discussed in Chapter 6, and with the deterioration in his behaviour. Conversely, Sue, Linda and Paula all experienced improvements in their support network. At the first interview Paula mentioned just one friend when I asked her about sources of support:

> Family, definitely no… all I have is a friend of mine who I will talk to, but I mean, she doesn't have any learning difficulties sort of children and her children are not really that, well, you know, not badly behaved either… I just have a talk, and let off steam. *Paula*

This appeared to be a real low point in Paula's life, which included divorce and multiple bereavements, and services did not seem to take sufficient account of the role of her collapsing social capital (see Chapter 8). By the final interview, Paula had mended relationships with her wider family, with apparently beneficial results.

There were few references in the interviews to service attempts to help parents build their social capital, to make more connections in their communities where they might seek, and offer, support. One social worker mentioned a mother's preference for group therapy, and the possibilities for forming supportive friendships from this. The HFP did discuss support networks with parents and encouraged some parents to make better use of possible sources of informal support, such as relatives, for example for childcare. One practitioner commented, when asked if there were other services a study mother would benefit from:

> I think throughout, had she had more support with childcare a lot of the difficulties that result from being a single mum and not having much support from her family of origin, you know if there had been--, but there isn't a service that provides that service… I think she should've had, you know, a supportive family who were there for her and a partner who's there and, you know, those things, if they'd been there they would've made a lot of difference but they're not there. *CAMHS practitioner*

Some of the families, then, had valuable relationships among their neighbours and local community but others had very little by way of a supportive network. Activities in the

local area, especially where funded, were appreciated. Families' issues to do with social support, housing and neighbourhood are summarised in Table 5.3.

Table 5.3 Summary of families' social support, housing and neighbourhood issues

Parent	Relevant social support, housing and environmental factors
Esther & Shaun	Esther had recently moved to a new housing association flat at first follow-up but by second follow-up eviction was likely for non-payment of rent; no under-18 dependants meant reduced benefits. Esther had family around but they had troubles of their own.
Linda & Jamie	Rehoused to larger property on different estate away from negative peer influences. Linda had refused to pay rent prior to the move in protest at the family's housing. Linda had some supportive friends and family and friendly new neighbours. Local activities were available in holidays.
Jenny & Tyler	Moved away from her place of origin because of the unsupportive and damaging influence of her family. Some local activities for both Jenny and Tyler had been suggested but not accessed.
Donna & Joe	Large local family network seen as more of a burden than a support. On good terms with neighbours. Son possibly involved in local antisocial behaviour with peers. Local activities no longer provided.
Mary & Ryan	Lived in neighbourhood a long time, supportive neighbours and a family network. Worried about influence of peers in the neighbourhood; warned Ryan to avoid certain areas. Teachers worry about his disputes in the neighbourhood. Access to sports facilities locally.
Kathleen & Michael	No supportive neighbours and some very antagonistic ones. Negative gang influences in the area. Fear of ex-partner living nearby. Wants to move to new area. Some supports mentioned at first follow-up, such as church, proved less supportive by the second follow-up. One supportive family member, but not local. Michael previously involved in local sport provision.
Sue & Aaron	Lived in same house for many years. Rent increased due to 'bedroom tax'. Wanted to move at first follow-up due to fears of local peer influences but by second follow-up wanted to stay because of support networks Aaron had developed, including sports. Sue worried about boys hanging around the neighbourhood late at night.
Bella & Palani	Had managed to negotiate a move to a slightly larger property and hoping for a further move so that her argumentative sons would not have to share. Family initially described as unsupportive, but more connected at second follow-up. Would like more activities locally.
Nicole & Ben	Neighbourhood gang influences a serious concern because of family links. Worries about Ben hanging out with older children. Wanted to move from area. Some local activities, but worries about peers at first follow-up, not at second.
Amana & Darius	Rehoused in a larger flat in a quieter street, making life easier. Amana's parents live nearby and are very involved in Darius's upbringing. A sometimes problematic relationship much improved by final follow-up. Good activities for young children locally.
Paula & Harriet	At first interview, home was on point of being repossessed and Paula had almost no social support. Things improved by the final follow-up with better relations with ex-partner and wider family, and mortgage being paid.

5.2.4 Work and benefits

It was common for parents to report that they could not work because of their child's needs, although several said they would like to. Sue, Donna, Kathleen, Bella, Mary, Nicole and Linda all commented on the impossibility of working, not only because of their child or children's behaviour *per se* but also because of the time taken to deal with services and schools (see Chapter 6). Sue had to give up a job which a practitioner said had been beneficial for her mental health because of constantly having to collect Aaron from school when he had misbehaved, Mary had to give up the job she loved to care for her grandson and Esther had given up a computer course after one day because she felt it conflicted with what she needed to do at home.

Amana was an exception, as she had always worked full-time. She seemed to have encountered criticism from services about working rather than having more time for Darius. During HFP she complained that her employer was insensitive to her needs as a parent, for example needing to take Darius to appointments. At the first follow-up however, she was enjoying being on maternity leave and having more time at home. At the final follow-up she had gone back to work full-time, but she was sad about this and said she had tried to go back part-time but her manager had not allowed it. Kathleen had been studying and volunteering and had attended some job interviews, but with the multiple crises and court cases she was facing, her employment plans were on hold.

The benefits system appeared to recognise parents' needs and, by the second follow-up, with no under-18s living at home, Esther was the only one who reported being pressured to find work. Two parents mentioned that they did not think they could risk getting a job and giving up benefits because they might find themselves worse off financially. Donna's sister's experience of this was a cautionary tale for Donna, although in principle she would like to work:

> She has to pay full rent, council tax, [by the] time she pays everything out, it's not worth her going to work! And you've got this soppy little sum you've got to last for a month. So really, you're only going to work just to put yourself in debt, that's the way I look at it. *Donna*

Esther did not understand how people could work full-time hours. She found her very occasional work as a cleaner extremely taxing and her benefits were stopped when this occasional work was discovered (she had not realised she had to declare it). Her son was

also employed on ‘zero hours’ contracts. She was caught in a bind over declaring that he lived with her; as he was of working age, this would affect her benefits, but her flat was considered too large just for herself. Her rent was in arrears and she was about to be evicted. Paula, the only one in the sample to own her home, had been on the point of having her home repossessed, during the chaotic period following her separation from her husband, several bereavements and the beginning of the involvement of social services.

Most parents, by the final follow-up, were getting extra carers’ allowances and disability payments, because their child was considered to have a disability, but how they came to be aware of this being on offer seemed to be a matter of luck; Linda’s CAMHS doctor had mentioned she could be eligible, for example, and a friend of Nicole’s had recently told her about it. It was not possible to get back-dated supplements.

Older children living at home but not paying rent created additional financial burdens for Linda, Nicole and Donna, as well as Esther. Donna described how she had to make benefits allocated for three people, stretch to five. Although her eldest at-home son did get some benefits himself, she did not want to take this money as she thought it was important for him to be able to go out with friends; she saw this money as his pocket money. Esther’s and Nicole’s elder boys had been given housing away from their mothers because of the risk they were seen as posing to their younger siblings but in both cases they seemed to eat and have their laundry done at their mother’s house.

Social and environmental factors, then, can contribute to families’ and individual children’s difficulties, for example with cramped housing, or negative local peer influences, or they can provide protective influences, for example with supportive neighbours or local activities for children.

5.3 Chapter summary and conclusions

This chapter has presented themes related to parenting children with difficult behaviour in the home and the influences of factors in the wider social environment. The themes arise from qualitative analysis of interviews and documentation relating to the eleven interview study families followed for five years. The analysis focussed on factors

related to perceived changes in children's behaviour, and in family functioning, to discover how services can and do contribute to bringing about change.

Research Question 1 asks how families benefit, or fail to benefit, from intervention. The analysis shows that therapeutic intervention could help some mothers see that their own behaviour affected that of their child, and that this can lead to positive change in child-parent relationships, and consequently in the child's behaviour. The findings suggest it is helpful for parents to have a balanced view about their child's behaviour; not to overly blame the child, or themselves, but to see there is a role for both to make changes. Practitioners are sometimes able to help parents understand the importance of their behaviour *towards* their children and, in addition, how they, and others, behave *in front* of them. However, if intervention makes parents feel bad about their parenting, and fails to acknowledge the difficulties they face, it can be counter-productive.

While for some parents a change in 'constructions' may be transformative, leading to changes in behaviours, others can improve parenting without this cognitive shift, through developing strategies for more effective parenting, another aspect of parent-child relationships. Parents in the study learn about ways of parenting their children through their years of experience, but also from other sources, including intervention programmes and individual practitioners, if they manage to try out suggested strategies, and see beneficial results. Useful strategies parents learned included making time for fun activities, praising the child, not shouting, leaving the room during tantrums, and having clear rewards and consequences: meaning no when you say no. Study parents found it hard to apply consistent boundaries, which was encouraged by practitioners, but recognised the value of this. In at least four cases intervention appeared to have helped mothers change the way they interacted with their child, particularly in two cases, with the mothers becoming less hostile and more empathetic towards their child. However, there is some indication that hostile emotions transferred to elsewhere, for example towards other services.

Research Question 1a, *What factors amenable to intervention influence family functioning and child behaviour?*, encompasses consideration of factors which could potentially be targeted and which appeared to have an impact on the child's behaviour and family functioning. The analysis shows that housing, family finances,

neighbourhood and social support all had a role to play in supporting or undermining family wellbeing; mothers 'blinded by stress' may not be ready to change parenting, and practitioners sometimes found themselves having to deal with crises, sometimes not leaving time for the planned activity. Parental stress has been suggested as one of the explanatory factors linking poverty to poor outcomes for children (Guo & Mullan Harris, 2000). However, conceptualisations of parents' 'toxic stress' have been criticised for locating blame within the parent (Gupta, 2017). The model of many interventions has also been criticised for heaping responsibility (and therefore blame) on parents without addressing the wider constraints on parents' actions (De Benedictis, 2012). Parents' stress can be exacerbated by inadequate or insecure housing, problems in wider family networks and money worries. However, most parents felt the level of benefits they received was adequate when there was recognition that the demands of their child meant they could not work, and they had an additional payment based on their child's 'disability'. Nevertheless some parents would have liked the opportunity to work, and Amana was determined to remain in work, even when she felt criticised for it by services.

Aspects of parents' lives, then, represent barriers to effective intervention, but also sometimes they are sites for potential intervention. For example, improvements in housing appeared to have benefitted three families, and intervention to boost social networks, improve neighbourhoods or allow access to flexible work opportunities could have knock-on effects for parents and children.

Of course these broader environmental (housing, neighbourhood and social) factors, and the burden of the child's behaviour, are not the only causes of parental stress and anxieties. It is impossible to talk about barriers to successful intervention without mentioning the impact of parents' own backgrounds and mental health, intrapersonal factors which affect parenting capacity (Schrank et al., 2015). It has been argued these might be more effectively dealt with earlier in their children's lives (Doyle et al., 2007). However, the interest of this thesis is in how intervention could help children and families during the school years, particularly at primary school age. According to the qualitative analysis of parents' and practitioners' experiences, effective practitioners look at these issues and try to address them where necessary, alongside or perhaps even

before addressing parenting practices. Doing so, however, runs the risk of alienating parents who do not want to confront these issues.

Attachment theory predicts that those whose early attachment has been insecure will find it painful to process certain types of knowledge relating to personal relationships (Dykas & Cassidy, 2011). However, the 'attachment' literature has been criticised for pathologising children and condemning them to assumed irreversible developmental shortcomings if they missed out on crucial emotional attachment in early childhood (Keller, 2012). Other literatures, such as those on improving psychosocial environments to help those with less developed resilience, suggest that these developmental shortcomings can be compensated for later in life (Sonuga-Barke, 2010).

Following these families over several years showed the way in which some messages regarding parenting might need a lot of reinforcement. In addition, although there were great improvements in some areas of personal relationships and family functioning, the difficulties children faced in the wider world resulted in continuing struggles for all the children and parents in the study. Practitioners wanting to help parents consider adapting their own behaviour need to balance positivity and challenge carefully and help parents feel empowered to make changes in their lives; otherwise parents are unlikely to be able to implement change. How practitioners can do this effectively, and how, conversely, services may at times exacerbate families' difficulties rather than solving them, is discussed in Chapter 8.

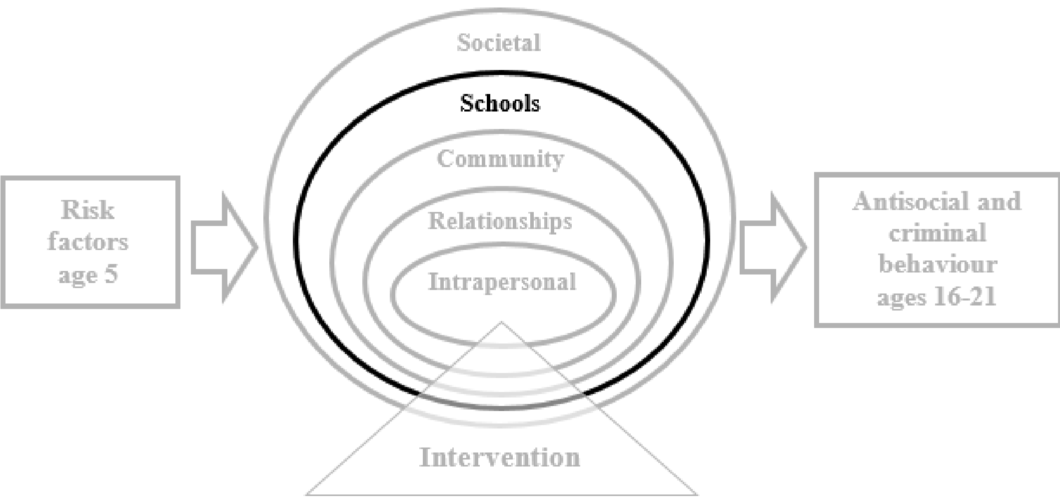
The future of these families is, of course, uncertain. The qualitative analysis suggests factors which may be important for children's behaviour in the longer term. There were appropriate data in the ALSPAC cohort study to allow examination of longer-term associations with antisocial and criminal behaviour for the following factors:

- Changes in parent-child relationships (reduced parental hostility)
- Changes in maternal mental health
- Mothers' feelings about the neighbourhood
- Mothers' social support
- Mothers' employment
- Constrained finances

These analyses are reported in Chapter 7. The next chapter, Chapter 6, covers themes connected with intervention aimed principally at the child, mainly through schools, the remaining level from the study's conceptual framework (Figure 1) at which children's trajectories may be influenced.

Chapter 6

Child and school



> It's all down to the school and things really. Once they're all at school and have a normal routine and be like a normal family, like the kids go to school… but when it's like this you're all over the place. *Linda, asked about hopes for the future*

This chapter discusses school-based factors which could affect children's trajectories towards or away from antisocial behaviour, as well as aspects of other non-school-based intervention delivered directly to the child. The themes presented here, as with the previous chapter, emerged from the qualitative analysis of interviews with parents, and with practitioners they nominated as helpful. The previous chapter discussed how changes in parenting can affect children's behaviour and how other factors in the neighbourhood and society more widely can influence both parents' and children's behaviour. Schools are the remaining sphere of influence from the conceptual framework (illustrated in Figure 1) and they loomed large in interviews as a source of both helpful intervention and possible harm.

The analysis of interviews focusses on what aspects of provision seem to be helpful, and what aspects seem to be unhelpful or potentially harmful. The analyses again address Research Question 1, but focussing primarily on children as the recipients of support: How do *children* benefit, or fail to benefit, from intervention? The chapter begins (section 6.1) by discussing a key theme arising from the qualitative analysis of the interview study data: the disjuncture between the balance of nurture and independence experienced at the end of primary school, and the contrasting expectations at secondary school. In section 6.2 themes about what seems to help and how problems arise are presented. The principal themes here are:

- getting the balance right between consistency and flexibility in the approach to discipline;
- the role of 'significant others' and relationships with non-familial adults;
- the importance of making communication between schools and parents useful, and not just an additional burden for parents;
- the role of schools in relation to other agencies working with the child; and
- addressing underlying reasons for children's disruptive behaviour, such as literacy deficits, which often go unidentified because of their behaviour.

The chapter's third section (6.3) discusses themes around school type, differences in school environments and why study children struggle in mainstream schools.

Table 6.1 shows the sources of data used in the qualitative analysis. Experiences with schools were a major topic in all twenty of the in-depth interviews with parents. Two of the children were present during interviews and commented on provision they received at school. Fourteen of the 23 nominated practitioners were based in schools, and all 14 were interviewed, with ten schools visited. Schools tended also to be a topic in interviews with non-school-based nominated practitioners. To maintain confidentiality, it has sometimes been necessary to omit pseudonyms from this chapter.

Table 6.1 Sources of data on school experiences

Source type	Institution	Number
Interviews with parents		20 (10x2)
Interviews with nominated practitioners:		
Teaching/learning support assistant	Mainstream primary school	2
Teaching/learning support assistant	Mainstream secondary school	1
Teacher & head of year	Mainstream secondary school	2
Vulnerable student and family support officer	Mainstream secondary school	1
Learning mentor	Mainstream secondary school	2
Teacher	Special secondary school	4
Headteacher	Special secondary school	1
Teaching/learning support assistant	Special secondary school	1
Total school-based practitioner interviews		14
Social worker	Children’s services	3
Family support	Children’s services	2
Family support	CAMHS	1
Psychiatrist	CAMHS	1
Total non-school-based practitioner interviews		7
Documentary data:		
Children with information on schools from other agencies pre-HFP	Children’s services	6
Families’ sets of HFP session notes	Institute of Psychiatry	11
School-completed Client Service Receipt Inventory from non-interviewed teachers	Schools	6
Teacher-completed Strengths and Difficulties Questionnaire	Schools	36

6.1 The difficult balance between nurturing children and promoting independence; problems with school support across transitions

> Oh the primary school were excellent, really, really good, they did a lot of work with Ben… they built him up, built up his friendships, 'cause he had a lot of problems with friendships, and I just feel like all the work that primary school have done, [secondary school] have undone. That's how I feel at the moment. *Nicole*

Study children's school histories are summarised in Table 6.2. While all the children were in mainstream primary schools at the time they were referred to HFP, by 2016 seven of the eleven study children were excluded or in some kind of special school. The secondary schools referred to here as special schools are either schools for children with social, emotional or behavioural difficulties, or pupil referral units (PRUs). The schools did not necessarily call themselves special schools, sometimes because of the associated stigma, and labelling of children. Nevertheless, it is an umbrella term widely used by government and local authorities (although recent government documents refer more broadly to 'alternative provision' (Department for Education, 2016a; Taylor, 2012)) and the term special schools will be used here.

Table 6.2 School history

Child (Parent)	Previous school type SEN Statement*	School type 2014	School type 2015	Summary
Shaun (Esther)	Mainstream primary No statement	Mainstream primaries	Mainstream primary- mainstream secondary	Moved primary school when fostered. The school found his foster parents very supportive but saw his desire to return to his birth family as a barrier to improvement. He was having trouble adjusting to the discipline at secondary.
Jamie (Linda)	Mainstream primary SEN statement	Part-time/shared primary schooling **EXCLUDED**[1]	Special school secondary following primary PRU	Excluded from primary in year 6 following an extreme behaviour incident seemingly mishandled by school. Multiagency effort to obtain statement allowed transfer to special small secondary which dealt closely with parents and CAMHS.
Tyler (Jenny)	Mainstream primary No statement	Mainstream primaries	Not known	Remained at supportive primary through care proceedings. 3 years later adopted in different city.
Joe (Donna)	**EXCLUDED** Primary PRU and mainstream primaries SEN statement	Part-time/shared secondary schooling	**EXCLUDED** Special secondary	Early exclusion & refusal. Mum banned from school for aggression. Good support from primary PRU, then mainstream primary. Refused to work in 1st year secondary, literacy problems not picked up until 2nd year. Hung out with trouble-makers. Period spent part-time mainstream and special, with mentor. Poor relationship between parent and mentor/school, but improved with new mentor and permanent move to special school Nurture Group. Considered vulnerable.
Ryan (Mary)	Primary PRU and mainstream primaries SEN statement	Move from mainstream secondary planned	**EXCLUDED** Special secondary	Early exclusion but great support from primary PRU and later mainstream primary with same TA at both; behaviour improved. Unable to focus in mainstream secondary environment, high anxiety & very poor behaviour, would only speak to one TA. Nurturing at special school suited his emotional needs but easily influenced by peers, prone to fighting. Lots of support including some one-to-one.
Michael (Kathleen)	Mainstream primary No statement	Mainstream secondary	**EXCLUDED**	Attended strict secondary, had several short-term exclusions at first but settled down and formed good relationships with a number of staff, no concerns over academic ability, following booster interventions. However, within a year, all key staff had left, behaviour had deteriorated and he was excluded at same time as traumatic exposure to local gang crime, no support from school. Took GCSEs outside mainstream.

Child (Parent)	Previous school type SEN Statement*	School type 2014	School type 2015	Summary
Aaron (Sue)	Mainstream primary SEN statement	**EXCLUDED** Special school secondary	Special secondary – poor attendance	Original concerns were all from home, none from primary school. But aspects of mainstream secondary were too challenging. Although he formed positive relationships with some adults, planned support was not put in place and he was excluded. Special school seemed even worse environment; destructive behaviour, school-parent battles. By last interview, exclusions & peer problems meant he was failing to complete vocational courses.
Palani (Bella)	Mainstream primaries No statement	Mainstream secondary	Mainstream secondary – just	Battles between mum and schools for more support. Turned down for SEN statement at primary. Good start at secondary with close mentoring programme, checking in at beginning and end of day. But ‘graduation’ from programme left him unsupported, behaviour deteriorated, faced many ‘internal exclusions’.
Ben (Nicole)	Mainstream primaries SEN statement	**EXCLUDED** Not in school	Special secondary – taught one-to-one	Highly nurtured at primary with permanent 1-to-1. Difficulty making friends. Primary put big effort into transition but sent to secondary where already had bad reputation, despite mum’s objections. Soon excluded. Eventually sent to special school where nearly all teaching was 1-to-1. Very backward in literacy & emotionally. He and mum (cooperative) keen for return to mainstream, but teacher did not think this was likely in near future.
Darius (Amana)	Mainstream primaries **EXCLUDED** SEN statement	Mainstream primary	Mainstream secondary	Very highly nurtured at primary, permanent 1-to-1 TA who’d borne very challenging behaviour. Statement for full-time support. Some weaning off in year 6; school and CAMHS put effort into transition and mum was supported over school choice. However, Darius had difficulty adjusting to secondary regime, constantly in trouble for ADHD-related behaviours. Inappropriate punishments and rewards. Planned support not put in place.
Harriet (Paula)	Mainstream primary SEN statement	Mainstream primary	Mainstream primary– special secondary **EXCLUDED**	Transfer straight to special school because of learning difficulties. Elder sister fitted study type better. Very troublesome and attention-seeking at mainstream, difficulty with peers, eventually excluded and sent to special school where she was managing much better.

* Special Educational Needs (SEN) statement (or not) by final follow-up.
[1] For simplicity the term Excluded is used throughout, however not all were official exclusions as they could in some cases be managed transitions to different educational provision without a period out of education.
PRU: Pupil Referral Unit; CAMHS: Child and Adolescent Mental Health Services

It emerged that some children were being intensively supported and nurtured in their primary schools (Ben, Darius, Ryan, also Tyler — according to the school's report). But often they had not been, according to available accounts (sometimes including the same children at previous schools). Several children (Ryan, Ben, Darius, Joe, Jamie) had moved out of primary schools which could not or would not, according to parents, cope with their behaviour, but had eventually arrived at a primary school, whether special or mainstream, where they had been highly nurtured.

Nurturing took the form of adults getting to know the child well, the child being given a lot of attention, tailored support to help them manage their behaviour, and adapted behaviour expectations, such as being allowed time out of class if they felt they were about to lose their temper. Five of the children had a one-to-one teaching assistant (TA) with them all the time at primary school. Even when attempts were made to reduce children's dependence on the TA in the final year of primary school, moving towards being 'on call' rather than always there, they were generally available. As Darius's TA pointed out: 'I am never far off for him to come and find me'.

Donna regretted that her son had not been able to stay in the one school that she felt had really suited him, a primary pupil referral unit (PRU):

> It's a shame he couldn't stay until he was 16. I reckon that would have made a hell of a lot of difference. He wouldn't have been up, down, up, down, up, down. *Donna*

A move to mainstream secondary school, then, generally meant a switch from a highly nurturing environment to one much less likely to have any emphasis given to personal relationships, and this was challenging for the study children. One school inclusion officer felt that much more 'scaffolding' was required for children with behaviour problems arriving at mainstream secondary school, coupled with a bigger effort to wean them off intensive nurturing in the final years of primary school. This summarises a tension between the need for nurturing support, and a desire for the child to become more independent — a desire from schools but also sometimes from the child and/or the parent. Sometimes, for example, children with a statement of special educational needs would be accompanied by a TA for the first couple of weeks at a new school to help ease the transition. However, children did not necessarily want this support, especially in a mainstream secondary school setting, because of the stigma attached.

Where children had intensive support at primary school it was funded through their statement of special educational needs (SEN). Seven of the study children had statements by the end of the study, three did not, and one appeared not to as far as could be ascertained (see Table 6.2). It appeared that those children who had difficult behaviour but were achieving academic results within the expected range would not be given statements, which was the case for Palani, Michael and Shaun. One senior leader said:

> The criteria's so strict now, that for a statement … you'd have to have evidence that despite everything you're doing, the child isn't making progress. And that would simply not be true in [his] case. *Mainstream deputy head*

Whether they had a SEN statement or not, the children tended not to have a TA assigned specifically to them once they had made the transition to secondary school. While some secondary school staff felt that the children should have got beyond needing such support before leaving primary school, one respondent acknowledged there was probably some unmet need for one-to-one support. From two practitioners' points of view, children's SEN statements included funding for this support, but the funds were not being released for this use. Another reported:

> I tried to arrange a meeting quite early in to try and help to ensure they were … pre-empting any problems … But they were kind of saying, oh well, we've not got any extra support for [him] because he needs to … learn to manage himself… You know, that's all very well, but he can't do that! *CAMHS practitioner*

In some cases, such support had been promised but did not materialise, while in others school policy did not support the use of one-to-one TA-pupil relationships. Reasons given included: that class teachers could provide the necessary 'differentiated' input, that is, altering the treatment and materials given to pupils according to their need; evidence of ineffectiveness of TA involvement, although the evidence seemed to relate to academic learning rather than behaviour, and was a consequence of reduced attention from a trained teacher (e.g. Blatchford et al., 2011); and the risk of stigma and of dependency, creating problems when that TA left, or had a day off. To counteract this, one special school instead advocated developing good relationships more widely.

A repeated theme from both parents and practitioners was that becoming more independent at mainstream secondary school meant, counter-intuitively perhaps, conforming to the same rules and behaviour as everyone else. While the move to secondary school means big changes for all children as they work out how to get to different classes, pack the right books and equipment, follow new school rules et cetera, it is particularly challenging for children who had higher levels of additional support, and more flexible behaviour expectations, at primary school:

> It's so big, the regime is completely different. They're not encouraged to think for themselves because a big mainstream can't. They don't know the child… You have a strategy in primary that worked quite well for them, actually. They're now coming to secondary, and secondary aren't able to manage that strategy, just because of the way it's made up. *Special school headteacher*

Where nurturing primary schools encouraged children to recognise their own stress points and develop their own strategies for self-regulation, mainstream secondary schools did not permit such flexibility:

> In my primary I was taught to, when I was getting angry, I would just run, run out the class… just go away from them and just calm down, but it's different in [secondary school], 'cause I do that and I get excluded. *Ben*

Ryan, Joe and Aaron were all removed from their mainstream secondary schools to small Nurture Groups in special schools where they were taught mainly in the same class and by a small group of teachers who knew them well. There were great concerns about their move to a provision for older children, given their difficult histories of many school changes:

> Massive anxiety about that, massive…from them, because change, any transitions are difficult…We're taking them up there for little taster lessons… but the anxiety levels are very, very, very high. *Special school teacher*

Practitioners agreed that experiences that children interpreted as failure were damaging and in some cases could be avoided by a transition straight to a special school, as happened in Jamie's case, when it was clear that a child was not going to manage in a mainstream secondary school environment.

> The sad thing is that this system causes a child to have many educational interventions and moves before I get them. So by the time I meet them they could be disadvantaged and totally unmotivated and turned off by education so we have a hard job turning the tide. A child displaying problems in year 7 can take years to get to me…It is short-sighted really because if they were in

> the correct educational setting then they would be able to work within the system and move forward. As it is if they drop out of education what hope is there? *Special school headteacher*

The transition to secondary school can be a challenging time for any child, but in this section we have seen the particular problems facing children with difficult behaviour, who may have already faced several changes of school until they found an institution prepared to accommodate them. Having eventually found nurturing support at primary made the contrast with secondary school all the greater. In the next section (6.2) further themes are presented which help explain what can help children and what goes wrong, while in section 6.3 the question of when a special school may be the best option is addressed.

6.2 Some explanations of what helps and what goes wrong

This section develops some of the themes referred to above and looks at how problems occur and what can help children with difficult behaviour manage at school.

6.2.1 Getting the right balance between consistency and flexibility in approach to discipline

There were big differences between schools attended by study children in approaches to discipline. The analysis suggested the dilemma over how to approach discipline can be summarised as how to balance flexibility and consistency. Primary school classes are taught mainly by one teacher, and schools are small enough for all staff to know what expectations to have of a particular pupil's behaviour. At large mainstream secondary schools it is more difficult to provide a tailored balance of consistency and flexibility. In some cases agreed strategies about how to treat certain individual children will be recorded, but may not be in the forefront of all teachers' minds, given the number of children they teach, and the turnover in teachers. One TA described her battles with other staff on a study child's behalf:

> I make people see the fact that yeah, he's just thrown a chair across the classroom, yeah, he's hit another student, but to get to that point there hasn't been support in his class for one; other kids were taunting him for two; and the classroom teacher didn't deal with it how she is supposed to and give him the time out which is set in place, so therefore, you can't exclude him for that when none of this has been in place. *Teaching Assistant*

In some mainstream schools time constraints mean there is very little in the way of pastoral contact. One learning mentor described how the school's regular life did not

allow space for one-to-one talks between children and teachers. Even form time was structured, and there was very little play time, a deliberate behaviour-control policy according to the learning mentor. Although Aaron, for example, had formed good relationships with individual adults, contact was not consistent enough for this to provide a buffer against the difficulties of dealing with the school environment.

Palani's learning mentor seemed to have a system that directly dealt with this lack of pastoral support. She saw children on her mentoring scheme (which included Palani) at the beginning and end of each school day, and, according to both her own and Palani's mother's accounts, was providing a level of consistency and nurture higher than most mentors who could only see children once per week. The system allowed children to build a relationship with someone who could be aware of their difficulties and treat them fairly and with understanding. She talked to her mentees, found out which subjects they struggled with and devised strategies to deal with their difficulties. Seating plans were key to this, to aid concentration, and she sat in on classes and gave teachers tips on how to deal with the child. However, once the children on her programme had met their goals they no longer received her support. This is the dilemma of 'reform': Palani 'graduated' from the programme within 8 weeks. He then suffered from losing the structure and consistency it had provided, his behaviour rapidly deteriorating. In one special secondary school they did use the same teacher all the time for the Nurture Group, but this practice had recently ended at Aaron's special school, despite the teacher's strong objections and warnings.

In at least five cases, appropriate plans seemed to have been made, but not implemented, or at least not implemented in time to avoid exclusions:

> He was meant to have a mentor in every class. Oh she'd turn up sick, or they didn't have one, or they couldn't get one, you know? It was like excuse after excuse. I said, 'Okay, I know schools are funded and all that. But if you're taking on a child and you see they've got these needs, why did you take them? Because if I had known that was going to happen, I would have put him in a different school'. *Sue*

In Ben's case there had been an attempt to link him with a mentor and a TA but a combination of circumstances — timetable changes, Ben's difficulty taking responsibility for his timetable, family crisis leading to absence and then Ben being put on a reduced timetable — led to insufficient mentoring support. His permanent

exclusion followed soon after. One school staff member said that out of at least thirty children who were supposed to have one-to-one support at the school, only six had had it. Sometimes, then, planned support for children was insufficient, while at other times planned support was not put in place.

Appropriate rewards and consequences

The special schools saw the importance of children being able to put misdeeds behind them and see every day as a fresh start. Linda compared Jamie's school's ethos to mainstream thus:

> If Jamie was to get into trouble today, if he was in a mainstream school, the next day, you know, your punishment carries on. At this school, they're always: 'every day's a new day'. *Linda*

Schools' approaches to rewards and sanctions were sometimes cumbersome or ill-thought-through. Punishments, even exclusion, could be threatened and then not decided on for weeks. The inflexible behaviour system at Michael's mainstream school added up 'behaviour points' throughout the year until you reached enough to have a suspension from school. A psychiatrist explained the need for swift and appropriate consequences for children to see the link with the misdemeanour and to avoid anxiety. Behaviour goals given to a study child were not sufficiently specific:

> It was just things like, 'I need to behave well in class at all times' or something like that, it was really vague. *CAMHS Psychiatrist*

And rewards were too hard to get:

> Bless him, he was trying with his reward chart, going round, and he wasn't getting any rewards, like for weeks. They were kind of saying…oh, not quite – not quite enough to get the reward. And I was like, no, that's not how you do a reward – you need immediate rewards. So then, at the next meeting we had, they were saying, the reward chart's not working! *CAMHS Psychiatrist*

Eventually the psychiatrist sent a trainee educational psychologist into the school to support the appropriate implementation of a reward system. Other children had faced similar difficulties in terms of receiving little positive feedback and committing minor misdeeds that led to constant punishments.

<u>Dealing with disruptive behaviour; symptoms of ADHD</u>

Six out of the ten children in this study had a diagnosis of ADHD. Expected standards of behaviour at mainstream secondary schools were not compatible with symptoms of ADHD:

> So he was first of all getting told off for things like not sitting still, not focussing, and it's like, well, these are all ADHD symptoms, and I mean, that's very frustrating. *CAMHS Psychiatrist*

> Some of the behaviours is a part of him, fidgeting, can't stay still, that's him... so why are you phoning me up for that? *Palani's mother Bella*

Parents and practitioners felt that getting reprimanded for this low-level disruptive behaviour could be the beginning of a downward trend in terms of children's behaviour. However, school staff also described these behaviours as just the sort of low-level disruption that makes it difficult to teach, and distracts pupils, including those like Ryan and Darius, who both engaged in, and suffered from, these behaviours.

> It's constant talking, constant throwing things across the classroom, disrupting others, talking over the teacher, being rude – stuff like that – it's just, it's unbearable sometimes. *Teaching Assistant*

Some primary and special schools provided a high degree of flexibility to combat these problems; sometimes, for example, allowing children to choose which lessons they went to, or where they worked, although not all school staff supported that approach. Ryan's TA had taken it upon herself to provide such flexibility within a mainstream school as the only way of helping him:

> Now I have him downstairs one-to-one we do reading, basic English, talk about life in general, just give him a bit of time to vent… Sometimes we do a bit of work – depending on his mood – sometimes we don't! *Teaching Assistant*

She criticised classroom teachers who showed insufficient flexibility:

> Yeah, they know him, but they're just so set in their ways that kids should all be reformed in the same way – all kids should be treated the same – which doesn't work. *Teaching Assistant*

Yet many of the practitioners providing flexibility also stressed the need for consistency from school staff, commenting on the importance of being firm and consistent with rules and expectations so that children knew what to expect and what the consequences

would be; this helped them to be able to take responsibility for their behaviour. For example, although most schools at least in theory had a no (play-)fighting policy, one of the special schools tolerated fighting to a high degree as confirmed by both a child's mother and teachers at the school:

> There's no boundaries at all… and I'm going to leave because of it …this school is not safe, it's not even safe for the children. *Special school teacher*

Another staff member interviewed explained that the study child was encouraged to join in the play-fighting as this might gain him more respect with peers because he was a good fighter. But the child found it difficult to understand the boundary between play and aggression. When a new headteacher started to try to assert more discipline, the child found his fighting classified as 'bullying' and was excluded from school several times, as well as being reported to police for violence against property. The lack of consistency was very difficult for this child.

Several of the children had periods of segregation where they were taken out of classes and taught one-to-one for hours, days or weeks, to enable them to catch up, or when they had difficulty focussing in the class environment. This was often interpreted as a punishment by parents and children. Sometimes they were excluded from class, or from school, explicitly as a punishment. Temporary exclusions, given to most of the children at some point, seemed a problematic approach. It could lead to increasingly negative sentiments towards school, the feeling that 'if they don't want me, I don't want them either'. It also meant the children fell even further behind with learning or missed out on other interventions.

There is, then, a tension playing out between consistency and flexibility towards children's behaviour. Having consistent expectations is a key theme in both parenting advice and school behaviour policy. However, it may also be necessary to allow flexibility in some rules to cater for individuals' particular needs; a combination of flexibility of approach and consistency of expectation for the individual might prove most beneficial.

6.2.2 'Significant others': enabling supportive relationships with non-familial adults

Previous discussion about the balance between nurture and independence (section 6.1) has shown that the value of a one-to-one TA is under debate, but there seems to be some evidence from this study that making a connection with an adult at school could be protective, as long as the relationship continues. Characteristics of successful child-practitioner relationships are discussed below.

Being non-judgemental

For these children, it could be quite new for them not to be immediately judged as in the wrong:

> When he realised that he wasn't getting into blame with everything within that year group that was happening in the classroom and that there was somebody there that was sort of defending him, or sometimes other boys did start it, it wasn't always him. And I was able to sort of say, 'Well no, this is what happened in this situation'. *Primary school TA*

A learning mentor said she made a particular effort not to judge children on their past, and the labels that had been associated with them previously:

> I don't even read their files because I say to the kids, I don't know anything about you. Anything I know, you will tell me. So, I think that there were times when I possibly knew more than the file said because they actually – they've told me everything…I've got no misconceptions of them then. *Mainstream secondary mentor*

In her role, as mentor to over seventy children, it was not possible to take a lot of time to build up relationships; she had to be able to do this immediately.

Beyond the call of duty

Several practitioners were described as going beyond the call of duty to keep a relationship going, sometimes after official intervention had ceased. Linda's son Jamie still had the mobile number of a mentor who used to take him on outings and Jamie called him every now and then to chat. Ryan's TA at school described the efforts she had made trying different approaches to engage Ryan in learning, even when not supported by the school and its systems. She had daily discussions with his grandmother and often called Ryan in the mornings to speak to him and encourage him to come to school, even though this was not technically part of her role. In one family a SEN teacher took the children on outings in her own time, at her own initiative and expense,

as she felt that what the children really lacked was opportunities and experiences. However, on my second visit to this family it was specifically this ‘going beyond the call of duty’ that the mother found suspicious: ‘very much on the grey areas of stalking, that’s what the solicitor said’. The practitioner had now become someone the family blamed for their continued involvement with social services.

The implication of this theme – going beyond the call of duty – is that services’ role descriptions are not adequate for the work actually being done. One full-time TA suffered physically and emotionally during her years supporting a study child and, initially at least, did not feel well supported at work:

> I felt like everybody was going ‘Ooohhh – rather you than me! Ooohhh – I heard you today! Oooohhh – I saw you running today!’ So it was always them and me, and everybody – ‘good luck with that one!’, and I’m thinking, I don’t need good luck – I need support! *Primary school TA*

She often spent weekends crying, and nursing bruises, but she was committed to supporting the child, putting off applying for better-paid roles while he remained at the school. Eventually she did get more support and had counselling for over a year (in unpaid after-school time) with a school CAMHS therapist which at least allowed her to talk about the situation. Her persistence with a child who no one else would work with seemed to be worthwhile in terms of his improved behaviour and aspirations, as well as improved relations between school and home.

Making a connection and having someone to turn to: mentoring in and out of school

> It’s not in the job description but you’re working with kids and they’re not animals at the end of the day – you’ve got to make a personal connection otherwise they’re not gonna give anything for you. *Ryan’s TA*

It was very helpful when children made a connection with a sympathetic adult who liked the child. This happened often, and in primary school could be a relationship that was maintained until the end of school (for Darius, Ben, Tyler) but when it happened at secondary school, although it was a potentially helpful factor, possibly crucial, it was more difficult for the relationship to be maintained, either because of staff leaving (Michael, Aaron) or because of the school’s systems (Palani, Ben) or because the child was excluded (Aaron, Ben, Ryan). When Michael was doing well at school he had

people he could talk to, even a receptionist, who could talk to him and help him calm down. Key seemed to be having someone to turn to when the child felt troubled:

> So in years 5 and 6 someone else would have watched him at lunch time and play time, but I always had one eye, and he would quite naturally come to me and say, 'That person, I swear to God, I'm going to blow up'. *Ben's primary school TA*

Making a connection with a particular teacher could also be inspiring. One child had left primary school with literacy levels typical of a child several years younger:

> He really, really disliked English, with a passion. Anything to do with reading, writing, anything like that, he hated every minute of it. He would hide under the table. He would do anything rather than do it. And I think the thing that's actually made a difference is the fact that he's got a good relationship with people in the school. So it just happened that he really, really likes the man that teaches English. *Special school headteacher*

Tyler's primary school reported having provided a whole team of people who Tyler had come to trust. While he no longer received regular one-to-one support in year 4, he had people he could go to for help and additional support was provided when he was 'going through a difficult patch', particularly a learning mentor who was credited with having been important for Tyler and was available when he 'needed to talk through issues'.

> Tyler really trusted our team and it gave him an outlet to turn to. *Deputy headteacher*

Children also made connections with professionals outside school. Five of the children had mentors outside school at least at one interview point; often this was someone specifically assigned due to a perceived need for a male role model.

> They used to go to the park to play football, they'd play golf, swimming, he absolutely loved it, y'know, he used to count down the days until Paul would see him next, he used to take him out driving in his car and, oh they had a brilliant bond them two. *Linda*

This child had been described by a practitioner as particularly hard to engage with but the mentor too had commented positively on their relationship, showing that Jamie was capable of making connections with adults. Prior to HFP, children's services had identified Michael's need 'to gain trust with a healthy adult male role model', following exposure to his father's violence towards his mother, and his own anger issues. Michael's delight at the idea had been noted, a volunteer mentor had been introduced

and the relationship had been very successful, still going strong at the time of the first follow-up interview three years later. Kathleen described their friendship:

> They go places, they go museums, cinema… just to walk around and they talk sometimes things about life, he sometimes advises Michael, how life is, how he should be, how he should work, how he should behave, respect me (laughs)…when he comes, yeah, we always talk and if Michael's not behaving quite good I always call him and say oh you need to talk to Michael, this and that's happening, [he says,] 'I'll have a word with Michael, just a tiny word to tell him how life is'. *Kathleen*

However, by the final follow-up when things had started to go wrong for Michael, he was no longer seeing the mentor. Kathleen suggested Michael felt too old for the relationship, and stopped meeting him, although the mentor continued to show an interest. Kathleen thought that Michael was ashamed of his recent behaviour and did not want to have to confront this man with his shame.

Michael and Aaron had both also developed important relationships with sports coaches outside school. Both provided a degree of support to the parent as well as the child. However, Michael had stopped going to the club where he had contact with the coach, at the same time as ending his relationship with the supportive mentor, and losing supportive school staff who left the school. Aaron's local relationship remained very strong however, to the extent that Sue would now not contemplate moving, explaining the man's importance in Aaron's life:

> He's got time for Aaron, he talks to Aaron … he knows when Aaron's upset, when Aaron's not upset …the bloke's nice, he's sort of like a father figure for Aaron…Yeah, it helps Aaron, he's been better, if he had [the club] everywhere he'd be alright. *Sue*

Good mentors, who have the right sort of background and local knowledge and experience to be useful to a young person, are hard to come by. It is easy to imagine the frustration of Michael's social worker when he rejected a series of new mentors offered. Unfortunately, we do not know Michael's explanations for rejecting the workers he met, but the social worker suggested they may have been too 'posh' for him to relate to:

> Not a professional who is formal – the one who is going to talk a bit of street language with him, but, you know, raising safety concerns – that's the one we want…Who knows the real street language which would be at his level, that's how we can get him involved. *Social worker*

Listening to children, as with parents, was a way to gain their trust:

> The main thing is building trust within that relationship. And once you know, a young person trusts you, then you can almost get them to do anything. And I think just through listening to them, whereas most people 'Oh don't worry, everything will be okay'. I was always, 'Okay, so how did that happen, why?' So it was a lot more active listening. *Teaching Assistant*

There are, of course, potential negative effects of dependency in having a person in this role, particularly because of the vanishing support when they leave, as all three school staff members Michael had got on well with did. Michael's brother had had a mentor who left suddenly without saying goodbye and the male mentor assigned to Darius failed to turn up. Both parents and practitioners felt this could be harmful for a child. Changing personnel can be damaging for children, as well as for parents, who have been disappointed by adults many times, as one special school teacher acknowledged when telling me she was planning to leave: 'I hate leaving because I don't think it will do them good'.

6.2.3 Communication between parents and school can be problematic

Communication was often mentioned in interviews. Many schools said they worked hard to encourage close relationships with parents, and to give positive feedback. Parents reported sometimes being called every day. Part of the aim of this communication appeared to be a) to get parents to support the work being done by the school and b) to get parents to reinforce discipline with repercussions (sanctions/admonishment or praise) at home. For example, 'if you carry on behaving like this I will call home' may be used as a warning of a consequence which then has to be followed through by calling home.

However, several parents complained about constant phone calls from schools. Donna described her response when she was called by Joe's special school about his behaviour:

> 'Well, *you* have to deal with it. I'm not being funny. *I* have to deal with it [at home]. That's what all your teachers in there are meant to be trained, so why are you ringing me?' And then I get stressed. You know what I mean? *Donna*

The one institution Donna was very positive about was the primary PRU; she said that by contrast they never used to telephone her. Instead they invited parents to school once a week to take part in activities. However, at the first follow-up interview Donna had wanted *more* communication from the mainstream secondary, saying she needed the

school to keep her informed so that when he had misbehaved she could implement consequences at home. Although Donna was belligerent and would tend to start by taking Joe's side, she would, the school agreed, eventually back up their disciplining once she was persuaded that Joe was in the wrong.

Bella was infuriated by constant calls from Palani's mainstream secondary school throughout the day and the staff's apparent lack of internal communication. She felt teachers were not being informed about Palani's behaviour and needs and were pointlessly calling her as a punishment to him for every misdemeanour:

> You said you could handle him, and you could support him, but obviously not because the teachers that are calling me, they're not even aware that he even has ADHD, so you're not making anybody aware, your communication skills are poor… The Head is telling me one thing but when all the teachers are calling me they're telling me a whole different thing. *Bella*

During HFP Amana had imagined a future where their problems were sorted out; a key indication of a successful outcome, she felt, was that there would be no telephone calls from school. Secondary school had not started well in this regard and Darius's CAMHS worker felt something was really wrong in the way the school saw the child and the way they communicated with Amana about him. She was shocked to hear him described to his mother as 'the rudest child I've ever met'.

Although argumentative parents could be difficult for schools to communicate with, both Bella and Nicole were complimented (by practitioners in research interviews) on their efforts to support their child. Another mother, however, who could, like Bella, be very belligerent in school meetings, was felt by teachers to not have a very strong feeling about the importance of education – and certainly not that she had any responsibility for it. Conversely Darius's progress at primary school seemed to have benefitted from enhanced communication between mother and TA by way of a diary where they could inform each other about what had happened that day, or the night before.

Two parents, Amana and Bella, had had support from advocacy organisations which had helped them negotiate with local authorities and schools regarding their child's special needs and school. In Amana's case they had also helped her to query the type of

support being given to Darius and whether it was consistent with his statement of needs. In their two cases, the contact with the advocacy organisation seemed to be empowering. They helped the mothers work out what questions they needed to ask, but the mother would ask the questions herself. Parents were often intimidated by school meetings, and practitioners from other services, including CAMHS and HFP, had attended meetings with parents to support them.

As we have seen, the way parents communicate with schools, and vice versa, was not always effective. Sue, for example, described her contact with the special school thus:

> I just go in for meetings to have another go at them. And have an argument. That's all I go in for. *Sue*

An advocacy role, supporting parents in their communication with schools, seemed a promising intervention area.

6.2.4 Schools as coordinators of support for children and multiagency working

Both mainstream and special schools were involved with multiple agencies, including social services, CAMHS, police and youth justice services. One special school regularly provided help to families with health, housing, neighbourhood support, summer holidays, issues in their wider family, as well as the health, psychological and behavioural interventions directly received by the child. They were in contact with siblings' schools and with family friends. The headteacher said she found it helpful to know as much as possible about what was going on with families:

> So basically what I see the role of the school as …is it's like with a wheel, you're like the hub in the wheel. So your job is to hold all the spokes together, so that…you know everything about that child. You know their medication, you know whether they're involved with CAMHS, with the YOT, speech and language, you know, all that stuff as well as the family. And you know what the home situation is. You know that they're sleeping on the floor because there's not enough room. You know that they're coming in because, you know, they weren't going to bed when mum tells them because they were up playing. You know that they're too frightened to turn their mobile off at night because somebody could phone them, so they take it to bed with them. You know all these things… And because you know everything about that child, you're able then to put a wrap-around package. Now that wrap-around package works for us and it should work [elsewhere], there should be something out there that does it. *Special school headteacher*

The independent status of this school gave them a lot of leverage to get the right support in place, and to accept only children who would fit their school. The headteacher said the school could make their offer of a place conditional on the local authority providing other services they felt were needed, such as CAMHS or youth offending services. They could also refuse to take children where the family were not prepared to engage with wider services.

Within mainstream schools, primary schools were more likely than secondaries to be aware of the wider challenges families were facing, especially if there was a single worker with responsibility for a child. There has been a move since the 1990s and the Every Child Matters initiative, to improve multiagency working (Cheminais, 2008), and recent policy changes provide further encouragement through Education, Health and Care (EHC) plans. These allocate children a named person to take responsibility for multiagency coordination, and see the child through to age 25 (Spivack et al., 2014). The headteacher quoted above discussed whether these changes were likely to provide the intensive oversight she felt was needed:

> It also will have a named person, which is good. Now whether or not that named person will be able to know what we would know, and to have the time and the expertise and also the will to want to do that. Because … it is a 24/7 job. *Special school headteacher*

Although not a formal part of her role, one CAMHS psychiatrist took a good deal of responsibility for coordinating intervention from other agencies including schools:

> Somebody might say, well why does it need a psychiatrist to do this? But actually, you know… when I kind of have a bit of authority people do sort of – sometimes they listen, sometimes they misquote me, but they will listen. But you know, I also feel that I have a good overview of his case and what his needs are. *CAMHS psychiatrist*

However, the two examples above were unusual. When families were involved with child safeguarding services there was a degree of coordination between services, but once the child was no longer designated Child in Need such coordination was unlikely.

6.2.5 Addressing underlying reasons for children's disruptive behaviour at school

Literacy problems were suggested as a contributing factor to poor behaviour at school in several cases and at least 8 of the study children had poor literacy skills. Previous

research has found that 59% of children with conduct disorders (age 5–10) were behind with their schooling, and 36% were at least two years behind (Green et al., 2005). Several practitioners referred to the benefits, including for children's behaviour, of specialised literacy programmes. However, there could be delays in recognising these difficulties and one secondary school learning mentor said she sometimes had children sent to her for misbehaviour in class who she discovered were unable to read but nobody had noticed.

These difficulties were also often coupled with a reluctance to ask for help as one teacher explained:

> He has a real issue with asking for help, or if you give him help he really sees that as a dent on his sort of persona. *Special school teacher*

But targeted school intervention to address these difficulties had been credited with success in improving both literacy *and* behaviour in at least two cases, Michael's and Tyler's.

Underlying emotional and psychological issues for the child were often something that services realised needed to be addressed, hence the heavy involvement of CAMHS. But a counselling-type role was often taken on by staff such as TAs. Sue, Nicole and Paula had all sought counselling for their children, feeling underlying issues had not been addressed.

While Michael and Ben had some good social skills in certain situations, other study children did not. One child who had been able to deal with his primary school environment found it difficult to communicate effectively when he arrived at secondary school, and responded instead with anger:

> When he was angry with somebody, he didn't know how to say, 'Do you know what, I'm angry with you'. His first thing would just be obscenities, that'd be it. Because he never, you could see he hadn't been taught it. You know what schools are like, you have this banter and jokes here and jokes there, and he couldn't deal with that. *Teaching Assistant*

Aaron, Ryan and Darius all seemed to misread other people, while Ben's peer relationships suffered because he always wanted to assert his dominance. Several of the children had received therapeutic interventions including art, music and even equine

therapy. Practitioners and parents were usually positive about these interventions. A special school teacher explained how equine therapy helped the children learn to read the horses' emotions and relate them to their own feelings and reactions:

> I think it was really brilliant for them ... they have to do tasks with the horses and they keep, all their fears and anxieties, they kind of see them in the horses… then the therapist will say, 'Do you think that might be, do you do anything like that?' And they sort of, 'Yeah, that's how I am, yeah that's me'. *Special school teacher*

Mentors could also be tasked with helping children work out appropriate responses:

> It's very, very, very useful for them. For that sort of student, that they need someone to let all this stuff out and explore it and work it out. Especially for [this child], he needs people reassuring him that that's, you know, how it is, or that's how it is. He can't work it out by himself… And even to go through with him, you know, when he said he wants to fight someone or something like that, they can go through with him and eventually get to the point where they can de-escalate him. Where he's not thinking clearly or perhaps not thinking at all. He's like reactory, he's just reacting to it. They can try and take him to that, you know, why he shouldn't do that. *Special school teacher*

Several of these services were likely to be lost when impending budget cuts came into force the following year. I asked what the impact was likely to be:

> It's giving him less opportunities, isn't it, less life choices. Because the easy path would be to go into the gang culture and be part of all that. *Special school teacher*

Table 6.3 shows the families for whom some of the themes covered in this section appeared in interviews. The section began by showing the importance of balancing consistency and flexibility, and appropriate rewards and consequences, in managing the difficult behaviour of children in schools. The quality of relationships with individual practitioners is again shown to be key, as well as schools' communication and coordination with both parents and other services. The difficulty of providing consistency of relationships and approach in certain environments such as mainstream secondary schools is apparent. The children had all had school experiences that could be interpreted as failing, and this was felt to be damaging to their self-image and future prospects. The final section of this chapter looks further at when and why mainstream schools might not meet these children's needs appropriately.

Table 6.3 Summary of selected school themes, factors which may help effective intervention with children

	Negotiating school's approach to disciplining child	**Child has 'significant other' relationship with adult**	**Communication from school**	**Received art, music, drama or equine therapy**	**Literacy difficulties?**
Esther & Shaun		Foster carers		Art therapy at primary, considered very helpful by school; Drama at secondary	Yes
Linda & Jamie	Disputes not mentioned until exclusion	Community mentor (ceased but occasional phone contact)	Period of positive daily communication at primary; 3x per week contact at special secondary, appreciated		Yes. Linked to behaviour.
Jenny & Tyler		Learning mentor at school			Yes. Literacy intervention linked to improved behaviour.
Donna & Joe	Many disputes. Takes Joe’s side until school can explain.	None mentioned	Requested daily update from TA but complains of too many other phone calls (special school; previously complained of too few at mainstream)	Music therapy (referred by primary, but outside); equine therapy	Yes. Behaviour disguised literacy problems, dyslexia noted in year 8. Given intervention.
Mary & Ryan	Good relations with school; Leaves sanctions to school	Mentor via school but outside school	Daily contact at mainstream and special school — appreciated		Yes, given intervention
Kathleen & Michael	No disputes, until exclusion	Volunteer mentor, non-school, 4 years	Calls generally about poor behaviour, appreciated		Yes, intervention had 'massive impact' on behaviour in class

	Negotiating school's approach to disciplining child	**Child has 'significant other' relationship with adult**	**Communication from school**	**Received art, music, drama or equine therapy**	**Literacy difficulties?**
Sue & Aaron	Many disputes. Feels school is inconsistent	Local sports coach, important relationship	At first follow-up special school teacher phoned giving both good and bad feedback, at second follow-up mainly bad	Art therapy, CAMHS; art therapy at special secondary	None mentioned
Bella & Palani	Supports school only if she agrees; often objects to sanctions	Learning mentor at school, but short-term	Constant calls complaining about child, considered harassment by Bella	Art therapy, CAMHS, helped with communication	Yes at primary but improved
Nicole & Ben	Conflicting reports; by final follow-up Nicole is supportive	TA at primary, one-to-one teacher at secondary	Daily contact at current special school, appreciated	Art one-to-one sessions, therapeutic if not actual therapy	Yes, tries to hide it with bad behaviour, says mum. Dyslexia
Amana & Darius	Backed up primary school, but TA thinks sometimes too harsh. Secondary school too intolerant.	TA at primary, important relationship	Frequent contact at primary, diary or in person; frequent negative contact on starting secondary, then insufficient		No, academically average
Paula & Harriet	Thinks school too soft on children	None mentioned	Very little contact		Yes, receiving intervention

TA: Teaching Assistant

6.3 When might a special school offer a better approach than mainstream school?

The sections above have referred to aspects of mainstream schools, particularly mainstream secondary schools, that did not fit well with study children's behaviour, meaning they were constantly being told off, and were treated inconsistently due to the many different staff involved. While this study is not designed to be able to say whether special schools are more appropriate environments for these children, aspects of environments which appeared beneficial or harmful are further discussed below. All the study parents were initially opposed to the idea of a move from mainstream education.

6.3.1 Parents' reluctance to move children to a special school

Six parents, all those with whom the issue was discussed, were fearful of their child moving to a special unit. Of those who had moved, two (Sue and Nicole) wanted their child to return to mainstream while four felt the special school was the right place, and Nicole was also positive that the special school was doing a good job as an interim measure. However, parents in the study always began by wanting their child to remain in mainstream school. They were worried about negative influences from peers at special schools.

> My experience of pupil referral units and the children that go there are quite bad, and I'm just worried about what Ben's going to be mixed with. *Nicole*

> All he's got is ADHD and a few learning difficulties – but because of the cutbacks, they have to throw 'em all in with all the rough lot, and I think it's terr – I go mad up there. *Donna*

Linda also worried about how her son would be treated by staff:

> I did a bit of background research about it. It's not appropriate for Jamie, they are trained to restrain children, in the school, which I've never had to do with Jamie …. I'm not sending him to a school that's able to restrain him if he wanders, you know, I'm not signing up for that. *Linda*

Parents who saw their child as needing help, and saw a pupil referral unit as a dumping ground for excluded kids, were keen to avoid this. But once they had experienced the different environment, and the different way the children were treated at a special school, they often changed their mind:

> They didn’t do the right thing with him [in the mainstream primary], if you understand what I mean, instead of being calm with him, and everything else, then maybe it would’ve helped him a little bit, I don’t know. And then [school] suggested him going into the PRU and I was quite upset because I thought, no this is a special school, he doesn’t need this, he needs help in other ways. But it was the best thing I've ever done. *Mary*

Despite this positive experience Mary, like the other parents, was nonetheless keen for Ryan to stay in mainstream for secondary school:

> But now, at his age, going to a special unit wouldn’t do him any good ‘cause I’ve heard terrible stories about these units, as somebody said, he’s not the type of child that should go to one of these units now. *Mary*

However, he was in fact moved from his mainstream secondary school to a special school only six weeks later, and had settled in by the time of the final follow-up interview. The TA had gone with him for a couple of weeks which helped with the transition, and Mary now felt he was better off there.

6.3.2 Why mainstream schools may not provide the right environment for some children

Jamie was the only study child who made the transition straight to a special secondary school. Despite Linda’s initial objections to the idea, described above, at the final follow-up she was delighted, and explained why this was the best option for Jamie:

> It deals with kids with special needs. But he's just took to it just fantastic. They work around his needs, where when he originally got into the new school and the hours there was, I think they was 8 till 4:30, so with his needs, I said, 'There's no way'. He's only been doing literally half days at primary. There's no way he's going to be able to fit around this. But we've got him in here… they work around his needs. It's not the school where, 'No you've got to stay and you've got to--'.. he's getting on fantastic... I don't know what I would've done, if he hadn't got in there. I'd be pulling my hair out. *Linda*

Six practitioners commented on why mainstream school was not the right place for study children, including a teaching assistant:

> He can’t learn here. He can’t even focus. He can’t – he’s not progressing at all... It’s too busy, it’s too hectic, there’s too much noise – like you can just see him in the classroom and you can see him trying to concentrate and he just can’t because there’s noises coming from everywhere. The ADHD makes it really hard for him to focus. *Teaching Assistant*

This child had returned to the mainstream school after a short period in an exclusion unit:

> When he came back from [the unit] last year, he was just – he was refusing to come in, he didn't want to be here, he openly said that he wanted to go to a unit, he wants to go somewhere with small classes. *Teaching Assistant*

For some (Darius, Ben, Aaron) the playground was a major problem, as another TA reported:

> Because he copes in the classroom, he copes around the school, he's just not able to cope in the playground. I think too many children and all it takes is somebody to bump into him and he blows the fuse. *Teaching Assistant*

Donna told a similar story:

> There was only 12 children in there [primary PRU], 'cause Joe don't like crowds, and then they put 'im straight into [mainstream secondary] with like over 1000 people and he just went off the rails. *Donna*

Significant barriers to returning to mainstream school for excluded study children, according to practitioners, included tendency to act up in a crowd, violent outbursts or childish behaviours (for example, sitting under tables and refusing to work), and poor literacy skills coupled with reluctance to ask for help.

Ryan's TA felt there were no problems with his behaviour when he trusted the people he worked with, but there was not enough consistency of approach in mainstream schools, where each subject would have a different teacher. The deputy headteacher at Palani's mainstream secondary school described what would be a more appropriate curriculum for someone like Palani, and it was something much closer to what was being delivered in the special schools visited for this study: short lessons, more variety, but consistency of personnel. The interviewee did not think this could be delivered in a school of their size (with more than 180 pupils in each year). The various interview accounts reflected a huge gulf between provision at special and mainstream schools. As Ben's one-to-one teacher said:

> If I was in mainstream I'd be dealing with the same sort of behaviour issues, but I'd have to teach a class of 30 at the same time. *Ben's teacher*

Most parents in the study did not seem to have many options over the type of school chosen for their child, particularly if the child did not have a SEN statement, and

options *within* mainstream schools were also limited. The mainstream schools visited reported being constrained by government expectations and league tables to prioritise academic achievement:

> Previously, we might have had more kids on vocational subjects like car apprenticeships, engineer apprenticeships, things like that. But they cost a lot of money, and the grades don't give you that currency when you want to show up in the league tables. *Mainstream school senior leader*

The special schools visited were still providing vocational routes, although the government's May 2015 policy paper also called for special schools to increase the number of children gaining five GCSEs with maths and English (Department for Education, 2015).

Palani's head of year could see two sides of the argument; he knew that the school had become better at improving chances for the majority of pupils within the current system of exams, but he was less happy with it from a more humanitarian point of view:

> That method delivers a greater percentage of success to the greatest number of students. And that is what they're judged on, the school's judged on. So until that pedagogy, that ideology changes, that is the one system that fits all. I mean, I think, what's going to benefit Palani? Would he benefit from getting through school and getting the highest grades he can get, to get him on a college course that he wants to do, that would enable him to make more choices? Now that seems to be a very moral, purposeful argument. If we step back from that purposefulness and said, what's going to make him a more well-rounded individual able to work within his peer groups better, form relationships more easily, become more reflective. Then that's perhaps idealistic. I think that's the issue in the way the schools are set up. *Mainstream school senior leader*

A special school inclusion officer, who had moved from a mainstream school, felt that in the mainstream school, there were staff with the skills needed to meet difficult children's needs, but the school systems did not allow them to do that:

> I put the children first. And I understand as a teacher that's not always easy, because you know, you're judged on how many sub-levels of progress the children have made. *Special school inclusion officer*

The accounts of research participants suggested that some mainstream schools did not want children with difficult behaviour. We saw earlier that children tended to move primary schools until they arrived at one prepared to accommodate them. Palani,

however, remained at his primary school, despite threats of exclusion and Bella's feeling that they wanted to get rid of him; he was only able to stay, Bella felt, because of the input of CAMHS in persuading the school to put in support, instead of threats. Linda had similar feelings about Jamie's primary school, under a change of leadership, following his temporary exclusion:

> We've come to the conclusion, kids with special needs, she can't deal with and she doesn't want them in her school. So literally within three weeks of Jamie being out of school she's kicked out two other children from her school. *Linda*

Nicole felt similarly about the mainstream secondary school attended only briefly by Ben:

> They just want As, they just want students who are getting grades. They don't want to put the time and the effort into children that aren't conforming. *Nicole*

One family worker described a mainstream school whose approach she felt contributed to children's difficulties:

> They wanted to get her out. She was a bit difficult but she wasn't – it was all low level behaviour stuff – it was nothing major and it felt like they could try and keep her in a little bit more. *Family worker*

She noted that ex-pupils from this school were over-represented at the special school for excluded pupils. Other mainstream schools had made much more effort, as was said of Ryan: 'we were very reluctant to get him out'. However, Donna said of the same school: 'it's a good school if you haven't got no problems'.

While Aaron was not having a good experience at his special school, Jamie, Ryan and Joe appeared to be enjoying and benefitting from their schools' approaches. Ben was getting a very intensive level of personalised intervention, and Ryan and Joe also had access to many different activities and therapies, some of which, according to teachers, were threatened by impending budget cuts. Nevertheless, there were challenges ahead and school staff were fearful about the children's futures.

There were fairly clear reasons why mainstream secondary schools were difficult environments for children in the study, but the contrast between these and the special

school provision was stark. The finding begs the question of whether there could be an in-between route between the two extremes of the mainstream school provision and the small, nurturing special schools discussed here; an alternative which could enable mainstream, universal provision schools to more easily foster nurturing relationships throughout the school.

6.4 Chapter summary and conclusions

The themes presented in this chapter are derived from parents' and practitioners' perceptions of factors that seemed to link to or get in the way of improvements in children's behaviour, addressing Research Question 1. The interview study followed children from primary school age and through the transition to secondary school, allowing examination of the difficulties involved. Children had often been removed from a previous primary school, or spent time in a special unit, before arriving at a primary school prepared to make the necessary (sometimes great) effort needed to support the child. Thus, children often finished their primary education in schools where they were well-known and understood by staff, sometimes with a dedicated one-to-one teaching assistant, or in small special schools where all staff understood their difficulties. Teaching assistants could go to quite extreme lengths to support very difficult children. But when children who had been highly nurtured in primary school moved to a mainstream secondary school with completely different expectations the transition was very difficult. Children's experiences post transition could partly explain why the benefits of support received at primary school age may not be long-lasting.

Funding for a one-to-one teaching assistant or a special school place was only available for study children with a statement of special educational needs (SEN), which seven of the eleven study children had by the end of the study. It appeared that study children whose academic progress was within an acceptable range were less likely to have a SEN statement and at least one school staff respondent stated that this was the case. At primary school, having a SEN statement made a big difference to the support children were provided with, but this seemed less true at secondary school until children were excluded. Once excluded from mainstream provision, some children then received resource-intensive packages of support tailored to their individual needs.

School systems, and practitioners, have difficult balancing acts to perform. In the first section of this chapter the importance of getting the balance right between nurturing children and promoting independence was discussed. The second section highlighted the difficulty of balancing consistency and flexibility, and offering appropriate rewards and consequences, in managing the difficult behaviour of children in schools. While school might be considered to offer an opportunity to expose a child to a different set of influences, options for adapting provision are in some cases restricted by the emphasis given to academic results.

A further balance mainstream school staff negotiate is between the needs of disruptive children and those of the remainder of their class. All the study children were subject to internal or temporary external exclusions, and while this may be necessary for the needs of other pupils, it was a problematic approach for study children themselves, leading to stigmatisation and labelling as a difficult child, and building oppositional sentiment towards school. It has been shown elsewhere that excluded young people can respond defensively at first, while generally coming to regret their exclusion later (Berridge et al., 2001).

School staff took on a variety of roles that do not necessarily fit their job titles or descriptions, and individual relationships between children and school staff were important in making school tolerable for children who were struggling. Features of practice which seemed to help these children included making a personal connection, being non-judgemental, focussing on positive feedback and addressing underlying problems. However, intervention sometimes ended when still needed, or was not put in place as planned. Practitioners were mindful of the need to encourage independence. This study indicates that a balance is needed, where there is some consistency in availability of support, and in expectations for individual children, while they are also being taught to regulate their own behaviour. Progress, and improved integration, could be made when underlying problems such as poor literacy skills, common for children with difficult behaviour (Carroll et al., 2005), were recognised and addressed.

While some of the problems of dealing with the children's needs seem intractable in large mainstream secondary schools needing to focus on academic results, and with increasingly constrained finances, parents and practitioners felt other problems could be

approached better. It was a common feature of mainstream schools in the study that the children were regularly getting into trouble for minor misdemeanours and some respondents felt this could provoke worse behaviour for the children concerned; once children had a reputation for difficult behaviour they could get blamed even when not solely at fault. Some discipline appeared to be poorly conceived, or not properly implemented, resulting in confusion and anxiety for the child, sometimes with a threat of exclusion hanging over them for some time. Following transition to secondary school some children found themselves without a trusted adult to fight their corner, or without sufficient access to an adult with whom they *had* made a connection.

Parents sometimes feel there is too much contact from their child's school and sometimes too little. The quality of the contact is what matters; good communication between schools and parents is useful, especially if there is a focus on positive feedback. Constant telephone calls with inconsistent messages from school staff put additional burdens on parents, as well as undermine trust. Practitioners' accounts suggest that schools sometimes appear defensive and unwilling to take advice from outside agencies, and that this may be partly because school staff do not think other agencies always appreciate the difficulties of schools' multi-faceted role.

The factors outlined above were identified through qualitative analysis. However, for some of the findings it is possible to construct hypotheses for further investigation in the longitudinal survey data from ALSPAC. The available data allow associations with longer-term antisocial behaviour to be explored, in Chapter 7, for the following factors:

- being ready for the transition to secondary school;
- being happy at school;
- having a statement of special educational needs (compared to having a similar level of problems without a statement);
- making a connection with an adult at school; and
- good communication between the school and the parent.

These factors, along with the others discussed above, have been shown in the qualitative analysis to be important for children; the hope is that, if these factors are addressed, longer-term outcomes will improve. The investigations in Chapter 7 look at whether there is evidence from survey data regarding their longer-term impact.

Chapter 7

Which factors are relevant to preventing antisocial and criminal behaviour? Using ALSPAC to investigate longer-term outcomes

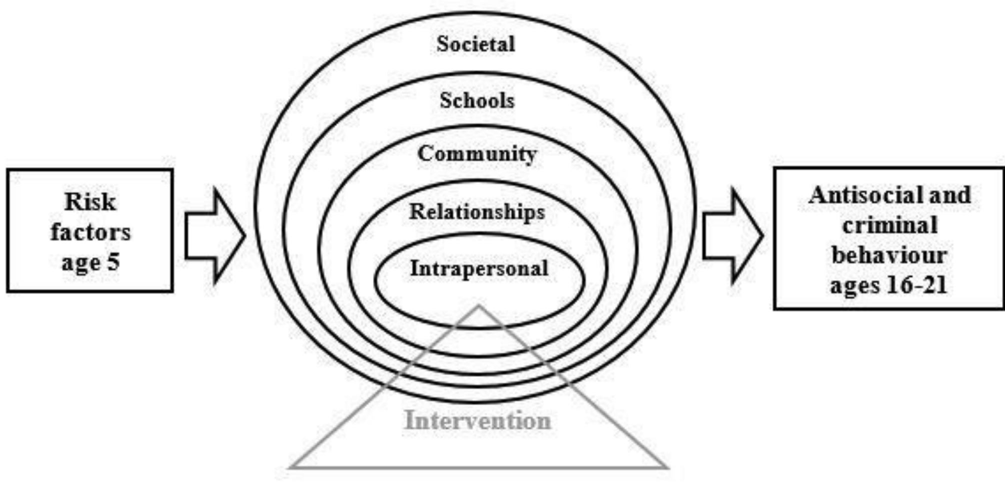


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> Well my hopes are for his needs to be acknowledged, and that's it, and my fears are that he'll just get lost in the system. I just want him to be given a fair chance. *Bella*

The eleven interview study families were followed over five years to explore factors which might be helpful in addressing the risk of future antisocial behaviour. To investigate Research Question 2, about whether these factors influence later antisocial and criminal behaviour, a larger sample of families from the ALSPAC longitudinal survey is analysed. ALSPAC children were born in 1991–3 in a defined area of South West England. Data are available in the ALSPAC cohort study to approximate a subset of the factors identified in the qualitative analyses. This chapter investigates associations between these age 6 to 13 predictor variables, and antisocial and criminal behaviour (ASB) at ages 16 to 21, to consider their potential role in modifying the relationship between risk factors and ASB.

The methods used in preparing and executing these analyses are set out in Chapter 3 including the derivation of the variables indicating primary school-age behaviour problems (age 6 to 10) and antisocial and criminal behaviour (age 16 to 21). The analysis approach is summarised in section 7.1 where the hypotheses to be investigated are set out, and potentially confounding characteristics presented. Hypotheses arising from Chapter 5, relating to the intrapersonal, relationships, community and societal levels of influence depicted in Figure 1, are investigated in section 7.2. Hypotheses arising from Chapter 6, relating to schools, are investigated in section 7.3.

7.1 Introduction to the analyses

Logistic regressions were conducted to investigate the role of potential modifying factors (hypothesised predictors), present during middle childhood, in reducing the risk of children's later ASB. Regressions were carried out both unadjusted, and adjusted for covariates which could confound any association between the hypothesised predictors and ASB. Most of the analyses use only the sample of ALSPAC children who had behaviour problems in primary school between ages 6 and 10, identified according to the criteria set out in Chapter 3. This is referred to as the *behaviour problems sample* (n=1249). Twenty-seven per cent of the behaviour problems sample go on to display antisocial behaviour at ages 16–21 (n=338) and these are referred to below as the *ASB*,

or *antisocial behaviour group*.[3] Sometimes analyses refer to comparisons between the behaviour problems sample and the *full sample* (n=7253). Unless otherwise stated, this refers to all ALSPAC children with outcome data available on antisocial behaviour, both those in the behaviour problems sample and those without primary school behaviour problems (referred to as the *no behaviour problems sample*).

The term *behaviour problems*, then, is used to refer to the sample of children identified as having problematic behaviour between ages 6 and 10. The term *antisocial behaviour* refers to the outcome measure, described in Chapter 3, which identifies young people who display antisocial behaviour between the ages of 16 and 21. Where the *level* of children's problematic behaviour, used as a covariate in analyses, is referred to, the term *conduct problems* is used. These conduct problem scores are derived from the Strengths and Difficulties Questionnaire (SDQ), as also used in the interview study, and described in Chapter 3. Questionnaires for ALSPAC mothers are occasionally completed by a primary carer who is not the mother (see Chapter 3), but the term 'mother' is used for convenience.

The logistic regressions reported in sections 7.2 and 7.3 estimate odds ratios (OR); an odds ratio of 1 suggests no relationship between the predictor and outcome variable. The further the odds ratio is from 1, the larger the indicated association. An odds ratio of more than one means those with the predictor present (for dichotomous variables, i.e. a value of 1 versus a value of 0) are more likely to have the outcome (ASB in this case) while an OR of less than one means those with the predictor are less likely to have the outcome. An OR of 0.5 for a dichotomous predictor variable means that there is a 50% decrease in the odds of having ASB if the predictor is present. Significance values (p) and 95% confidence intervals (CI) are presented in the text and tables. A p value below 0.05 is referred to as indicating a statistically significant effect, although it is acknowledged that this is an arbitrary cut-off and that p values somewhat above this level do not necessarily indicate a spurious relationship (ALSPAC, 2016; Wasserstein & Lazar, 2016). The 95% confidence interval gives the range of values the odds ratio would be expected to take 95% of the time if different samples were drawn from the

[3] In comparison, 13% of those who did not have behaviour problems at primary school went on to have ASB, a statistically significant difference (Chi-square(1)=170.6, p<0.001)

same population. The odds ratios reported always relate to the hypothesised predictor to show the effect of inclusion of different covariates.

7.1.1 Hypotheses to be investigated

Where suitable data were available in ALSPAC to match themes which emerged from the qualitative analysis of interview study data, appropriate hypotheses were developed and predictor variables were chosen or constructed. The hypotheses are set out separately below for themes presented in Chapters 5 and 6. All hypotheses relate to children with behaviour problems between the ages of 6 and 10. The predictor variables are presented at the beginning of each analysis reported in sections 7.2 and 7.3.

Hypotheses about parenting (intrapersonal and relationships), community and societal factors

Chapter 5 presented key themes arising from the qualitative analysis of interview study data relevant to the topic of parenting, and potential factors influencing family functioning and child behaviour. It is hypothesised that these school-age factors may be related to children's development of antisocial behaviour in the longer term. In some cases the factors relate to *changes* occurring during the school years. For example, parents becoming less hostile towards their child, or giving attention to their own mental health and therefore being better able to deal with their child's behaviour, may reduce the likelihood of children being involved in antisocial or criminal behaviour in the future.

The interviews also highlight the possible risks and benefits, for children's behaviour and family functioning, of neighbourhood factors, and of social network, housing, work and money issues. The evidence suggests that if mothers feel their neighbourhoods are good places to live, it can benefit family wellbeing and child behaviour, and that, conversely, lack of social support can be a risk factor, although aspects of social networks can also have negative impacts. Many mothers said they would like to work but that it was not possible because of the demands of looking after the child, and money worries, particularly where housing was affected, are a source of maternal stress.

ALSPAC data allowed the following hypotheses to be tested:

Hypothesis 1: Children with behaviour problems whose mothers become less hostile towards them are less likely than those whose mothers remain hostile to display antisocial behaviour in the future.

Hypothesis 2: Improved maternal mental health during the primary school years reduces the risk of children going on to display antisocial behaviour.

Hypothesis 3: Children whose mothers consider their neighbourhood a good place to live are less likely than others to display antisocial behaviour in the future.

Hypothesis 4: Children whose mothers have more social support are less likely to display antisocial behaviour in the future.

Hypothesis 5: Children with behaviour problems whose mothers are not working by choice, compared to those with mothers who would prefer to be in employment, are less likely to display antisocial behaviour in the future.

Hypothesis 6: The children of mothers who have difficulty paying rent when the child is primary school age are more likely than others to go on to have antisocial behaviour.

Investigation of these hypotheses, and details of the predictor variables representing the hypothesised modifying factors, are presented in section 7.2.

Hypotheses about school-related factors

The qualitative analysis of interview study data presented in Chapter 6 identified factors connected to children's school experiences which could be important in influencing their behaviour in the future, such as reducing dependence on one-to-one support before leaving primary school, forming connections with sympathetic adults, a helpful relationship between their family and their schools, and addressing underlying reasons for poor behaviour. A key theme in Chapter 6 was the big difference between primary and secondary schools (as well as between different schools) in the way they responded to children with difficult behaviour. There was clearly unease from both parents and practitioners about the extent to which nurturing support at primary school prepared children for secondary school. Some children were receiving more intensive school

support than others, and this was at least partly related to whether or not they had a statement of special educational needs. The following hypotheses, developed from themes presented in Chapter 6, but constrained by the variables available, were investigated in ALSPAC to look at longer-term associations with antisocial behaviour:

Hypothesis 7: Children with behaviour problems who are ready for the transition to secondary school, compared to those who are less ready, are less likely to display antisocial behaviour in the future.

Hypothesis 8: Children with behaviour problems who are happy at school are less likely, compared to those who are not, to display antisocial behaviour in the future.

Hypothesis 9: Children who are given statements of special educational needs (SEN) are likely to receive more support, and less likely to display antisocial behaviour in the future, than children with similar levels of problems who are not given SEN statements.

Hypothesis 10: Children who form good relationships with adults at school are less likely, compared to those who do not, to display antisocial behaviour in the future.

Hypothesis 11: Children whose school and parent/carer communicate well are less likely, compared to those where there is not good communication, to display antisocial behaviour in the future.

Investigation of these hypotheses, and details of the predictor variables representing the hypothesised modifying factors, are presented in section 7.3.

7.1.2 Potential confounders of the relationship between hypothesised modifying factors and future antisocial and criminal behaviour

Table 7.1 and Table 7.2 present the covariates used in subsequent regression analyses, and compare these for those who do, or do not, go on to have antisocial behaviour at ages 16–21. All covariates, other than children's conduct problems, were measured in early childhood, that is, before age 5. Table 7.1 presents categorical covariates, showing the number (n) and percentage of children with, or without, age 16–21 ASB who have

each characteristic. For example, 83.5% of young people without ASB at age 16–21 were living in owner-occupied housing at age 3 compared to 66.6% of those with ASB.

Table 7.1 Comparison of key covariates (categorical variables) for children with behaviour problems (at ages 6–10), comparing those who go on to have antisocial behaviour (ASB) with those who do not

Categorical variables (Child's age when measured)	Categories	Group with no ASB age 16-21		Group with ASB age 16-21		p*
		n	%	n	%	
Child's sex (birth)	Male	472	51.8%	193	57.1%	0.096
	Female	439	48.2%	145	42.9%	
Mum's highest educational qualifications (birth)	No post-16 qualifications	485	57.5%	209	64.9%	0.021
	Post-16 qualifications	359	42.5%	113	35.1%	
Biological father lives with child (47 months)	No	95	11.8%	54	17.9%	0.008
	Yes	710	88.2%	247	82.1%	
Housing tenure (33 months)	Not owned	133	16.5%	104	33.4%	<0.001
	Owned	671	83.5%	207	66.6%	

*ASB groups compared with chi-square tests

Table 7.2 compares mean scores and standard deviations (sd) on the continuous variables used as covariates for the young people who display ASB and those who do not.

Table 7.2 Comparison of key pre-baseline and conduct problems covariates (scale variables) for children with behaviour problems (at ages 6-10), comparing those who go on to have antisocial behaviour (ASB) with those who do not

Scale variables (child's age when measured) Scale range	Group with no ASB age 16-21	Group with ASB age 16-21	p*	95% CI of Difference in means	n
	Mean (sd)	Mean (sd)			
Mother's age in years (birth) Range: 15-44	29.0 (4.6)	28.2 (4.9)	0.005	0.25, 1.43	1209
School entry ability score (4-5 years) Range: 0-20	13.2 (3.2)	12.6 (3.4)	0.009	0.16, 1.14	850
Stressful life events score (47 months) Range: 0-79	13.6 (10.7)	17.1 (12.0)	<0.001	-4.96, -2.05	1119
Financial difficulties score (33 months) Range: 0-15	3.3 (3.7)	4.6 (4.3)	<0.001	-1.91, -0.82	1110
Conduct problems score (SDQ) (4 years) Range: 0-10	2.9 (1.51)	3.16 (1.60)	0.003	-0.51, -0.10	1105
Conduct problems score (SDQ) (6 years) Range: 0-10	3.26 (1.62)	3.66 (1.58)	<0.001	-.062, -0.19	1090
Conduct problems score (SDQ) (9 years) Range: 0-10	2.79 (1.69)	3.33 (1.92)	<0.001	-0.77, -0.30	1085
Conduct problems score (SDQ) (13 years) Range: 0-10	2.16 (1.64)	3.18 (2.01)	<0.001	-1.26, -0.78	1014

*Unpaired t tests

Table 7.1 and Table 7.2 show that those in the ASB group are more disadvantaged on every variable. Table 7.1 also shows that although the proportion of boys was higher in the ASB group, the difference is not statistically significant at the $p<0.05$ level (gender differences in components of ASB are further explored in Appendix 5).

Although all children in the behaviour problems sample (all children included in Table 7.1 and Table 7.2) score over the threshold for conduct problems at some point between ages 6 and 10 (as described in Chapter 3), Table 7.2 shows that children who went on to display ASB have higher average conduct problems each time this is measured. Adjustment is therefore made for the level of conduct problems in each set of analyses.

As explained in Chapter 3, covariates of theoretical relevance to each hypothesis are included in two ways. Firstly, each covariate is entered individually along with the hypothesised predictor (if preliminary analyses show a statistically significant association between the two). Secondly, all covariates which retain a significant association with ASB when included individually with the predictor, are entered together. The aim was to achieve a parsimonious set of models retaining statistical power and transparency of interpretation. Appendix 5 reports further analyses which led to the choice of covariates, and correlations between covariates.

7.2 ALSPAC analyses of parenting (intrapersonal and relationships), community and societal factors

The following sections present the ALSPAC analyses investigating each hypothesis in turn.

7.2.1 Parental hostility

Hypothesis 1: Children with behaviour problems whose mothers become less hostile towards them are less likely than those whose mothers remain hostile to display antisocial behaviour in the future.

In ALSPAC, parents are asked about their attitudes towards their children at ages 4 and 8. Responses to the following items have been used previously, supported by factor analysis results, to measure parental hostility (Fisher et al., 2013; Waylen et al., 2008):

I often get very irritated with this child

I have frequent battles of will with this child

This child gets on my nerves

Responses could be coded 2 (yes), 1 (sometimes) or 0 (no). Following Waylen and colleagues, responses to these three items were summed to make a scale of 0-6 and recoded into 3 categories: low hostility (0-2) moderate (3-4) and high (5-6). Of those with data at both timepoints, 57% of mothers with high hostility towards their child at age 4 continued to feel hostile at age 8, with the remainder feeling less hostile (Table 7.3).

Table 7.3 Parental hostility towards child at ages 4 and 8, behaviour problems sample

		Hostility age 8			
Hostility age 4		**Low**	**Moderate**	**High**	**Total**
Low	**n**	364	146	69	579
	%	63%	25%	12%	100%
Moderate	**n**	138	137	106	381
	%	36%	36%	28%	100%
High	**n**	61	112	229	402
	%	15%	28%	57%	100%
Total	**n**	563	395	404	1,362
	%	41%	29%	30%	100%

In the behaviour problems sample high maternal hostility is associated with later antisocial behaviour at both age 4, although not quite reaching the usual threshold for statistical significance (OR=1.3, p=0.053, 95% CI=1.00 to 1.75) and, more strongly, at age 8 (OR=1.7, p<0.001, 95% CI=1.28 to 2.27).

As the hypothesis proposes that *changing* to become less hostile towards your child might be protective, the next step was to stratify the sample, looking at only those in the behaviour problems sample whose mothers reported high hostility at age 4, to see whether becoming less hostile by age 8 is associated with reduced risk of antisocial behaviour (Table 7.4).

Table 7.4 Relationship between hostile parenting age 8 and antisocial behaviour age 16-21 (ASB), for those in the behaviour problems sample with high parental hostility at age 4

Maternal hostility at age 8, compared to age 4	n (% of total) with ASB at ages 16-21	Total
Reduction in maternal hostility to low/moderate	27 (22%)	121
Hostility remains high	64 (36%)	176
Total	91 (31%)	297

$\chi^2(1)=6.66$, p=0.010

Table 7.4 shows that the children of mothers who become less hostile are significantly less likely to display later antisocial behaviour. This relationship remained statistically significant after adjusting (either individually, or all entered together) for key covariates (Table 7.5). Children's conduct problems rating at age 6 is the only covariate that preliminary analyses showed to be significantly associated with the predictor (reduced maternal hostility), but reduced hostility remains a statistically significant predictor of ASB even after adjustment for conduct problems. Although none of the other covariates are associated with the predictor, Table 7.5 also shows, because of their theoretical importance, the effects of adjusting for conduct problems at ages 4 and 8. The table also shows the effect of entering together all the covariates which significantly predict ASB when entered with the predictor, showing the robust statistical significance of the predictor, reduced maternal hostility. Although improvements in children's behaviour may precede, and cause, reduction in parental hostility, these findings suggest that lowered parental hostility has an independent effect on later antisocial behaviour.

Table 7.5 Predicting antisocial behaviour (ASB) from reduced mother's hostility at age 8, for the behaviour problems sample with high hostility at age 4

Predictor of ASB	Adjusting for (each individually):	Odds Ratio*	p	95% CI	n
Reduced maternal hostility age 8	Unadjusted	0.50	0.010	0.30, 0.85	297
	Conduct problems age 4	0.50	0.010	0.29, 0.85	296
	Conduct problems age 6	0.57	0.042	0.33, 0.98	287
	Conduct problems age 8	0.54	0.025	0.31, 0.93	283
	Entered together: Conduct problems age 6 Financial difficulties Housing tenure Biological father lives with child age 4 Mother's age Stressful live events[1]	0.45	0.008	0.24, 0.81	276

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which remained significantly related to ASB ($p<0.05$) when entered with the predictor and other covariates

The findings support Hypothesis 1, and the suggestion of the qualitative analysis, that helping parents to become less hostile towards their child during the primary school years could protect against future antisocial behaviour.

7.2.2 Mother's mental health

Hypothesis 2: Improved maternal mental health during the primary school years reduces the risk of children going on to display antisocial behaviour.

In ALSPAC mother's mental health was measured when children were aged 6 and 10 using validated psychometric questionnaires: Depression was measured on a scale of ten items from the Edinburgh Postnatal Depression Scale (Cox et al., 1987) while anxiety was measured with the eight anxiety items from the Crown Crisp Experiential Index (CCEI) (Crown & Crisp, 1979). The association between mothers' depression at both age 6 and age 10 with children's later ASB is statistically significant as is the association between mothers' anxiety (when children are 10, but not when they are 6) and later ASB (Table 7.6). Mothers' depression scores six weeks postnatally are also included in Table 7.6 because they are used in subsequent analysis.

Table 7.6 Mother's mental health by young person's (age 16-21) antisocial behaviour (ASB), behaviour problems sample

		No ASB			ASB			Difference	
Measure	**Child Age**	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**(95% CI)**	**p***
Postnatal Depression EPDS	6 weeks	6.95	4.98	838	7.12	4.97	308	-0.2 (-0.82,0.48)	0.603
Depression EPDS	6 years	5.72	3.85	781	6.50	4.21	296	-0.8 (-1.32,-0.26)	0.004
Depression EPDS	10 years	5.34	4.12	787	6.12	4.52	297	-0.8 (-1.35,- 0.22)	0.007
Anxiety CCEI	6 years	6.32	3.92	783	6.64	4.08	295	-0.3 (-0.84,0.22)	0.240
Anxiety CCEI	10 years	5.14	4.00	787	5.74	4.23	297	-0.6 (0.06,1.15)	0.029

*Unpaired t tests
EPDS: Edinburgh Postnatal Depression Scale; CCEI: Crown Crisp Experiential index, for both scales higher score=more symptoms

Because the relationship is strongest for depression, the remaining analyses focus on depression. The regression models represented in Table 7.7 look at the effect of *change* in mother's depression on children's later antisocial behaviour. As mother's depression is a continuous measure, a different approach was taken compared to Hypothesis 1. Firstly, the change in mother's depression between child's ages 6 and 10 is the predictor, and mother's depression at child's age 6 is controlled for through inclusion as a covariate. This change is not statistically significantly associated with the child's later antisocial behaviour. The hypothesis was also investigated by examining a sub-group of mothers with high depression at child's age 6 who recover by child's age 10, confirming the result: children of mothers whose depression improves between when their child was age 6 and age 10 are no less likely to have antisocial behaviour than those whose mothers remain depressed at age 10.

It is possible that the timescale in question (four years) is not long enough to see any effect on children's later antisocial behaviour outcomes, and so a further analysis looked at change in mother's depression score between eight weeks postpartum and when children were aged 10, controlling for baseline (postpartum) depression score. This change, over ten years, is significantly related to children's later antisocial behaviour (Table 7.7), with a reduction in mother's depressive symptoms being associated with a lower likelihood of the child developing antisocial behaviour.

Table 7.7 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with change in mother's depression, behaviour problems sample

Predictor of ASB	Adjusting for	Odds Ratio*	p	95% CI	n
Change in depression score (age 6 – age 10)	Depression age 6	0.98	0.213	0.94, 1.01	979
Change in depression score (postnatal – age 10)	Postnatal depression	0.95	0.012	0.92, 0.99	1034
	Entered together: Postnatal depression Conduct problems age 6 Child's sex Housing tenure Financial difficulties Stressful life events	0.95	0.009	0.91, 0.99	885

*All Odds Ratios show the association between the hypothesised predictor and ASB

Although, other than child's sex, the key covariates are all significantly associated with postnatal depression (children's age 6 conduct problems, housing tenure, financial difficulties and stressful life events), they are not significantly associated with the change in depression scores, when adjusting for postnatal depression rates. Therefore they are not shown individually as covariates in the model in Table 7.7, having little effect on the odds of change in depression affecting children's antisocial behaviour. To illustrate the point, the effect of including all these covariates together is shown. This evidence suggests that the children of mothers who become less depressed between the postpartum period and the child being 10 are less likely to have antisocial behaviour in late adolescence, and that this is not due to the background factors examined.

The evidence for Hypothesis 2, therefore, was mixed. Improved maternal mental health between the postnatal period and child's age 10 but not between ages 6 and 10 was significantly associated with a lower risk of children going on to have antisocial behaviour. Although a causal effect is not proven the finding raises the possibility, as suggested by the qualitative analysis, that intervention to help reduce mothers' depressive symptoms during childhood could have a beneficial effect on children's antisocial behaviour.

7.2.3 Views of neighbourhood as a place to live

Hypothesis 3: Children whose mothers consider their neighbourhood a good place to live are less likely than others to display antisocial behaviour in the future.

In ALSPAC parents are asked their opinion of their neighbourhood as a place to live when children are aged 5, 7 and 10. At all ages those in the behaviour problems sample are far more likely than others to answer 'not very good' or 'not good at all', rather than 'good' or 'fairly good'. Table 7.8 compares the numbers and percentage of children with later antisocial behaviour for mothers who said their neighbourhood was, or was not, a good place to live. The comparison of percentages in Table 7.8 shows that at all ages children of mothers who say their neighbourhood is *not* a good place to live are significantly more likely to go on to have antisocial behaviour.

Table 7.8 Mother's view of neighbourhood as a place to live by ASB, behaviour problems sample

Mother's view of neighbourhood		n (% of total) with ASB at ages 16-21		Total	$\chi^2(1)$	P
Age 5	**Not good**	27	(42%)	64		
	Good	271	(26%)	1,027	7.58	0.006
Age 7	**Not good**	20	(41%)	49		
	Good	272	(26%)	1,032	4.96	0.026
Age 10	**Not good**	16	(40%)	40		
	Good	279	(27)	1,053	3.57	0.059

NB the significance of these relationships disappeared when adjusting for housing tenure.

At age 5 the association remained statistically significant when adjusting for the child's conduct problems at age 6, financial difficulties or child's sex; however, the association is reduced when adjusting for earlier stressful life events and is no longer statistically significant after adjusting for housing tenure at birth (Table 7.9). The statistical significance of associations at ages 7 and 10 only remains near the 0.05 level when controlling for child's sex, but not the other key covariates. Because less than six per cent of mothers said their neighbourhood was not a good place to live at any timepoint, numbers are too small to look at the relationship between *change* in views of the neighbourhood and antisocial behaviour (for example, only five individuals whose mothers said the neighbourhood is a bad place to live at both ages 5 and 10 went on to have antisocial behaviour).

Table 7.9 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with mother's opinion of the neighbourhood (ages 5, 7 and 10), behaviour problems sample

Predictor of ASB	Adjusting for	Odds Ratio*	p	95% CI	N
Neighbourhood is a good place to live, age 5	Unadjusted	0.49	0.007	0.29, 0.82	1091
	Conduct problems age 6	0.57	0.047	0.32, 0.99	1030
	Housing tenure	0.65	0.124	0.37, 1.13	1041
	Financial difficulties	0.54	0.024	0.31, 0.92	1038
	Stressful life events	0.60	0.079	0.34, 1.06	1053
Neighbourhood is a good place to live, age 7	Unadjusted	0.52	0.028	0.29, 0.93	1081
	Conduct problems age 6	0.61	0.113	0.33, 1.13	1036
	Housing tenure	0.86	0.632	0.45, 1.62	1032
	Financial difficulties	0.73	0.312	0.39, 1.35	1029
	Stressful life events	0.75	0.385	0.40, 1.43	1043
Neighbourhood is a good place to live, age 10	Unadjusted	0.54	0.063	0.28, 1.03	1093
	Conduct problems age 6	0.56	0.106	0.28, 1.13	992
	Housing tenure	0.78	0.499	0.39, 1.59	1002
	Financial difficulties	0.66	0.235	0.33, 1.31	998
	Stressful life events	0.64	0.212	0.32, 1.29	1010

*All Odds Ratios show the association between the hypothesised predictor and ASB

Evidence to support the hypothesis is therefore limited. There is evidence that mothers' views of their neighbourhood are related to children's later antisocial behaviour but this may have been due to pre-existing socioeconomic background factors, represented here by financial difficulties and housing tenure. There was insufficient data to conclude what any effect of changing views of the neighbourhood during the school years might be.

7.2.4 Social support

Hypothesis 4: Children whose mothers have more social support are less likely to display antisocial behaviour in the future.

In ALSPAC, questions about parents' social support and social network were asked when children were aged 5, 6 and 12. A social support scale was constructed from responses to a 10-item inventory that assessed whether parents experienced emotional support (e.g. sharing feelings, being understood) and instrumental support (e.g. others helping with tasks, providing financial help if needed) from partners, neighbours, friends and family (see Appendix 5) (Dunn et al., 1998; Thomson et al., 2014). A separate measure, social network, was derived as used previously in ALSPAC from responses, in the same questionnaires, to items about numbers of friends and family, and frequency of contact (listed in Appendix 5).

A number of the mothers in the interview study praised the tolerance of their neighbours. Although this question is not asked in ALSPAC respondents are asked, as part of the social support scale, the degree to which, in moments of difficulty, they believe their neighbours would help. In the behaviour problems sample, the child of 26% of those who could call on a neighbour for help at least sometimes, at age 5, went on to have antisocial behaviour, compared to 33% of those who could not $\chi^2(1)=4.42$, $P=0.035$). This question does not distinguish between groups, however, at ages 6 or 12.

Comparing those in the behaviour problems sample who go on to have antisocial behaviour with those who do not, the ASB group score lower for social support and size of social network at every timepoint; the difference is statistically significant for social support at age 6 and for social network at ages 5 and 6 (Table 7.10).

Table 7.10 Social support and social network scores by antisocial behaviour (ASB) at ages 16-21, behaviour problems sample

Measure and	Group with no ASB age 16-21		Group with ASB age 16-21		Difference in means	
child age	Mean (sd)	n	Mean (sd)	n	(95% CI)	p*
Social support age 5	16.8 (4.7)	789	16.5 (4.8)	297	0.34 (-0.29 to 0.97)	0.286
Social support age 6	16.8 (4.6)	774	16.0 (4.8)	294	0.78 (0.15 to1.40)	0.015
Social support age 12	16.5 (4.9)	721	16.0 (5.0)	279	0.51 (-0.17 to 1.19)	0.143
Social network age 5	22.1 (4.2)	791	21.4 (4.8)	296	0.78 (0.20 to 1.37)	0.009
Social network age 6	22.2 (4.3)	777	21.5 (4.7)	295	0.69 (0.10 to 1.28)	0.023
Social network age 12	22.1 (4.6)	729	21.8 (4.8)	279	0.25 (-0.40 to 0.89)	0.460

*Unpaired t tests

Logistic regression was used to look further at the relationships between the age 6 scores and later antisocial behaviour, adjusting for key covariates (Table 7.11). Adjusting for any covariate other than child's sex reduced the statistical significance of the relationships to below the p=0.05 level (Table 7.11), indicating that the other family characteristics related to later antisocial behaviour are stronger predictors than social support and social network. An exception is the case of social network adjusted for stressful life events, where fewer stressful events mean a lower chance of children's antisocial behaviour in the future. All the covariates remain statistically significant predictors of ASB when entered with social support or social network scores. Preliminary analyses showed that all the covariates were also statistically significantly related to social support and social network, except for stressful life events which were significantly associated with social support at child's age 6, but not social network.

Table 7.11 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with mothers' social support and social network, behaviour problems sample

Predictor variable	Adjusted for:	Odds Ratio*	p	95% CI	N
Social Support age 6	Unadjusted	0.96	0.015	0.94, 0.99	1068
	Conduct problems age 6[1]	0.98	0.149	0.95, 1.01	1024
	Housing tenure[1]	0.97	0.067	0.94, 1.00	1020
	Financial difficulties[1]	0.98	0.170	0.95, 1.01	1016
	Stressful life events[1]	0.98	0.147	0.95, 1.01	1034
Social Network age 6	Unadjusted	0.97	0.023	0.94, 1.00	1072
	Conduct problems age 6[1]	0.98	0.180	0.95, 1.01	1027
	Housing tenure[1]	0.98	0.178	0.95, 1.01	1023
	Financial difficulties[1]	0.98	0.140	0.95, 1.01	1019
	Stressful life events[1.]	0.97	0.044	0.94, 1.00	1038

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB (p<0.05) when entered with the predictor

In order to further investigate whether *increasing* social support might be associated with a lower risk of antisocial behaviour a 'low social support' group at child's age 5 was identified (see Appendix 5). Those whose mothers' social support remained low at age 12 were compared with those whose social support improved. However, the difference in rates of antisocial behaviour is very small, and not statistically significant ($\chi^2(1)=0.29$, p=0.588). Changes in social support and social network scores were also compared (Table 7.12) with the method used in section 7.2.2, and again show no significant association between change in social support or social network scores and children's later antisocial behaviour.

Table 7.12 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with change in mothers' social support and social network scores, behaviour problems sample

Predictor of ASB	Adjusting for	Odds Ratio*	p	95% CI	n
Change in social support score (age 12 – age 5)	Social support age 5	0.98	0.21	0.94, 1.01	910
Change in social network score (age 12 – age 5)	Social network age 5	1.01	0.55	0.97, 1.05	915

*All Odds Ratios show the association between the hypothesised predictor and ASB

To summarise, there is some evidence supporting Hypothesis 4, showing that the parent's social support and social networks are both related to the child's later antisocial behaviour in a statistically significant way. However, once key covariates are adjusted for, these relationships become non-significant. Further examination of relationships between the covariates and the social support and network scores show that children's childhood behaviour and family socioeconomic factors are consistently related to social support and networks at all ages, as well as to later antisocial behaviour, suggesting that families' socioeconomic circumstances, or factors related to these, may have a causal role in the development of children's behaviour, poor social support and later antisocial behaviour.

7.2.5 Work

Hypothesis 5: Children with behaviour problems whose mothers are not working by choice, compared to those with mothers who would prefer to be in employment, are less likely to display antisocial behaviour in the future.

In the ALSPAC behaviour problems sample, whether or not the mother was working when the child was age 8 makes no difference to the likelihood of the child going on to have antisocial behaviour. Although some parents in the interview study felt work was important, were sorry when they had to give up work or strongly wished to remain in work in one case, there is no association in ALSPAC between the variable 'mother is in paid employment' and the ASB outcome (p=0.591). It is possible, as indicated in the qualitative analysis of interviews, that there could be both positive and negative effects of mothers' work on child behaviour. Mothers in ALSPAC are also asked when their child is 7 whether they are not working because they chose to stay at home with their child. Most parents who reply to this question say yes. However, 17% of those whose children do not have behaviour problems at primary school age say no, they did not choose to stay at home with their child, compared to 23% of those whose children do have behaviour problems, a statistically significant difference ($\chi^2(1)=10.7$, p=0.001). Nevertheless, in the behaviour problems sample the difference in the likelihood of antisocial behaviour between children of non-working mothers who did or did not choose to stay at home with the child is not statistically significant (Table 7.13). Despite

large differences, the numbers are small and there is insufficient evidence to support the hypothesis.

Table 7.13 Mother chooses not to work to stay at home with the child, age 7, by ASB, behaviour problems sample whose mothers are not in work

Mother chose not to work to stay at home with child	n (% of total) with ASB at ages 16-21	Total
No	22 (34%)	64
Yes	56 (26%)	218

$\chi^2(1)=1.9$, $p=0.172$

7.2.6 Difficulty paying the rent

Hypothesis 6: The children of mothers who have difficulty paying rent when the child is primary school age are more likely than others to go on to have antisocial behaviour.

Some families in the interview study had periods when there was a lot of stress associated with money worries, often around paying rent, sometimes because of benefits changes. Financial difficulties and housing tenure in early childhood have already been shown to be highly statistically significant predictors of whether a child with behaviour problems at primary school is likely to go on to display ASB (section 7.1.2). A further useful question asked of ALSPAC respondents when the child is aged 7 concerns the level of difficulty they (the parent) faced in paying their rent, an indicator of a combination of housing and money difficulties. In the behaviour problems sample, children of those who found it difficult to pay the rent (responding that they found it either ‘slightly’, ‘fairly’ or ‘very’ difficult), were significantly more likely to go on to have antisocial behaviour than children of those who answered it was ‘not difficult’ (Table 7.14).

Table 7.14 Difficulty affording rent age 7 by later ASB, behaviour problems sample

Difficulty affording rent, age 7	n (% of total) with ASB at ages 16-21	Total
No	170 (23%)	735
Yes	78 (37%)	214
Total	248 (26%)	949

$\chi^2(1)=15.23$ $p<0.001$

In logistic regressions, this relationship remained statistically significant, when adjusting for a number of key covariates, entered singly and was just under the usual cut-off for statistical significance (p=0.053) even when adjusting for financial difficulties at age 3 (Table 7.15). Ease of affording rent remains a highly significant predictor of ASB status when adjusting for mother's mental health at age 6; as shown previously, mother's depression alone is a statistically significant predictor of ASB (OR=1.05, p=0.004). Mother's depression becomes a less significant predictor when entered in logistic regression with 'ease of affording rent' (OR=1.03, p=0.095). Mother's depression when the child is age 6 is also a strong predictor of difficulty paying rent at age 7, suggesting that financial stresses such as difficulty paying rent may partially mediate the relationship between mother's depression and ASB (Table 7.15). When all the covariates which remained significantly associated with ASB when entered individually with 'ease of paying rent' are entered together, there is no longer a statistically significant relationship between ease of paying rent and ASB (p=0.18). However, difficulty paying the rent at child's age 7 remains a significant predictor if the variable representing financial difficulties when the child is aged 3 is excluded from the regression (p=0.021).

Table 7.15 Logistic regressions predicting antisocial behaviour (ASB), age 16-21, with ease of affording rent at age 7, behaviour problems sample

Predictor	Adjusting for	Odds Ratio*	p	95% CI	n
Ease of affording rent	Unadjusted	0.52	0.000	0.38, 0.73	949
	Conduct problems age 6[1]	0.54	0.000	0.38, 0.75	917
	Housing tenure[1]	0.57	0.001	0.41, 0.81	910
	Financial difficulties[1]	0.69	0.053	0.47, 1.01	907
	Stressful life events[1]	0.57	0.001	0.41, 0.80	918
	Mother's age[1]	0.55	0.000	0.39, 0.76	949
	Mother's depression age 6[1]	0.58	0.002	0.41, 0.81	907
	Entered together: Conduct problems age 6 Housing tenure Financial difficulties Stressful life events Mother's age	0.76	0.18	0.51, 1.14	860
	Entered together: Conduct problems age 6 Housing tenure Stressful life events Mother's age	0.65	0.021	0.46, 0.94	863

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB (p<0.05) when entered with the predictor

There is therefore evidence to support Hypothesis 6. Children whose mothers had no difficulty paying the rent were less likely to have antisocial behaviour in the future, even when controlling for children's level of conduct problems at around the same timepoint, housing tenure, stressful life events and mother's age.

7.3 ALSPAC analyses of school-related factors

The following sections present analyses addressing each school-related hypothesis in turn. In the ALSPAC surveys parents, and also teachers (in years 3 and 6), were asked questions about the child at school. Administrative data from schools have also been linked to ALSPAC participants at certain timepoints. Thus it is possible to investigate longer-term associations between school-related factors and age 16–21 antisocial

behaviour using ALSPAC data. A slightly different set of covariates is used in the analyses below, including mother's education and child's school-entry ability score (see section 7.1.2), because of their relevance to the school-related hypotheses. In the analyses reported below, children's ages are given in years; for teachers' ratings, school year rather than child's age is used as this was the criterion for data collection. In the UK children in year 3 are aged 7 to 8 and year 6 is the final year of primary school, when children are aged 10 at the beginning of the school year and have their eleventh birthday at some point during the year.

7.3.1 Readiness for transition

Hypothesis 7: Children with behaviour problems who are ready for the transition to secondary school, compared to those who are less ready, are less likely to display antisocial behaviour in the future.

The data in ALSPAC are not perfectly timed for looking at the transition to secondary school; data were not collected from individual teachers about pupils at secondary schools. However, teachers in the final year of primary school (year 6) were asked about their perception of the child's readiness for the transition to secondary school. In the behaviour problems sample, 48% of the children are deemed 'very much' ready for transition, compared to 66% of children in the full sample. Table 7.16 compares, conversely, the proportions of children with later antisocial behaviour between those who are 'very much ready' and 'somewhat or not very ready' for transition to secondary school.

Table 7.16 Readiness for transition to secondary school according to teachers, age 10, by antisocial behaviour (ASB), ages 16-21, behaviour problems sample

Readiness for transition	n (% of total) with ASB at ages 16-21	Total
Very much ready	82 (24%)	352
Somewhat or not very ready	110 (30%)	369

χ^2 (1)=3.91, p=0.048

The chi square indicates the statistical significance of the finding that those children with behaviour problems who are considered very ready for the transition are less likely

to go on to have ASB than those who are only considered ‘somewhat’ or ‘not very’ ready for transition by their teachers. Exploring this in a logistic regression, to control for the level of conduct problems (Table 7.17), shows that adjusting for parent-rated conduct problems at age 6 or age 9 only slightly alters the odds ratio, but, perhaps because of the reduced sample size, reduces the statistical significance. In fact, preliminary analyses showed no statistically significant association between parent-rated children’s conduct problems and readiness for transition in the behaviour problems sample (Age 6, OR=1.04, p=0.346, 95% CI=0.96 to 1.12; Age 9, OR=0.94, p=0.104, 95%CI=0.88 to 1.01). Adjusting for other background confounders, such as mother’s education and financial difficulties, makes similarly small changes to the association between ‘ready for transition’ and ASB. However, the housing tenure confounding variable has a larger impact on the association (Table 7.17). Stratified analysis by child’s sex suggests the effect of readiness for transition on later antisocial behaviour was larger for girls than for boys, however in neither sub-group was the relationship statistically significant.

Table 7.17 Logistic regression predicting ASB with readiness for transition to secondary school, behaviour problems sample

Predictor	Adjusting for	Odds Ratio*	p	95% CI	n
Very Ready for Transition	Unadjusted	0.72	0.048	0.51, 1.00	721
	Conduct problems age 6[1]	0.73	0.090	0.51, 1.05	620
	Conduct problems age 9[1.]	0.74	0.106	0.51,1.07	611
	Mother’s education	0.72	0.064	0.51,1.02	669
	School entry score	0.73	0.152	0.48,1.12	510
	Child’s sex	0.74	0.082	0.53,1.04	721
	Housing tenure at birth[1]	0.81	0.261	0.57, 1.16	637
	Financial difficulties in early childhood[1]	0.74	0.089	0.52, 1.05	634
	Unadjusted, boys only	0.81	0.370	0.51, 1.28	381
	Unadjusted, girls only	0.66	0.109	0.40, 1.10	340

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB (p<0.05) when entered with the predictor

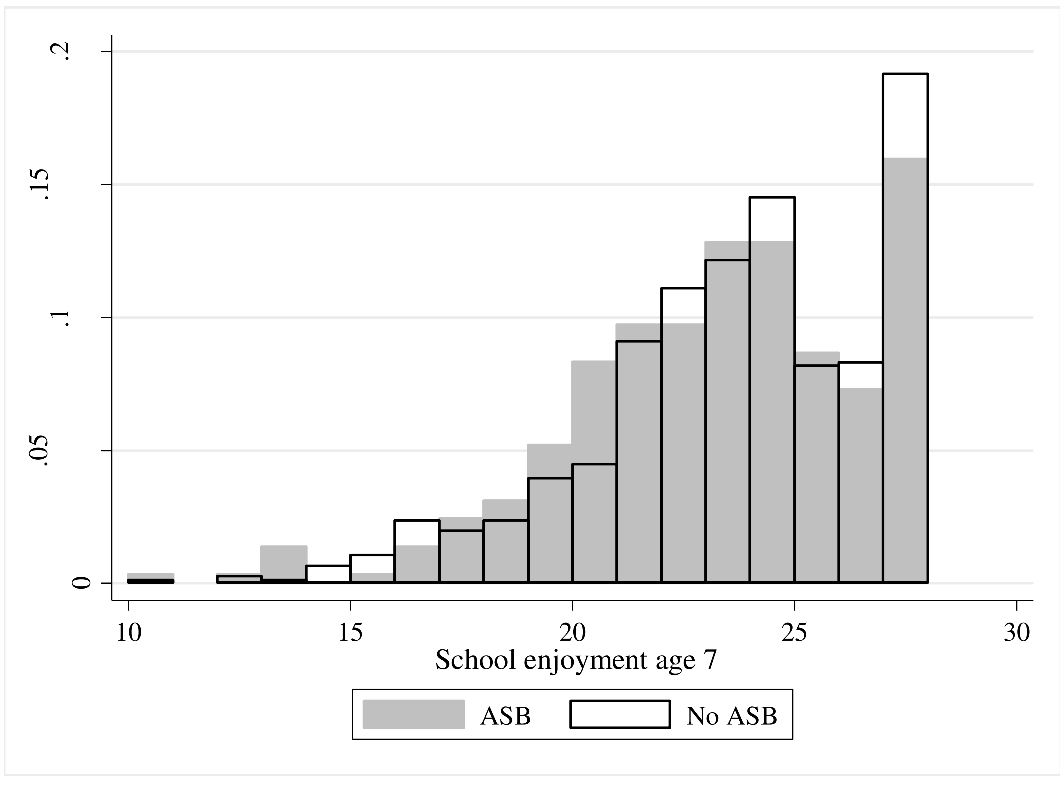
The analysis suggests some tentative support for Hypothesis 7 because of the statistical significance, in the unadjusted regression, of readiness for transition to secondary school in predicting ASB. In addition the odds ratios in the behaviour problems sample, shown in Table 7.17, are all in the same direction, although most are not statistically significant. However, the associations are small and analyses may have been underpowered to detect any effect when covariates were included.

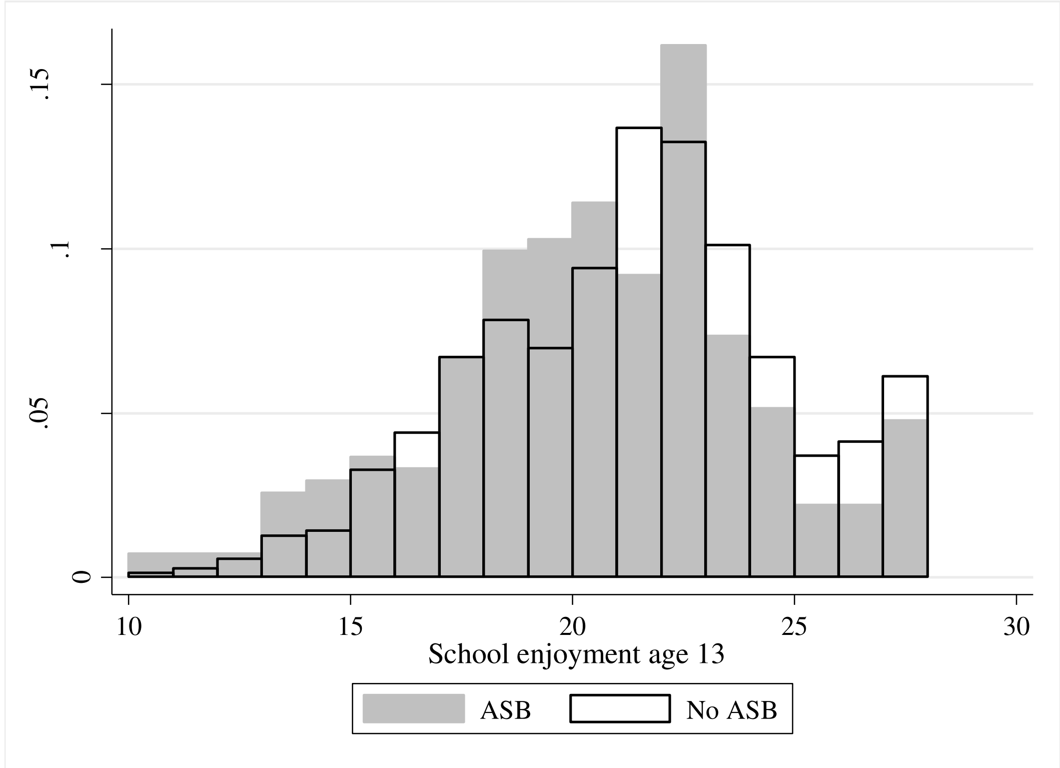
7.3.2 School enjoyment before and after transition

Hypothesis 8: Children with behaviour problems who are happy at school are less likely, compared to those who are not, to display antisocial behaviour in the future.

Another way of looking at transition in ALSPAC is to compare parent-reported school enjoyment at ages 7 and 13. Bowen and colleagues used a school enjoyment scale (see Appendix 5 for individual items) with ALSPAC data, showing that school enjoyment was associated with a lower likelihood of antisocial behaviour at age 10, in the presence of risk factors (Bowen et al., 2008). The distributions of school enjoyment for the behaviour problems sample at ages 7 and 13 are illustrated in Figure 9. The bars outlined in black represent the distribution for the whole behaviour problems sample, and the shaded superimposed bars illustrate the distribution for the subsample who will display later ASB. The distributions for the behaviour problems group as a whole and the ASB subsample are similar, but the ASB distributions are shifted slightly to the left, indicating lower levels of school enjoyment. Comparing the two graphs shows the change from a distribution skewed towards enjoyment at primary school, to a more normal distribution with a lower average enjoyment at secondary school.

Figure 9 School enjoyment density distribution at ages 7 and 13, behaviour problems sample





T tests show a small difference, which approaches statistical significance, in mean school enjoyment at age 7 between ASB groups (22.8 for the group who go on to have ASB versus 23.2 for the no-ASB group; t=1.765, df=1043, p=0.078) and a statistically significant difference between groups at age 13 (mean of 20.8 versus 20.1; t=3.06, df=972, p=0.002). Those who have ASB between ages 16 and 21 are less likely to have enjoyed school when younger.

Logistic regression was used to examine the role of school enjoyment as a predictor of ASB adjusting for potential confounders (Table 7.18). With the inclusion of covariates the relationship between school enjoyment at age 7 and later antisocial behaviour remains non-significant at the p=0.05 level. However, when the covariate is school entry ability score the statistical significance of the relationship between school enjoyment at age 7 and later antisocial behaviour becomes stronger, suggesting that children's academic abilities are masking the relationship when not taken into account.

School enjoyment at age 13 continues to be associated with ASB when adjusting for age 6 conduct problems, and with each key covariate entered in turn. However, when all covariates which are significantly associated with ASB when entered individually with school enjoyment are entered together, school enjoyment is no longer significantly associated with ASB (p=0.413). The relationship also became non-significant when adjusting for contemporaneous (age 13) conduct problems. Further investigation showed a highly statistically significant inverse correlation between school enjoyment and conduct problems at age 13 (-0.26, p<0.001).

Although the analyses suggest some support for Hypothesis 8, additional regression analyses confirm that the early childhood sociodemographic variables that might indicate relative deprivation are significantly associated with school enjoyment and confound the relationship between school enjoyment and antisocial behaviour.

Table 7.18 Logistic regressions predicting antisocial behaviour (ASB), age 16-21, with school enjoyment, age 13

Predictor	Adjusted for	Odds Ratio*	P	95% CI	n
School Enjoyment age 7	Unadjusted	0.96	0.078	0.93, 1.00	1045
	Conduct problems age 6[1]	0.97	0.241	0.93, 1.02	985
	Mother's education[1.]	0.96	0.054	0.92, 1.00	1010
	School entry score[1]	0.95	0.034	0.91, 1.00	704
	Child's sex	0.97	0.106	0.93, 1.01	1045
	Housing tenure at birth[1.]	0.97	0.126	0.93, 1.01	986
	Financial difficulties in early childhood[1]	0.97	0.236	0.93, 1.02	984
School Enjoyment age 13	Unadjusted	0.94	0.002	0.90, 0.98	974
	Conduct problems age 6[1]	0.94	0.005	0.90, 0.98	892
	Conduct problems age 13[1]	0.97	0.235	0.93, 1.02	888
	Mother's education[1]	0.95	0.013	0.91, 0.99	926
	School entry score[1]	0.95	0.027	0.90, 0.99	657
	Child's sex	0.94	0.005	0.91, 0.98	974
	Housing tenure at birth[1]	0.95	0.015	0.91, 0.99	897
	Financial difficulties in early childhood[1]	0.95	0.031	0.92, 1.00	895
	Entered together: Conduct problems age 6[1] Mother's education School entry score Housing tenure at birth[1] Financial difficulties[1]	0.97	0.278	0.92, 1.03	578

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB ($p<0.05$) when entered with the predictor

7.3.3 Child has statement

Hypothesis 9: Children who are given statements of special educational needs (SEN) are likely to receive more support, and less likely to display antisocial behaviour in the future, than children with similar levels of problems who are not given SEN statements.

The interview study suggested that having a statement could be a passport to additional services, as well as improving school choice, which could in principle be beneficial. However, statements are given in response to children's difficulties and so children with statements are more likely to have longer-term problems (Ofsted, 2010). While from the qualitative analysis of interviews it was possible to hypothesise about what the positive effect of getting a SEN statement might be, it is difficult to look at this issue in ALSPAC because it is likely there will be factors not measured and recorded by ALSPAC which both contributed to the statement being given and are associated with ASB.

School report of child's special educational needs status

Support for children with special educational needs (SEN) at the time ALSPAC information was collected was categorised as School Action (the mildest level of additional provision, not associated with any additional funding), School Action Plus (which could lead to additional funding for external provision) or Statement of SEN (for those with the highest level of need requiring extra funding for support). This information was collected from schools and later linked to ALSPAC cases. School reports on SEN status in year 3 for children with primary school behaviour problems show that those on School Action Plus were more likely to go on to have ASB (35%) than those with no special needs, School Actions, or Statements (all between 27 and 28%). However, cell sizes are small and the difference is not statistically significant. Similar proportions are found when the measure is repeated one year later when the children are age 10 (Table 7.19).

Table 7.19 School report of Special Educational Needs (SEN) designation for children in the behaviour problems sample, by antisocial behaviour age 16-21 (ASB)

PLASC[1] SEN status, age 10	n (% of total) with ASB at ages 16-21		Total
No special provision	229	(28%)	831
School Action	33	(29%)	112
School Action Plus	19	(35%)	54
Statement of SEN	7	(23%)	30
Total	288	(28%)	1,027

[1] Pupil Level Annual School Census, data linked to ALSPAC

The data raise the question of whether those who have a level of problems sufficient to warrant their designation under 'School Action', but not sufficient for a SEN statement, and the associated additional funded support this can bring, are receiving insufficient support and are therefore most likely to go on to have antisocial behaviour. Unfortunately, numbers in the behaviour problems sample were too small for any further analyses, or for firm conclusions to be drawn. Even in the full sample there are only 32 children who are designated School Action Plus at age 10 and who go on to have antisocial behaviour. Numbers with SEN statements and available ASB data are even lower. Nevertheless, recoding the SEN status variable as School Action Plus versus everyone else at age 10, the chi square statistic shows a statistically significant difference in the proportions going on to have ASB ($\chi^2(1)=5.26$, $p=0.022$), suggesting that this might be a useful area for future research (Table 7.20).

Table 7.20 School action designation by antisocial behaviour (ASB), full sample

PLASC[1] SEN status, age 10	n (% of total) with ASB at ages 16-21		Total
No special provision, School Action or statement	885	(15%)	5,891
School Action Plus	32	(22%)	146
Total	288	(28%)	1,027

$\chi^2(1)=5.26$, $p=0.022$

[1] Pupil Level Annual School Census, data linked to ALSPAC

Parent report of child's special education needs status

Parents were asked about their child's SEN status at ages 7 and 10, and the response frequencies for ALSPAC children with primary-school age behaviour problems group are shown in Table 7.21. This is a larger sample than in the analyses above as it is not limited to children with ASB outcome data available.

Table 7.21 Parent report of Special Educational Needs (SEN) statement and happiness with provision, behaviour problems sample

		n	%
Mother is happy with special needs provision for child - age 7	Yes, very happy	76	32%
	Yes, quite happy	97	40%
	No, not happy	67	28%
	Total responding	240	100%
SEN statement - age 7	Has a statement	87	6%
	Currently being assessed	32	2%
	Has been refused	13	1%
	Has never been considered	1,422	92%
	Total responding	1,554	100%
Mother is happy with special needs provision for child - age 10	Yes, very happy	83	34%
	Yes, quite happy	96	40%
	No, not happy	62	26%
	Total responding	241	100%
SEN statement - age 10	Yes, has a statement	87	34%
	No, but is being assessed	19	7%
	No, was refused a statement	33	13%
	Never been assessed for a statement	117	46%
	Total responding	256	100%

Note: At age 10 only respondents who answered a previous question by saying that the school or LEA had ever said the child has special educational needs were asked to answer the question about SEN statement status. Many more answered the question at age 7, hence the disparity in total n and % between timepoints.

Most parents are at least 'quite happy' with the special needs provision received by their child, although only just over a third are 'very happy'. Those in the behaviour problems group are more likely to be unhappy with the special needs provision for their child than those not in the behaviour problems group at age 7 (27% versus 20%, $\chi^2(1)5.09$, $p=0.024$). The difference is smaller, and not statistically significant, at age 10. As would be expected, those in the behaviour problem group are also more likely to have a SEN statement at both ages 7 and 10 than those not in this group.

Analyses looking at the association between having a statement (at either age 7 or 10) and antisocial behaviour (ASB) at ages 16–21, show no significant association in the behaviour problems group or in the full sample. Numbers are very small in some cells (only ten children at age 7 and twelve children at age 10 have a statement *and* age 16–21 ASB) and so it was not possible to do further analyses adjusted for behaviour. Although the analysis is underpowered, the lack of association could reflect Hypothesis 9, that having a statement led to provision of services which levelled the likelihood of statemented children developing antisocial behaviour with that of those with problematic primary school behaviour but without a statement. SEN statements are not routinely given for behaviour problems alone, as demonstrated in the interview study, so it is also possible that having a statement is more likely to reflect types of difficulties that are not related to antisocial behaviour.

7.3.4 Making a connection

Hypothesis 10: Children who form good relationships with adults at school are less likely, compared to those who do not, to display antisocial behaviour in the future.

A factor which emerged as important in the interview study was whether the child made a connection with an adult at secondary school. It seemed easier for this to occur, or at least to be maintained, at primary school. The subtlety of this type of relationship is difficult to capture in survey data, even in a rich data set like ALSPAC. However, parents were asked about how often their child (aged 13) liked their teachers.

Table 7.22 shows that those who always or usually (usually being the most common response) like their teachers are less likely to go on to have ASB than those who 'sometimes' like their teachers or do not like them at all.

Table 7.22 Frequency child likes teachers, age 13, by antisocial behaviour (ASB), behaviour problems sample

Frequency child likes teachers, age 13	n (% of total) with ASB at ages 16-21	Total
Always	15 (23%)	64
Usually	117 (24%)	481
Sometimes	127 (31%)	410
Not at all	20 (49%)	41

$\chi^2(3)=14.5$, p=0.002

'Likes teachers' was recoded as a binary variable, 'always or usually' versus 'sometimes or not at all'. In the behaviour problems sample, 52% always or usually like their teachers whereas in the 'no behaviour problems' sample the figure is 72% ($\chi^2(1)=193$, $p<0.001$). Table 7.23 shows that in the behaviour problems sample, that is, those children who had behaviour problems in primary school, those who retained problematic behaviour at age 13 were less likely to 'always or usually' like their teachers than those who no longer had problems.

Table 7.23 Child likes teachers, by conduct problems, age 13, behaviour problems sample

	Response by conduct problems age 13		**Total**
Frequency likes teachers, age 13	No conduct problems (n=819)	Yes conduct problems (n=271)	(n=1090)
Sometimes or not at all (n=523)	44%	60%	48%
Always or usually (n=567)	56%	40%	52%
Total (n=1090)	100%	100%	100%

$\chi^2(1)=20.11$, $p<0.001$

The binary variable 'likes teachers' is significantly associated with antisocial behaviour, an association little affected by adjustment for baseline (age 6) parent-reported conduct problems. There is a larger effect for contemporaneous (age 13) parent-reported conduct problems (p=0.088) (Table 7.24). Odds ratios are only slightly affected by any of the covariates entered singly. However, when the covariates were entered together, the odds ratio for 'likes teachers' as a predictor of antisocial behaviour becomes statistically less significant (p=0.32).

Table 7.24 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with 'child likes teachers', at age 13

Predictor	Adjusted for	Odds Ratio*	p	95% CI	n
Likes teachers age 13	Unadjusted	0.66	0.003	0.50, 0.87	996
	Conduct problems age 6[1.]	0.65	0.004	0.48, 0.87	911
	Conduct problems age 13[1]	0.77	0.088	0.57, 1.04	908
	Mother's education[1]	0.71	0.018	0.53, 0.94	948
	School entry score[1]	0.66	0.017	0.47, 0.93	673
	Child's sex	0.67	0.005	0.51, 0.88	996
	Housing tenure at birth[1]	0.76	0.066	0.56, 1.02	918
	Financial difficulties in early childhood[1]	0.77	0.079	0.57, 1.03	916
	Entered together: Conduct problems age 6[1] Mother's education School entry score Housing tenure at birth[1] Financial difficulties[1]	0.82	0.32	0.56, 1.21	590

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB ($p<0.05$) when entered with the predictor

The hypothesis from the qualitative interview study analysis proposed that good relationships with adults at school could be protective, but these good relationships were often not with teachers, and therefore might not be reflected in answers to the available ALSPAC question. While the hypothesis is partially supported by the associations reported above, whether or not children like their teachers is evidently related to family background factors as well as to children's behaviour problems. Nevertheless, alongside the qualitative findings, these associations may provide some support for the importance of developing positive relationships between school staff and pupils.

7.3.5 Communication

Hypothesis 11: Children whose school and parent/carer communicate well are less likely, compared to those where there is not good communication, to display antisocial behaviour in the future.

The qualitative analysis indicated that there is not a straightforward relationship between how much communication there is with school, and how helpful that communication is. Sometimes parents felt there was not enough communication while at other times, schools were getting in touch too much, usually with complaints about the child's behaviour. In ALSPAC parents were asked whether or not they are kept informed by school about their child's school work, and their behaviour, at age 7 (Table 7.25).

Table 7.25 Mother's opinion of whether they are kept informed about child's school work and behaviour (age 7), by antisocial behaviour (ASB) ages 16-21, behaviour problems sample

		n (% of total) with ASB		Total n (%)	$\chi^2(1)$	p
Kept informed about child's school work, age 7	**No**	48	(37%)	130		
	Yes	237	(26%)	911	6.81	0.009
Kept informed about child's school behaviour, age 7	**No**	45	(37%)	123		
	Yes	240	(26%)	913	5.76	0.016

As Table 7.25 shows, there is a statistically significant difference in the likelihood of future ASB, between those children whose mothers do and do not feel they are kept informed by schools, with mothers whose children went on to have ASB feeling less informed. 'Kept informed about child's behaviour' continues to significantly predict ASB when controlling for a child's conduct problems (Table 7.27). However, the association between 'kept informed about child's school work' and ASB becomes non-significant in regressions adjusting for children's conduct problems (p=0.083) (Table 7.26). In separate regressions investigating the covariates, the only one, other than children's conduct problems, significantly associated with whether or not parents felt 'kept informed' was financial difficulties in early childhood, and these covariates had little effect on the odds of 'kept informed' predicting later antisocial behaviour (Table 7.26).

Table 7.26 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with whether or not parents felt kept informed by school about child's work, behaviour problems sample

Predictor	Adjusted for	Odds Ratio*	p	95% CI	N
Kept informed about school work, age 7	Unadjusted	0.60	0.010	0.41, 0.88	1041
	Conduct problems age 6[1]	0.70	0.083	0.47, 1.05	982
	Mother's education[1.]	0.64	0.027	0.43, 0.95	1006
	Mother's age[1.]	0.64	0.028	0.44, 0.95	1036
	School entry score[1.]	0.61	0.043	0.38, 0.99	703
	Child's sex	0.60	0.010	0.41, 0.89	1041
	Housing tenure at birth[1.]	0.58	0.008	0.38, 0.87	982
	Financial difficulties in early childhood[1]	0.65	0.041	0.44, 0.98	980
	Entered together: Conduct problems age 6[1] Mother's education Mother's age School entry score Housing tenure at birth[1] Financial difficulties[1]	0.75	0.299	0.44, 1.29	621
	Entered together: Conduct problems age 6[1] Financial difficulties[1]	0.71	0.100	0.47, 1.07	942

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB ($p<0.05$) when entered with the predictor

Table 7.27 Logistic regressions predicting children's antisocial behaviour age 16-21 (ASB) with whether or not parents felt kept informed by school about child's behaviour, behaviour problems sample

Predictor	Adjusted for	Odds Ratio*	P	95% CI	N
Kept informed about behaviour, age 7	Unadjusted	0.62	0.017	0.42, 0.92	1036
	Conduct problems age 6[1]	0.64	0.031	0.43, 0.96	978
	Mother's education[1.]	0.63	0.023	0.42, 0.94	1001
	School entry score[1.]	0.63	0.059	0.39, 1.02	701
	Mother's age[1]	0.62	0.020	0.42, 0.93	1031
	Child's sex	0.61	0.015	0.41, 0.91	1036
	Housing tenure at birth[1.]	0.58	0.011	0.38, 0.88	978
	Financial difficulties in early childhood[1]	0.69	0.080	0.45, 1.05	976
	Entered together: Conduct problems age 6[1] Mother's education Mother's age School entry score Housing tenure at birth[1] Financial difficulties[1]	0.75	0.302	0.44, 1.30	620
	Entered together: Conduct problems age 6[1] Mother's age[1] Financial difficulties[1]	0.71	0.108	0.46, 1.08	938

*All Odds Ratios show the association between the hypothesised predictor and ASB
[1]Indicates covariate which was significantly related to ASB ($p<0.05$) when entered with the predictor

Table 7.26 and Table 7.27 show that children with behaviour problems whose mothers feel well-informed by their school are less likely to go on to have ASB, supporting Hypothesis 11. Although no individual background factor explained the relationship, the effect did disappear when several background factors were taken into account together. As the odds ratios remain similar and in the same direction, with just the p values changed, it is possible that the reduced sample size leaves the study underpowered to detect an effect when all covariates are included. Whether or not parents felt kept informed depended somewhat on the degree of behaviour problems the

child had and on the families' financial difficulties. Older mothers were somewhat more likely to feel kept informed about their child's behaviour.

We do not know whether the perception of being ill-informed is related to the level of information the parent is given, and we do not know to what extent parents take advantage of opportunities to become informed. In ALSPAC one way to look at this further is to look at whether parents attend parent-teacher meetings, which is a question asked of teachers in school years 3 (age 7/8) and 6 (age 10/11). Teachers report that nearly all parents attend parent-teacher meetings (97% of the behaviour problems sample in year 3 and 91% in year 6). Although a lower percentage of those in the ASB group attended parent-teacher meetings than in the non-ASB group, the numbers are very small and the difference is not significant (Table 7.28).

Table 7.28 Attendance at parent-teacher meetings by antisocial behaviour ages 16-21 (ASB), behaviour problems sample

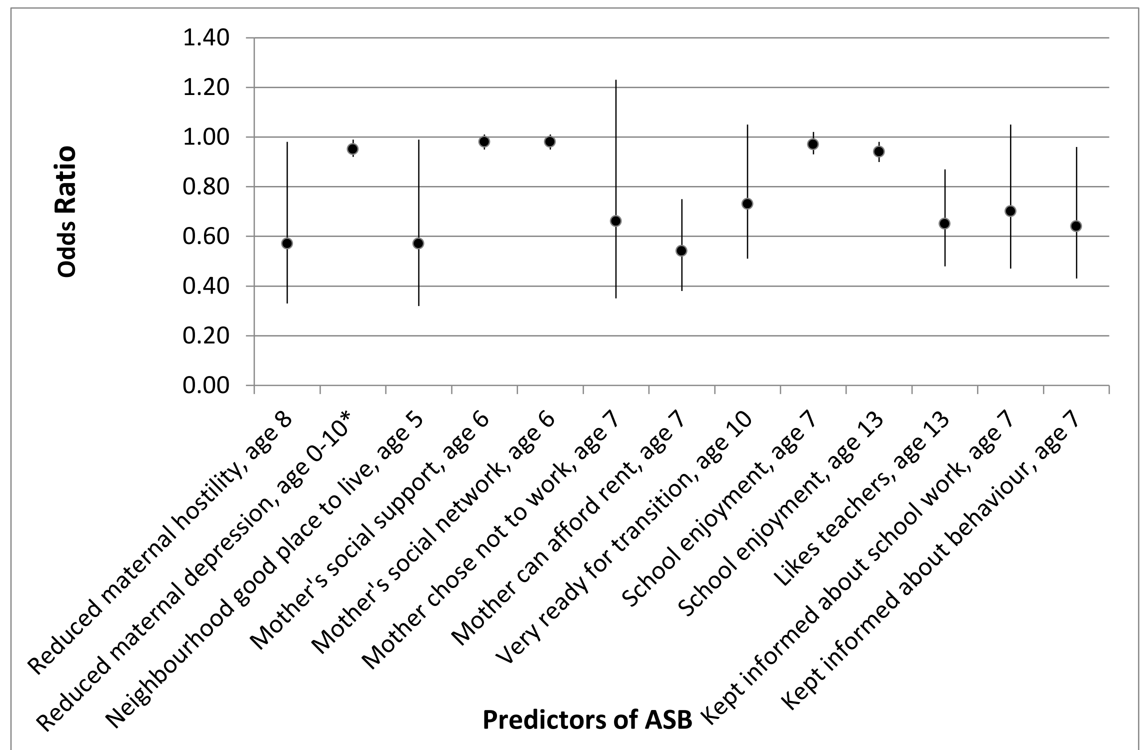
		n (% of total) with ASB at ages 16-21		Total	$\chi^2(1)$	p
Behaviour problems sample, year 3						
Parents have attended parent-teacher meetings	**Yes**	146	(25%)	586		
	No	9	(43%)	21	3.43	0.064
Behaviour problems sample, year 6						
Parents have attended parent-teacher meetings	**Yes**	177	(27%)	662		
	No	18	(29%)	62	0.15	0.697

7.4 Summary of findings and conclusions

In response to Research Question 2 the analyses reported in this chapter investigated the role of factors suggested by the interview study's qualitative analysis, in influencing the later antisocial and criminal behaviour of children with primary-school-age behaviour problems. It was possible to find ALSPAC variables to mirror findings from the qualitative analysis for a surprisingly large number of the suggested factors.

Figure 10 brings together findings from the key regression analyses presented above. The chart shows the odds ratios, and their confidence intervals, for each hypothesised predictor of children's future antisocial behaviour, adjusting for children's behaviour scores at baseline (age 6).

Figure 10 Comparison of Odds Ratios and Confidence Intervals for hypothesised predictors of age 16-21 antisocial behaviour (ASB), controlling for child's conduct problems score age 6, behaviour problems sample



* Also adjusted for postnatal depression score.

The unadjusted comparison data presented in sections 7.2 and 7.3 show that each hypothesised protective factor was more common for the group that did not go on to have ASB. However, level of baseline (age 6) conduct problems differed between those

who did or did not display ASB at ages 16-21. Therefore it was important to examine the strength of associations adjusted for baseline conduct problems. These adjusted analyses (represented in Figure 10) support many of the associations suggested by the qualitative analysis. All the adjusted odds ratios are less than one, implying a reduced likelihood of ASB where the hypothesised factor is present. However, these reductions are not statistically significant at the p=0.05 level for all hypothesised predictors, that is, those where the upper limit of the confidence interval is more than one.

Regarding hypotheses arising from themes presented in Chapter 5, less hostile parenting (Hypothesis 1), lower rates of maternal depression compared to postpartum (Hypothesis 2), good feelings about the neighbourhood (Hypothesis 3), and no difficulty paying the rent (Hypothesis 6) are all associated with a lower likelihood of antisocial behaviour. Regarding the school-related hypotheses arising from themes reported in Chapter 6, children who enjoy secondary school (Hypothesis 8) and like their teachers (Hypothesis 10) at age 13, and whose parents feel they are kept informed by school about their child's behaviour (reflecting good home/school communication, Hypothesis 11) are less likely to display later antisocial behaviour.

Figure 10 shows that although all the adjusted odds ratios are below the OR=1 line (OR=1 indicates no effect of the predictor) for some of the hypothesised predictors, the confidence interval includes OR=1, showing that the association is not statistically significant at the p=0.05 level. Thus, adjusting for children's level of conduct problems at age 6, there is insufficient evidence to conclude that their later ASB is predicted by mothers' social support or social network (Hypothesis 4), not working by choice (rather than not working when they would prefer to work; Hypothesis 5), being considered ready for the transition to secondary school (Hypothesis 7), school enjoyment at age 7 as opposed to age 13 (Hypothesis 8) or parents being kept informed about school work, as opposed to behaviour (Hypothesis 11).

The associations of antisocial behaviour with less hostile parenting (change between ages 4 and 8), improved parental mental health (compared to the postnatal period) and difficulty paying the rent, remain statistically significant when the role of additional background covariates is taken into account. These findings suggest a relationship with

ASB above and beyond what could be explained by the family background factors investigated.

The association between children's school enjoyment at age 13 and ASB also remains strong when adjusted for each background confounder included individually but less so when entered together. The associations between school enjoyment and ASB, and between 13-year-olds liking their teachers and ASB, become less statistically significant (with p values above 0.05) when adjusted for age 13 conduct problems. Evidently children's enjoyment of school at age 13, including their teachers, is related to their behaviour at that time. A decline in school enjoyment between primary and secondary school was also shown.

Regarding Hypothesis 9, primary school children with behaviour problems who were just below the threshold for having a statement of special educational needs (SEN), were more likely to have antisocial behaviour at ages 16–21. However, numbers in some groups were too small to allow further analysis. Analysis of the full sample of children shows that the 'School Action Plus' group of children, those with additional needs but without a SEN statement, are more likely than other children to display later ASB, a statistically significant association.

Although a statistically significant association was not found in the present analysis, much research has pointed to the protective role of supportive social networks (see Chapter 2), and some of the interventions encountered in the interview study tried to encourage the development of better informal support. The qualitative analysis showed the important, but complicated, role of social networks in helping a family in difficulties to bring up a challenging child. Wider family and social connections could be a crucial support but in some cases could be more of a hindrance. This is a good example of how relationships between potentially protective factors and outcomes can be difficult to tease out in survey data.

The principal interest of this study is in how families and children can be helped and supported, during the school years, to prevent at-risk children developing antisocial behaviour. Therefore, although there is evidence that mothers' mental health during primary school is associated with children's later antisocial behaviour, of particular

interest is any evidence that *change* in the hypothesised important factors during the school years, is linked to lower risk of antisocial behaviour. There is some evidence for this with regards to lowered parental hostility towards the child, and improved maternal mental health (compared to postpartum), both seeming to be protective. No statistically significant role was found for change in maternal mental health or social support occurring *during* the primary school years. For the remainder of the factors it was not possible to reliably examine the associations with *changes* during the school years either because of the timing of survey questions in ALSPAC, because of interrelatedness of the predictor variables or because subsample sizes were too small.

Interview study children were not considered 'very' ready for the transition to secondary school. The period following transition was particularly problematic for all children except one, for whom a special effort had been made to transfer him directly to a small special school. However, in the ALSPAC analysis it appeared that although those who are not considered very ready are more likely to go on to have antisocial behaviour, this was explained by the level of children's conduct problems and other sociodemographic factors. The findings suggest, however, that improving communication for more disadvantaged parents and for parents with children exhibiting difficult behaviour might be an area where enhanced intervention is warranted.

As shown above, antisocial behaviour is related to a large number of background individual, family and environmental socioeconomic characteristics. The inclusion of more than a few covariates eliminates many of the associations found here, partly because there are strong interrelationships (multicollinearity) between many variables. The qualitative analysis suggests factors which appear helpful, as well as other factors which hold back change; this analysis thus uncovers some of the subtleties around need for and provision of help which could not be replicated in survey data. The ALSPAC analyses presented here show that children who later displayed antisocial behaviour were, on average, disadvantaged on every one of the hypothesised protective factors in middle childhood. These factors can be targeted by intervention, aiming for example to improve parent-child relationships, mothers' mental health, neighbourhood conditions, social support and school-based provision. The next chapter (Chapter 8) returns to the qualitative analysis of the interview study families' experiences. The chapter looks at what those experiences suggest about features of individual practitioners, and of

organisations providing services, which help bring about, or prevent, the types of change the current and previous chapters have suggested could help families in the longer term.

Chapter 8

Support, reform or surveillance: the conflicting roles of services intervening with parents

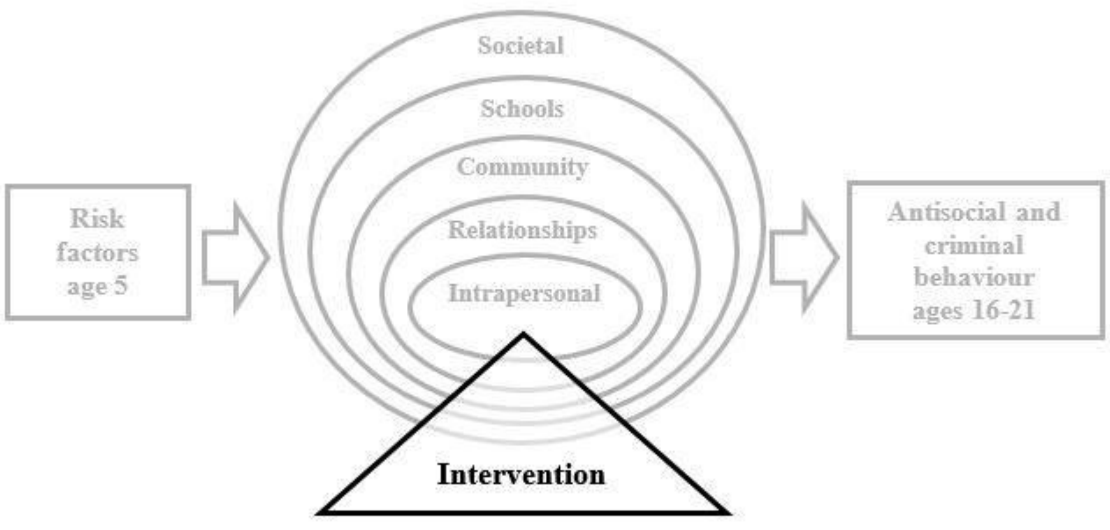


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> Don't tell me what you know until you know what I've said. Do you know what I mean? No. You've got to listen to the person first before you know you can help them. Because not every child's the same. *Sue*

This chapter argues that services intervening in families have conflicting roles and that this constrains their ability to do a difficult job effectively. The chapter draws on the qualitative analysis of interviews and related documents, including 20 interviews with ten parents and interviews with 21 different practitioners. Between them the three preceding chapters have suggested ways in which trajectories may be affected by intervention, through their impact on the spheres of influence represented in Figure 1. Chapters 5 and 6 looked at experiences of intervention, but also at other factors influencing family functioning and child behaviour which could potentially be targeted by intervention or policy. Themes in those chapters principally addressed the first part of Research Question 1, about factors amenable to intervention. This final empirical chapter focusses more specifically on what aspects of services' and practitioners' culture and practice make intervention more effective, or reduce its effectiveness, addressing part b) of Research Question 1: *What features of intervention help bring about change? Conversely, what features of intervention prevent families benefitting?* The services discussed in this chapter are those delivered mainly to parents, usually in the home or in a clinic-type service setting, such as social work, mental health and family support services. An overview of the service involvement of interview study families, their ratings of services encountered and the impact of their child protection status on the provision of services was presented in Chapter 4.

A key finding explained in this chapter is the tension around whether the main focus of services in relation to families is support, reform or surveillance. Section 8.1 describes how developing trust with parents who may have had bad experiences with professionals is difficult and takes time; pressures from the organisation can push practitioners in the opposite direction. The surveillance role of services, now that 'child protection is everyone's business' (Fraser, 2008) and 'safeguarding is everyone's responsibility' (HM Government, 2015) can undermine development of trust, without which any progress appears to be unlikely. Fear of surveillance can also discourage parents from accessing services. The section then explains how the desire to *reform* families or individuals may lead to the service targeting factors that are easier to change, but may not be seen as helpful by families. Section 8.2 looks at the tension between the

reform and support roles of services, and some of the consequences, such as a reluctance to remain involved with families in the longer term. Despite this, some of the mothers in the study *have* had a long-term relationship with a practitioner and seem to have benefitted from this.

Parents' attitudes to services have an impact on how effective services can be; past experiences can make parents wary of trusting practitioners. Parents' attitudes to services are discussed, and a typology presented, in section 8.3, while features of effective parent-practitioner relationships are presented in section 8.4. The character and behaviour of *individual practitioners* emerges as key in overcoming parents' antipathy. It is individuals' skill and efforts to break down barriers, make connections and sometimes go against, or revisit, the approach of others in their organisation which seems to make the difference in being an effective practitioner.

8.1 Surveillance as a primary role of services undermines parents, trusting relationships and help-seeking

What are the aims of intervention? For the majority of interventions discussed in the interviews it appears their aims could be broadly categorised as one or more of the following:

- To affect the primary carer's wellbeing, particularly her ability to maintain a stable mood in front of her children, but also by supporting mothers who experienced domestic violence
- To affect the primary carer's parenting directly
- To affect the child's behaviour directly, through therapeutic input or strategies for the child or those working with the child
- Surveillance of parents for child protection
- To affect the broader environment in which the child lives e.g. housing, money, activities, school environment

The odd one out in this list is surveillance. The others relate directly to the concentric circles of the conceptual framework (Figure 1) representing spheres of influence on children's trajectories. Surveillance of parents occurs because of the statutory obligation on key services, including school, social work and police, to protect children (HM Government, 2015) and can lead to a child being removed if it is felt that the parenting

and environment of the child cannot keep the child safe. Two children in the interview study’s small sample were removed from their mothers’ care. Practitioners are aware of the high risk of poor outcomes for children who are taken away from their parents, and so such decisions are not taken lightly. However, practitioners are also aware that they themselves will be blamed if the child comes to harm in their current situation (Featherstone et al., 2014).

8.1.1 Effect of perceived surveillance role on help-seeking

For services which deal principally with parents, building trust is crucial. Social workers in general may not be well placed to provide non-judgemental support because of the prominence of their mandatory surveillance role, although other agencies also have a responsibility to report child protection concerns (HM Government, 2015). Sometimes parents in the study aimed to avoid service involvement because of the perceived threat of having their child taken away.

> I do sort of think… if I do try to talk to someone about it then my kids will be taken away… If I knew for a thousand and one million like percentage of a definite certainty, that my kids won’t be taken away from me, then probably yes [I would seek support]. *Study mother*

While some parents avoided services because of this threat, others felt they had to accept intervention offered or risk looking uncooperative and being placed on the child protection register. Amana and Linda both referred to using services to pre-empt any accusations related to child protection. Amana took her baby to the GP because he had some bruises, and wanted it on record that she had voluntarily done so; Linda was advised by a duty social worker to take her baby to A&E for a check-up after her son Jamie reported her to 999 for harming the baby, despite Jamie admitting he had invented it because he was angry with his mother. Linda described the conversation with the social worker:

> So she went, 'Oh well if I was you, considering the amount of times you've had a social worker, I suggest you go'. I said, 'I'm telling you now, I am not going'. *Linda*

Although she refused, she did take the baby to see the GP the next day, even though the GP thought it was ridiculous. Linda wanted to make sure she could not be criticised for having refused to make the trip to A&E.

Amana’s first experiences with a social worker had made her resistant to seeking support:

> She is one of those people that you would go I would never, ever, ever, ever get involved with social services ever again, and it was almost like, I came to you, but now you're accusing me of these horrible things. *Amana*

Amana had been shocked that her social worker went ‘behind my back’ to question her parents: ‘I was outraged, but I couldn't complain’.

Case notes for one family show the professionals involved giving different views as to whether the child protection plan should cite abuse or neglect as the reason for concern. The case did not fit either category, although professionals agreed that the family should remain under surveillance, and should receive support. There are repeated assertions that the mother is ‘doing her best’ and that the children’s basic needs are well met. The concern was the child’s extremely difficult and sometimes antisocial behaviour, as well as the danger he posed to a younger sibling, but there is not an available category for this – the available categories for referral to child protection implicitly blame the parent.

Sue had defended social services, as a place to seek support, to other parents who had expressed fear of getting involved:

> What I'm saying, trying to say to some people is, social services ain't all bad... the only reason they take the kids away is when it's to the extreme. That's what I'm saying. They are quite helpful, they've been helpful for me. *Sue*

However, other parents’ feelings about social workers in general were negative:

> I don’t deal with them sort of people. *Donna*

> To be honest with you I’ve never really liked social workers, I think they’re horrible people, but with [my current social worker] she’s quite nice and I can tell her things, I would say she is someone that I could sit and talk to. But at the end of the day, you are still a social worker. *Linda*

Bella felt that what social services needed to do was boost parents’ confidence, but that they seemed instead to undermine it. While some parents accepted that social workers were ‘only doing their job’, parents could resent the way they were made to feel bad about themselves:

> I know they're only there to help me, but it's still, I've got to meet this person, I've got to meet that person. It's as if I've done something wrong, sort of thing, like I'm being punished. *Linda*

> I just feel like I'm being put down every single bleeding time. You know, and I just keep – I'm always having to go there like a boxing match each time to fight my corner. *Paula*

Linda, despite liking her current social worker ('The one I find really helpful is the social worker, she's really, really nice'), could not see her as someone she could confide in:

> *Interviewer:* Who would you go to now if you felt you needed support?
>
> *Linda:* Hmm, I don't know really, I wouldn't really know.
>
> *Interviewer:* You wouldn't go to the social worker?
>
> *Linda:* Oh no, no!

The surveillance part of social workers' role was uppermost in many parents' minds:

> If I get them days when I sit there and say to someone, you know what, I'm going to kill Jamie, but not literally mean it as I'm going to kill him … I'd like someone like [HFP practitioner] who, she would take it in her stride like and just listen to it whereas, ears pricked up, you know, they might take it the wrong way? *Linda*

So even though Linda did feel she had made a connection with the social worker, the relationship was undermined by the general perception of children's services as a threat to parents rather than a support. Paula was convinced that she was only on the child protection register because of one school-based practitioner's concerns, and indeed her social worker did cite this person as her most important informant.

There was some evidence that social workers had done their best to counteract this image of unsupportive surveillance. Two parents particularly commented on what they had been told regarding the role of social services. Nicole mentioned several times that social services did not have any questions about her parenting, but were just interested in keeping the children safe from the wider criminal environment around them. Paula reported the attempted reassurances of children's services: 'They said that, you know, for these meetings these are supposed to be there to help protect your child – not go against you'.

Donna tried to have nothing to do with social workers, and Mary and Bella expressed similar views. Donna had been referred to social services for child protection concerns by a previous headteacher and was very angry about it:

> It's always the people that look after their children that have social workers on their backs and the people that really neglect their children, nothing don't happen to them! *Donna*

Donna and Bella had both been very defensive when visited by social services, refusing to engage with them. As concerns about risks to their children were not high enough to warrant intervention, and perhaps also because they were both involved with CAMHS, this approach, according to the mothers' accounts, seemed to have curtailed any further involvement.

Those who are already on the child protection register are obliged to cooperate with services. Jenny and Esther were not considered to have engaged sufficiently with services, or tried to implement changes, and their children were removed from their care.

8.1.2 Focus on trivial issues can blame and alienate parents

Social workers, whose ultimate goal in child protection cases is a very serious one, can find themselves, according to the accounts of both parents and practitioners, having to focus on trivial issues, which can further undermine parents. While the surveillance obligation is meant to encourage practitioners to note and act on evidence of abuse or neglect, there is often an emphasis on apparently minor issues such as tidiness and household routines. This emphasis can make it difficult to develop a trusting relationship, as it makes practitioners appear to prioritise unimportant things. The importance given by children's services to good housekeeping seemed to be quite entrenched:

> It's hard to say what I think — what she needs really. Um… because, I mean, she keeps that house tidy. *Social worker*

Social workers' tick-box approach can seem inappropriate to parents when they come to look at what food is in the fridge, and comment on the amount of sugar eaten, whether clothes are appropriate for the season, the tidiness of the home and whether the children

have nits.

> I sort of like personally feel that my life has been too much of a huge fish tank … you know, I want some privacy now. *Paula*

Paula's case was an example where a lot of services had been put in place, but seemed to have caused additional stress without having achieved much.

> Paula's story
>
> Paula had recently split up from her husband and suffered a number of bereavements. She suffered from depression and had significant financial difficulties putting her home in jeopardy. All her children had very challenging behaviour in different ways. She had fallen out with her wider family who were critical of her parenting and she did not seem to have much else in the way of social support.
>
> Children's services practitioners queried Paula's ability to manage family finances, and voiced concerns about the state of the house and about the children's personal hygiene. The children were on the child protection register and the family was being supported by a family intervention project.
>
> Two years later, much had changed. One child had been permanently excluded from school and was attending a small special school; various restrictions had been put on this child's activities by children's services, which Paula had to oversee and report on. There had been a further bereavement but this seemed to have brought the wider family together, and Paula now had better family relationships.
>
> Paula had a negative view of children's services, and had been through almost constant changes of social worker. The family had experienced a very burdensome level of compulsory intervention involving being visited every day for several months, with two different family intervention projects one after another. Lots of targets had been set to do with the home environment and the visits and targets had caused Paula a great deal of stress. Paula felt that services were only interested in the children and the state of the house, that they never considered her own wellbeing or needs. However, she liked the latest social worker, who she nominated for interview, and felt she was listened to by her.
>
> The new social worker concurred with Paula that the case had not been handled well – that no account had been taken of the underlying causes of the family's distress at the time of the initial referral, including the adjustment to becoming a single mother. She felt there were inaccuracies and wrong emphases in records about the family and that nobody had really listened to the children or the mother; the many changes of social worker may have been partly to blame. This social worker felt that there were no serious safeguarding concerns and that the two family intervention projects had probably been unnecessary; the small amount of change which had been achieved could have been achieved without them. She had moved the family

from the 'Child Protection' level of need down to 'Child in Need', a lower level of concern. Nevertheless, she still focussed on apparently trivial and seemingly arbitrary targets for Paula such as making sure Harriet changed out of uniform after school, and particular aspects of tidying she wished to see done.

In Paula's case, the overriding impression from the interviews is that children's services' input had made a stressed family more stressed and undermined the confidence of a mother struggling in difficult circumstances. Paula did not receive the Helping Families Programme, because the worker who had been trained in it left almost as soon as Paula had been offered the programme. The approach of the programme, aiming to be 'purposeful' and bring about reform according to goals mutually agreed with the parent, might have been useful to Paula as it recognised that support issues and crises needed to be dealt with first. The large amount of family intervention that *had* been put in place had been carried out by inexperienced workers, according to the practitioner interview. Paula experienced it as burdensome rather than supportive.

Paula's case is an example of possible negative consequences resulting from a focus on trivial issues, itself a consequence of the surveillance role taken by social services. Concerns about the surveillance role of services came up in interviews with eight of the families, and respondents in five families talked about services' interest in apparently trivial issues. Some parents saw this as a tick-box approach by services to monitoring children's wellbeing, which as well as being part of surveillance efforts may also be linked to a desire to show evidence of families having implemented changes. Services' conflict between needing evidence of reform, while offering support, is the subject of the next section.

8.2 Reform versus support; does 'purposefulness' leave room for long-term support?

Services were often put in place as a response to crises, or referrals from schools, rather than requests for help from parents, and ongoing 'on call' support was not usually felt to be available. Chapter 4 briefly discussed the 'cliff edge' of support being in place short-term, followed by nothing. This relates to services' desire to have targets which are met; families which are 'reformed', not just supported. A few parents or children, however, were able to get occasional ongoing support, usually by phone, from a practitioner they

had formed a relationship with in the past, despite the relationship having officially ended.

8.2.1 Organisational expectations of short-term, goal-focussed involvement

Several practitioners mentioned the increasing expectation that intervention should have stated goals which you aim to reach. One family worker explained how the promoted model of working with families had become much more purposeful:

> I'm not saying those things are bad, you find you could be stuck, like I said, in cases for years and you're holding these people's hands when technically we've got to empower them to move on and get on and manage their situations rather than holding their hand all the time. *Family worker*

Several practitioners (those working with Donna, Kathleen, Linda, Paula and Bella) commented on services' move towards a more circumscribed role, with goals that were expected to be met (in tune with a 'treatment model' of service provision). Practitioners understood that ongoing day-to-day support was not seen by their service as a helpful aim of intervention, at least not in the longer term:

> Well the pressures here are that the kind of models that we're supposed to be working with now are that people come in; you assess them; you treat them for a certain period; they improve and you discharge them. Which, in my experience, is not really how things tend to work. *CAMHS worker*

Bella described this CAMHS worker as 'a big part of [Palani's] life now'. But the CAMHS worker had to battle against the expectations of her unit in order to continue working with Bella's family after four years. Intervention was expected to be short-term, ending with achievement of a goal. The practitioner herself questioned what she was doing:

> *Practitioner:* I think Bella likes me and I think that's different from being helpful.
>
> *Interviewer:* But it must be helpful for her to have somebody just to be able to talk to, who knows...?
>
> *Practitioner:* Yeah, that's her definition of what is helpful you see, the clinical definition would be whether I have made any changes in her symptoms …

Another CAMHS practitioner, a psychiatrist, agreed that in principle her service did not encourage cases being open for more than two years, but that long-term conditions required long-term support, and she had provided this for Amana and Darius:

> We still do offer very long-term psychotherapy, and most of my cases you know, people with ADHD, complex problems, it's not going to go away. *CAMHS Psychiatrist*

She attributed their ability to continue providing a longer-term service where needed to sympathetic service commissioners. She felt that the service was very fortunate to have this support and it allowed them to provide a good service. However, she admitted that if the child had not been on medication for ADHD they would not have been able to justify keeping his case open in CAMHS. This implies that for children who have not responded well to medication, they are also denied other aspects of longer-term support. In Darius's case the medication was a small part of the help and support given to the family by the CAMHS psychiatrist. But Palani, whose needs were just as high, became very depressed on medication so did not take it. He was therefore assigned to a less qualified, though helpful, CAMHS worker, and his case was closed when he became 12, an age limit for that particular service.

8.2.2 Lack of perceived purpose

Some parents could at times be receiving a burdensome amount of intervention. Bella, Paula, Kathleen and Sue all had periods where they felt the amount of service contact or appointments they had to have was too much, and they could not always see how the appointments were helping.

> I'm not just letting someone just dig into my life for nothing. You know what I mean? They've got to have an aim. *Sue*

Although Child Protection or Child in Need plans did involve thinking through the best approach to supporting children in their families, parents sometimes experienced a lack of coordination between services and Nicole commented that nothing seemed to happen to implement planned support until just before a review meeting was due, when practitioners would hurry to tick the correct boxes.

While some parent-practitioner relationships brought about real change, other support programmes may have carried on too long, and parents on occasion could not see the point when messages became repetitive:

> It's just the same things every week, and you're like, do you know what? It's strategies we've been through in the past, and I've seen so many of you professionals over the course of the years. *Linda*

When the latest practitioner left her post and Linda was offered a replacement she opted to end the intervention.

A lack of purpose may be perceived on both sides. The HFP practitioner working with one mother noted early on his ‘worries that the relationship settles into one that is not a purposeful partnership’ — a fear borne out, perhaps, by the mother’s recall of his involvement, which she had nearly forgotten three years later: ‘he was a nice chap … [but not useful]’.

A family worker felt she had continued working with another mother for too long, without any real change, and put this down to it having been her first case, but she nevertheless identified some benefit of support:

> How helpful? It’s interesting – I think I could score it high in some respects and very low in some respects. Like, helpful at making meaningful change? Quite low. But helpful at the time in kind of being there, and reflecting and giving – you know, providing some of that kind of support? Quite helpful. *Family worker*

It is not necessarily easy to tell when a support is useful. The examples above, particularly some of the intervention with Paula and with Linda, where neither parents nor practitioners could see the point of intervention, probably indicate wasted resources. However, in other cases, support that is appreciated is stopped.

Linda and Jamie’s social worker stopped working with them because she felt she was not achieving enough change. In some ways this was more worrying than in Donna’s case as Linda had found the social worker very supportive, particularly in supporting her in the face of criticism from other practitioners. She was the first social worker that Linda had liked, and she had been allocated many. But the social worker commented:

> I think to be quite honest, I didn't mind the move. Although I like the family, I didn't mind because I did kind of feel that for a time things were kind of stuck, that there wasn't a lot of progress, and so you know, I didn't – at the time when I was told that I could hand over a case … me and my manager both had the same case in mind. *Social worker*

But this approach could mean that those families who are hardest to help will experience the most changes in social worker, making building trust even more difficult. Linda's family were then allocated a new, inexperienced social worker, perhaps as a result of them being considered hard to help. Paula's family were also given inexperienced family support workers, and they were another family where social services felt they had not achieved much change. Linda however, lost support that she had found useful, when no benefit was perceived from the practitioners' side. The implication may be that families need to be listened to more, so that benefits of intervention which may not be the stated aims can be acknowledged, or so that parents are not left receiving services for which they see no useful role.

8.2.3 Sometimes support, rather than reform, is required

In some cases support and a listening ear are desired by parents, and may be useful in themselves, without *reform*. Such support could include someone to turn to when there were crises or difficult decisions to be made. Bella's CAMHS worker felt that part of what Bella had needed from services was compensation for the lack of social support in her life, to help with childcare, for example:

> I think she should've had, you know, a supportive family who were there for her and a partner who's there. You know, those things, if they'd been there that they would've made a lot of difference but they're not there and there isn't a service that sort of provides surrogate families is there? *Bella's CAMHS worker*

Bella experienced two interventions where what she wanted from them was support but this did not fit with the service aims, which were more aligned with reform. HFP worked by developing shared goals with the parent. Bella wanted 'supportive sessions', a space to openly discuss the stresses of her life, but it was explained to her that HFP was explicitly goal-oriented and purposeful, and this was core to its rationale. The HFP documentation reported that Bella connected with the worker, but not with the programme.

Bella and Sue had both enquired about getting some support at certain times, feeling they were on the edge of being able to cope. Both mentioned wanting some sort of respite, but neither had received it. Even at the final interview, when Bella felt greatly empowered following her tribunal win, she still wished for someone to take the children out for a couple of hours occasionally. Other families did get such support, with community mentors for the child, providing some respite to the parent, as well as benefits for the child (the principal aim; see Chapter 6). Bella and Sue both commented that they were seen as 'copers' who got on with it and could manage without additional help.

But some parents want an ongoing source of support, for example Linda, who had wanted to continue with HFP:

> I think you should be given the option whether or not you want to, like, extend it or if you feel like you've done what you've achieved, I think you should've been given the chance to extend it. *Linda*

At the first follow-up Kathleen wished she still had some of the services she had been receiving at the time of HFP:

> At first I didn't agree for all the services to stop, but there's nothing I can do because of the cuts, so, I had to agree with them to go and help others. *Kathleen*

Kathleen really missed the service involvement, and indeed as her son's behaviour and the family's circumstances had deteriorated by the second follow-up, her wish may have been justified (see Chapter 4). However, her ex-family worker, commenting in general about the new focus on achieving goals, rather than providing support, hinted at frustrations when parents do not take enough responsibility for their own progress:

> It's like many families, you've got generational problems, you know, issues of worthlessness or whatever it is. It's like, okay, we've gone through everything, we've done the whole CV bit, we've gone through the training and mentoring, I've taken you around, and you've actually got to now get on with it, you know? *Family worker*

In the second follow-up interview with Kathleen, the question of whether it would have made any difference if she had continued to have service involvement in between the two crisis periods was discussed. She would have liked a one-to-one person, who knew the family, to stay involved. However, her social worker, interviewed at the second

follow-up, felt that the long-term involvement of a family support worker had stopped being effective *because* of the length of the contact.

Social workers' own language backed up the idea that services were for reform not support. For example, Darius's school had suggested to Amana that they contact social services to see if they could offer the support that she wanted, but one of the social workers had queried with Amana why she had been referred if she was not a risk to her son.

Bella had thought a lot about distribution of services between those with higher and lower levels of need:

> If I was within the government, this is what I will do, there's very severe children that's very understandable, you give 50% of that to the severe, the other 50% you divide it between the moderate and the mild, so we all do get a piece of the cake, we're just not getting a big piece which is directly for the severe disabled and we understand that. But then what they've done, they've given 80% to the severe and 20% for the rest of us where everybody's fighting for that one piece of the cake and that's unfair, that's all it is, if they were to divide it a bit more better and give the parent the access, you have to fight to know where the access is, that's unfair, there's a lot of parents that don't know what help is out there. *Bella*

An aspect of support that some professionals provided was something akin to an advocacy role. Sue described Aaron's art therapist attending a lot of meetings with her, and sticking up for her, including with both schools at the time of Aaron's transition to special education. Amana, Bella and Nicole also received support in meeting other services, from CAMHS, HFP or official advocacy organisations, as discussed in relation to schools in Chapter 6.

Such support in navigating and negotiating with other services could help make parents' discussions with, and use of, other services more productive, although the focus would need to be on empowering the parent, rather than the practitioner advocating on behalf of the family without agreeing aims with the parent, as seems to have happened in Paula's case.

8.2.4 High staff turnover and the benefits of longer-term support

As would be expected, it is more difficult for parents to make a connection with a

practitioner when key personnel keep changing. Out of the nine practitioners initially nominated by parents as helpful at the first follow-up, one had already left her post, three others were planning to leave their posts, and another was stopping work with the family in question by the time interviews could be arranged. One family worker had been in his post for some time, but saw some other practitioners pass through quickly:

> Ah, yeah, I mean the nature of the job--, the job is you're walking into people's lives that have been devastated by--, whether it be abuse, violence, emotional stuff, it's--, and it's very draining, it's hard going. But that's the work, so when you come in, saying, 'Oh these parents are very difficult!' Eh, what?! Well yeah! *Family support worker*

Conversely, for him, staying in the role long-term provided part of the reward of the job:

> I'll meet [study mum] on the street quite regularly and we'll stop and talk and catch up, and I can see by the way she walks, the way she now looks to when I first worked with her that she's in a totally different place. I see the children and we'll stop and chat, so I can see that they're in an entirely different place and it's nice watching them grow than when we were working 2010, 2011. I mean for me that's fantastic, and that's the beauty of being community based, 'cause I see a lot of people I work with, so there's that kind of like relationship and attachment, which is absolutely fantastic. *Family support worker*

These *ad hoc* chats in the community also occurred for Donna, Linda and Mary and could be important in maintaining some continuity of support or perhaps a reminder of key learning from intervention.

Sue had had bad experiences of trying to receive consistent support when she was really struggling with the burden of Aaron's challenging behaviour:

> I don't know how many counsellors I saw, I saw them for about six weeks, um, and I said 'What do I do? *I* got to go home with him, you know, what do I do?' 'See you next week'; I go there, it'd be a different person! So it was like, I had to go over and over and over and I said I've been doing this for nearly ten years, going over the same fucking story, I said 'Ain't you got a folder now for me?' And then eventually I met [art therapist] and she's the one that actually helped us. *Sue*

Linda had made a connection with a school nurse who had left, and did not like having to tell her family's story again:

> I don’t feel comfortable with this new one, you know when you just — I know it might sound silly but you’ve got someone that knows the background history and things, like so you feel comfortable with, but when they send someone that just don’t… I just can’t be bothered to explain it all. *Linda*

The practitioner who worked with Linda on the Helping Families Programme described the need for ‘holding back’ and taking time to develop a relationship before asking too much:

> It was key to respect Linda’s pace with regards to the amount of information she shared as it took some time to build up her trust. Often it was a case of holding what was not being said. It was only after session 5-6 that the relationship could tolerate gentle challenging. *HFP psychologist*

Evidently, if trust is needed for effective intervention, and if trust takes time to build up, then frequent changeover in staff is a serious problem.

This section has looked at some of the tensions between services’ desire for reform and parents’ desire for support. Purposeful, useful intervention depends on building trusting relationships, so staffing issues such as multiple changes in practitioner create barriers to achieving effective intervention. Intervention without purpose, or without parents knowing the purpose, might be a waste of parents’ and practitioners’ time, but purposeful does not necessarily have to mean that parents cannot be provided with support they want. Parents sometimes felt they needed quite a low level of support over a longer period of time, however services usually preferred short-term goals to be met, and then intervention ended. We already saw in Chapter 4 that parents sometimes sought additional help but if they were not considered high enough need at that point they would not get it. Having easier access to earlier support might potentially help avert crises and future heavy service involvement.

8.3 Parents’ attitudes to services can affect how useful they are

> Oh, I need them. At the moment I need them, and I don’t want to drop none of them now. I need them with all this trial, and myself, court is coming, and I need them, yeah. *Kathleen*

> I don’t know why they even gave me a new social worker that thought he could look in my cupboards ‘cause my children were not at the risk of stuff and that’s when I went crazy, and I said, ‘You sign me off now today’. Two days later they sent me a letter saying they signed me off and their apologies

> of how he came and treated me and my family, and I ain't heard anything since. *Bella*

Bad experiences with services in the past, feeling blamed and judged, could lead parents to have negative attitudes towards services. In general parents wanted support, though they could be critical of support they had received, and would not necessarily engage with support provided.

Both Donna and Bella could be characterised as battlers directing their considerable energies towards fighting for and with services for their child. However, Donna's combative attitude seemed to sometimes get in the way of useful collaboration. She was described as confronting services 'with all guns blazing' and they would have to wait until she calmed down to talk things through. She was prepared to put up a fight to get what she felt her son needed, against the advice of practitioners on occasion, and was often unhappy with the results. However Bella, also proactive and assertive with services, seemed to achieve better results. Her son's learning mentor said of her:

> She's really good to deal with. I mean, she does – I like – she's so straightforward and she sort of comes to us, getting the maximum out of us, and she will ask questions. She's doing those questions so that she knows that [her son] is supported, but just by asking those questions you can feel that she's really supportive of her son and she really wants him to do well. *Learning mentor*

Amana and Bella, despite the prejudice they had faced as young parents, had both formed important bonds with practitioners from CAMHS. Amana's relationship with CAMHS had improved after she had confronted them about their treatment of her:

> In the end we had a really good relationship 'cause I just was honest with her and said, 'Look I don't like the way that you speak to me, I feel that you're patronising and because I'm young you are treating me like I'm young and I don't know a lot…And I don't like the fact that you won't finish the ADHD thing, and no one's taking me serious'. *Amana*

While Amana and Bella both developed a somewhat belligerent attitude towards services, particularly schools, they made a key ally in their CAMHS worker, who they remained in contact with throughout the study. Although there might be a danger of a long-term support like this leading to dependency on the worker, Amana and Bella both appeared instead to be empowered by these relationships which helped the young women to argue their case with other services. It is possible that if these mothers had

not developed their proactive approach, their children might not have had access to as much support as they had.

8.3.1 Typology of parents' attitudes to, and relationships with, services

Analysis of the data suggested a typology, with Donna, Bella and Amana taking a proactive, and at times belligerent approach to services, whereas Kathleen, Paula and Mary tended to be more passive recipients of services, although they did cooperate to varying degrees with services offered. Kathleen was on the whole an enthusiastic receiver of services while Mary and Paula were far more wary. Paula said that she saw her relationship with services, in fact with the whole world, as a battle, but this seemed to be largely an internal battle, as she did not appear to be assertive with services. Nicole, Linda and Sue were somewhere in the middle, with phases of confrontation with services. Sue could be very angry with services and have shouting matches with them on occasion, taking a friend along to back her up. She described threatening to punch a bully in the face, and to kill a teacher if Aaron came to harm in their school.

The two mothers whose children were taken into care during the time of the study, Jenny and Esther, did not, on the whole, respond to service intervention. They seemed either unable or unwilling to put into place changes suggested by services to help keep their children safe. The other parents, with the possible exception of Donna (who did actively engage on a certain level, but placed blame away from herself and her son), all enacted some sort of change at home, although this was not necessarily attributed to service intervention, as explained in Chapter 5.

Figure 11 shows how parents fit this typology by way of a Venn diagram with interconnecting circles showing three types of attitude to services: proactive/assertive, passive/compliant and unresponsive/noncompliant.

Figure 11 Primary carers' attitudes to services: A typology

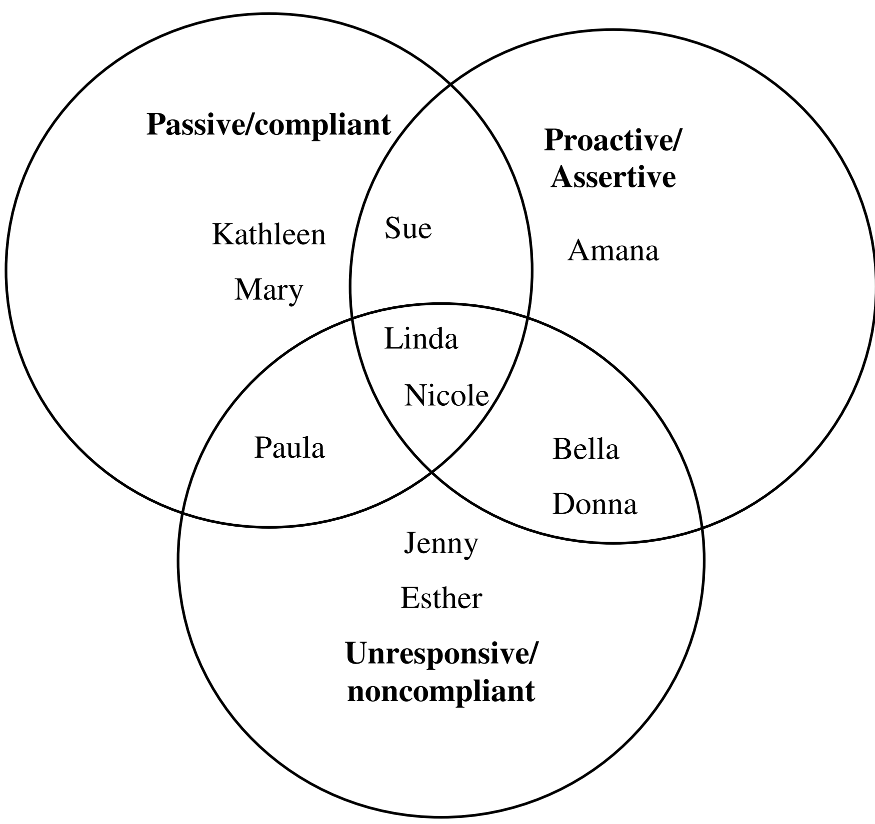


Figure 11 shows how some parents fit into one type while others have aspects of two or three types, and hence are placed in the intersecting segments. In some cases, parents changed their attitudes between timepoints, as in Nicole's case, while others had inconsistent attitudes, as with Sue and Donna. There can be both negative and positive aspects to each type. Parents needed to be proactive to acquire the services they or their child needed, but they could also be assertive in an unproductive way if it just led to angry outbursts. Equally on occasion it might not be in families' interests to be compliant if services were not helping. Amana and Bella were probably those who made best use of services. While both were proactive in seeking support, and would complain if they did not agree with actions taken, Bella also sometimes ignored, or disengaged herself from services' contacts when it became too burdensome or too unhelpful.

Nicole had been criticised in the past for not engaging with services, but seemed to become more proactive over time. Ben's teacher said of Nicole at the second follow-up that he wished all parents were like her; she accompanied Ben to school every morning

and according to Nicole's account it was because of her requests for Ben not to be exposed to negative influences from peers that he was being taught on his own.

Although her intervention seemed to have had less influence Sue also saw herself as fighting for her son's needs:

> I know when Aaron was wrong, I'd say he was wrong. When he's right, I would defend him. I'll go head and head to defend him. *Sue*

Sue and Amana both felt, however, that they had had very good support at crucial moments, and they both wanted to address stigma in seeking support, and encourage other parents to make use of services.

Donna was quite self-righteous in her attitude to services. When talking about her son she was quite calm, even slightly humorous about his foibles. When talking about services she was angry and blamed them for any incidents involving Joe's bad behaviour.

Kathleen did not have the same belligerent attitude towards services but by the final follow-up, overburdened by the amount of service involvement, now that her son was involved in criminal behaviour, she was asserting herself in her own way by not answering the phone or door. It was suggested of two parents that they knew how to give the appearance of being compliant:

> She was always very good at telling me--, which any parent with any modicum of intelligence… what you want to hear …'What's been working well?' sort of thing, 'Oh, I've been using this, I've been using that.' … Whether it's true or not, or you know, how much of it is often different but yeah. But you know, you've got to take your hat off to parents who do that because it does show that, you know, at least something's gone in. *Family worker*

Poor attendance at interventions was often cited as a problem by services. As might be expected this was more likely to be the case with those parents who were not assertive with services but tended to leave things up to fate, and had low expectations of their ability to influence things (Esther, Jenny, Paula, Kathleen). Those who were the most vociferous in supporting their child and provision for them (Donna and Bella) were most likely to attend appointments promptly. Four or five of the parents retained a

belief, which seems to be borne out to a certain degree, that they could have an effect on the service provision for their child, despite experiences where they had not been listened to.

Contemplating or implementing change can be difficult, and parents' attitudes to services may affect opportunities for being helped. Donna always looked for change to be implemented by services, rather than addressing issues in the family or neighbourhood. Donna and Kathleen seemed at the first follow-up to represent two divergent attitudes to services, one negative and one positive; however, the effects of these attitudes are somewhat more complicated. Negative views of services can coexist with any of the three attitude types in Figure 11: A negative attitude combined with a proactive stance (as in Donna's case) can lead to difficult and confrontational relationships with services. A negative attitude combined with a passive stance, such as Paula's, may be damaging if the family is not making itself heard. Parents' attitudes to services, then, play an important role, but they can also be changed by good experiences with practitioners as we will see in the next section.

8.4 Features of effective parent-practitioner relationships: trust and shared purpose

The previous sections have implied features of practice which may be conducive to forging fruitful relationships between parents and practitioners. To some extent a balance needs to be struck between being purposeful and being supportive. The data suggest that skilled practitioners can avert the risk of undermining parents' confidence and trust, by taking time to listen, not judging, and focussing on parents' strengths; they can be purposeful in partnership with parents by setting goals together. This is a skilled approach and takes time, which data from this study suggest are not supported by some aspects of organisational requirements.

Although not many parents had received formal counselling there was often a counselling aspect to relationships. This may have been beyond the official scope of a role, but parents value a practitioner who will take time to listen, and this was said of many different practitioners in the study. Both parents and practitioners spoke of the

importance of making a connection with each other, as we also saw with child-practitioner relationships in Chapter 6. Sue, Linda and Amana all felt they had made a connection with the HFP practitioner. Sue had also made a connection with Aaron's art therapist and with one social worker, Amana and Bella with their CAMHS practitioners. GP appointment lengths and performance management priorities may not be conducive to listening and yet GPs (Kathleen's, Sue's, Mary's) were reported as taking the necessary time, as were a diverse range of other practitioners: social workers, headteachers, teaching assistants. However, individuals from all these practitioner roles were also criticised for not taking this time, and for lacking understanding.

Sue Bond-Taylor, in her interviews with recipients of the Troubled Families Programme, found they judged the value of support they received on the basis of the quality of relationships built within the family and between the family and the key worker (Bond-Taylor, 2015). Sometimes success in relationship-building is a question of the practitioner's experience; several parents in the current study complained about social workers who were new and did not know what they were doing. However, some practitioners seemed to have natural skills for making connections with people and understanding them.

Kathleen's family worker certainly believed the success of interventions was down to the facilitator rather than programmes, not just personal characteristics but also individuals' approach and commitment:

> I've always got good retention figures but I think that's more about my delivery style 'cause I've been a personal trainer, fitness instructor and I'm a people person, which makes a huge difference than just having a programme. You could have a rubbish programme and still have great outcomes because of the person who's delivering, it's about the facilitator, you know what I mean? *Family worker*

This conversation led to discussion of current recruitment practices which, by giving preference to graduates at the shortlisting stage, meant someone like him might not get to the interview stage if applying for the job now.

Discussions with parents suggested that being a non-judgemental and strengths-based practitioner involved listening to parents, not assuming you know what is going on, not blaming, and focussing on what parents do well. A CAMHS worker commented:

> They must feel – you know, from school and everywhere – it must feel like people are always kind of thinking well, it's their fault – you know, for raising this rudest child in the world. *CAMHS worker*

Parents could talk more easily to someone who was non-judgemental, as Linda commented in relation to the HFP practitioner:

> You can talk, you can let everything out that you hold inside sort of thing, they don't judge you, what you say. *Linda*

Mary explained why she and her husband had enjoyed seeing the HFP practitioner, despite feeling, looking back, that there was little purpose to the intervention:

> He wasn't judgemental … he was easy to talk to. He's quite a laid-back person… It was really nice welcoming him into the house, you know, it was that sort of, it was, he became more of a friend… He weren't doing things by the book as it were, it was natural. *Mary*

One social worker felt she was the first in a long line of social workers to listen to one study mother and her children, and to compare the family's version of their story with the version recorded by her predecessors. She explained making a connection with them:

> It might just be my personality. As I said, I think the way that I looked at it was actually – yeah, this family has too much tasks to do and they've been overwhelmed, and kind of no wonder things aren't working. So I just wanted – I think I just kind of wanted to start again, and start afresh, so I think when I first went to conference I kind of unpicked all the nonsense that was in the report before. *Social worker*

Many parents, as well as some practitioners, commented on social workers sometimes being unnecessarily critical:

> You know, I think [families] want to be heard – you know, not kind of judged straight away. I know that this family is a difficult family – they are – you know, they are a difficult family – but I just think that we make our work much harder when we kind of start off negatively. *Social worker*

This social worker explained that she found some social workers to be overly negative in their reports about families. In this particular family's case one social worker had reported the house to be 'chaotic' whereas this parent was known for her obsessional tidiness, and a second social worker had contradicted the report. She said she could not see the point of not being on families' side. When asked whether it was perhaps to do with collecting negative instances in case they are needed to make a child protection

case later she said maybe, but she felt it was more personal: ‘I wonder if it’s to do with power?’

Amana and Bella were used to being criticised and patronised by services, and having their youth held against them:

> I didn’t get any really support at [the school] until I had to have all the big meeting, everybody around the table, because they were telling me I was a young mum and I didn’t know how to handle my children, that’s what they had me down as. *Bella*

Amana’s HFP therapist commented how difficult it had been at first to build a purposeful partnership because of Amana’s past experiences with services. But Amana felt that the HFP therapist had helped bring about a real improvement in her home situation, and when probed about this said:

> It was really helpful, and it was nice to have support. He was very understanding, and praised me for the things that I was doing, even though I was struggling at some points, and it was very, very hard…. he just showed me I was on the right track, and he helped me think of ideas and stuff. And he reinforced, and just praised quite a lot of things with Darius. *Amana*

Bella said she was able to make better progress when she felt that she was doing a good job. In interview Amana’s CAMHS consultant apportioned no blame to Amana or to Darius. She did blame the secondary school and the local authority who she and Amana both felt had mishandled the transition, initially disallowing Amana’s choice of school for mistaken reasons, adding to the stressors around this time. The psychiatrist also noted that Amana’s mother could be quite undermining of her, for example contacting the psychiatrist to question Amana’s parenting. The consultant was always very careful to speak to Amana first – ‘your mother has asked me this, what do you want me to say’. This approach helped build up the trust that had made this relationship supportive and lasting.

HFP’s work with Sue, focussing on both her and Aaron’s strengths, empowered Sue to take a stand with other services. The HFP worker noted:

> Sue was able to assertively articulate to the family therapy team her concerns about moving forward and not keep revisiting the past. They have now agreed to take this into account. In doing so she was able to advocate on Aaron's behalf. *HFP therapist*

Parents wanting to improve their family's situation felt more able to do so when they had support which acknowledged things they were doing well, and pointed out their strengths. To have productive relationships with parents practitioners needed to build trust and this involved listening, taking parents' views seriously and not judging. Building these relationships became harder when parents had previous negative experiences with services.

8.5 Chapter summary and conclusions

We have already seen, in Chapter 5, how changing relationships within families can lead to parents' perceptions of improved child behaviour and family wellbeing; aspects of the wider neighbourhood, community and society can also have an impact on family functioning and child behaviour. The current chapter addressed the second part of Research Question 1, reporting themes from the qualitative analysis around parents' and practitioners' experiences of services working mainly with the parent, and how different service approaches may contribute to, or fail to contribute to, bringing about change in factors influencing children's trajectories. Some of the characteristics of helpful practice are also true for intervention with children, as reported in Chapter 6, such as practitioners being non-judgemental, taking time, making a connection and sometimes going beyond the call of duty, or against accepted organisational cultures. The skills and characteristics of practitioners are key in forming useful relationships, and several practitioners were highly praised by parents. However, service systems and culture are also important in enabling practitioners to practice in useful ways. It can take time for practitioners to be able to build trust, which is not necessarily part of services' modus operandi.

The data show a tension between the different roles of services regarding support, reform and surveillance of families. Some parents felt they were being constantly watched for evidence of less-than-perfect parenting and this undermined trust and help-seeking. One social worker suggested that some social workers may take advantage of their power over parents. This study has shown that both the surveillance and reform roles of intervention can lead to approaches which inadvertently undermine parents, potentially leading to more harm than good. Resorting to tick-box approaches to social work intervention may be an inevitable consequence of high staff turnover and not

knowing the family; some intervention focussed on apparently trivial matters which seemed only to police parents with little benefit. Some parents resisted intervention which they felt undermined them, while others, such as Paula, accepted it, feeling they had no choice if they wanted to avoid their children being taken into care. Focussing on parents' strengths seemed to be more productive.

A typology of attitudes to services, with parents placed at different points on three dimensions: Proactive/assertive, Passive/compliant and Unresponsive/noncompliant, shows both the contrasts and overlaps in attitudes. There was some antagonism towards services and defensiveness in the face of perceived attacks from services. It may be that parents need to have experienced a good, trusting relationship with a service provider in order to be able to make good use of future services. The proactive efforts made by mothers like Bella and Donna, which affected service provision for their children, raise questions about the differences in services' provision for those who are less adept at fighting for what they feel their family needs.

Many parents wanted support that was not available, while at times of crisis too many services could get involved. While parents understand that there may be others in greater need of services than them, it is clear that in some cases much intervention is put in place with insufficient coordination. Could, for example, the crisis facing Kathleen and Michael and the consequent heavy use of services reported in Chapter 4 have been avoided by having the lower level support which Kathleen wanted, available more permanently?

Social workers, family workers and CAMHS workers all face tensions in their role between offering ongoing support to try to help families stay on an even keel and achieving some change in parents, showing that intervention is successful and can therefore end. There are several examples of families finding a practitioner they really like, but the relationships are usually short-lived, with some notable exceptions such as those with Donna, Amana and Bella's CAMHS practitioners. Linda and Paula, in particular, had many changes in social worker, and this seemed unhelpful. Neither family had brought about much change in response to social work intervention but it could be this lack of reform which led to the changes in social worker rather than the other way around. This was the conclusion of Linda's departing social worker, who was

moving on because she did not feel she was making much difference, despite being the first social worker the family had liked, and that they considered a helpful support. One interpretation of this finding is that, because of the focus on reform, families with the most intractable problems may be least likely to receive consistent intervention and experience the most changes in service personnel, which further diminishes the likelihood of effective support. This echoes criticism of the Troubled Families Programme suggesting that those targeted are not those with the most difficult problems but rather, encouraged by the payment-by-results format, those who are most likely to meet the required targets (Crossley, 2015).

An ongoing opportunity for support seemed to be needed by parents having great difficulty with their children. It is welcomed where available, and important, but is not usually an official feature of practice, and relies on practitioners going beyond the call of duty; this is referred to by others as practitioners' informal support (Tillard, 2016). Practitioners who form supportive relationships with parents are non-judgemental and take time to build trust; they focus on parents' and children's strengths and give positive feedback. Helpful practitioners listen to parents and jointly discuss goals and how they can be reached. Good experiences with helpful practitioners appear to empower parents to deal more proactively and effectively with other services.

This chapter, and the four previous empirical chapters, have shown the complexity of families' needs and responses to those needs with potential influences at all the levels depicted in the conceptual framework (Figure 1). In the following discussion (Chapter 9) the empirical findings of the thesis are related to the broader literature to reach conclusions about how family and other environments around at-risk children can be improved to help prevent future antisocial and criminal behaviour.

Chapter 9

Discussion and conclusions:
What helps families prevent high-risk primary school children developing antisocial and criminal behaviour?

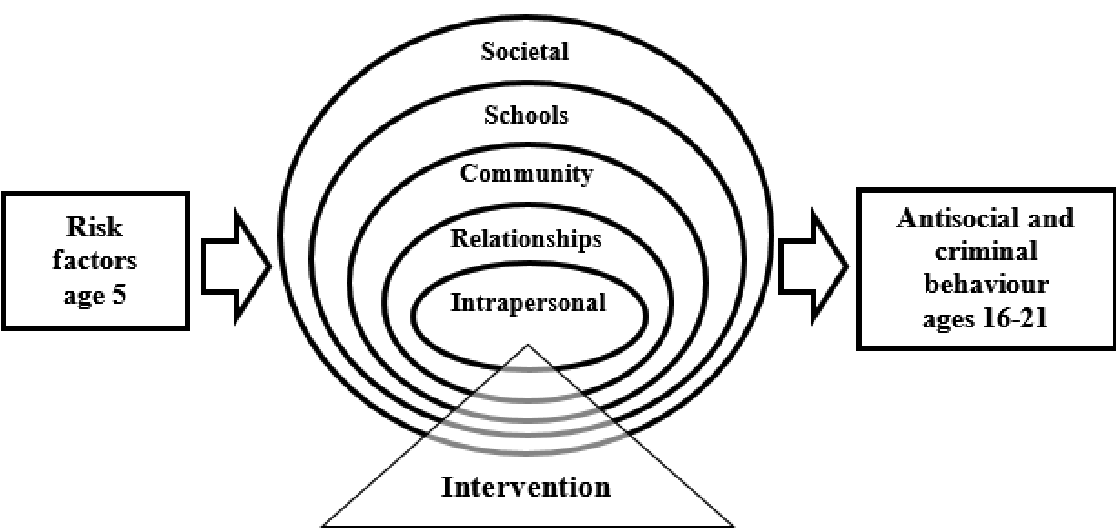


Figure 1 Conceptual framework:
Levels at which middle childhood intervention could influence causal pathways

> And you know he was involved with a lot of gangs, he was involved with the police, yet about midway through I think Year 9, he just suddenly woke up and decided, 'You know what? Actually, I don't want that life. I want this life'. *Special school staff member regarding non-study child*

In this final chapter the study's findings are summarised (section 9.1) and discussed in the context of the wider literature; implications are considered and conclusions formed. The discussion of findings is divided into two sections. The first (section 9.2) explores how families can be supported, and the barriers created when the manner of intervention overemphasises blame on parents. This section draws particularly on the findings presented in Chapters 5 and 8. The second section (9.3) is focussed mainly on schools, and how children can be supported in school settings, drawing particularly on Chapter 6. It begins with an examination of the potential benefits of involving parents in this process. Both sections also draw on the ALSPAC findings presented in Chapter 7. The implications for policy and practice of these findings are then summarised in section 9.4. In section 9.5, study limitations are reflected upon, and implications for future research set out.

9.1 Summary of findings

The findings suggest that changes are possible in families with the presence of risk factors, but that help may need to be available on different levels (Figure 1), some directly aimed at parents and children and some less directly, affecting the wider influences on the family from community, school and society. The analysis also suggests aspects of intervention which are unhelpful, or even harmful. Relationships are key, not just within families, and between families and practitioners, but within wider neighbourhoods and school communities.

As shown in Chapter 4, the behaviour of all the interview study children remained problematic five years following the families' referral to therapeutic intervention, during which time a wide variety of interventions had been received, though in irregular patterns. Nevertheless, the interview study reveals that some parents successfully altered their parenting behaviour and improved their relationship with their child. Some parents had transformative experiences with therapeutic intervention whereas others benefitted from support which helped them to develop strategies to manage parenting, family life

and broader relationships. Where intervention has played a role in these improvements, there are clear findings about what aspects of individual practice are beneficial.

Parents express a range of views of services and of schools, and their attitudes towards services have an impact on the effectiveness of the services on offer. However, negative attitudes and expectations of services, resulting from on past experiences, can be overcome, with skilled and empathetic intervention. Positive views of services were more common than negative views and some individual practitioners were very highly praised by parents.

However, improved family relationships do not necessarily indicate a permanent change of trajectory. Although some may argue that this is due to the overriding and long-lasting importance of experiences in the early years (e.g. Allen, 2011), findings from the interview study reveal a plethora of additional influences, including those in schools and neighbourhoods, on children's behaviour. Measuring success of intervention in terms of summary outcome measures, the study suggests, may fail to register important, but subtler, changes that take place. Nevertheless, although interview study children's futures are uncertain, the ALSPAC analysis provides evidence that changes in middle childhood, for example parents becoming less hostile to their children, can reduce the likelihood of later antisocial and criminal behaviour.

The principal findings in response to the research questions are summarised in the tables below, and discussed in sections 9.2 and 9.3 with headings worded in response to the overarching research question, which also heads this chapter:

> What helps families prevent high-risk primary school children developing future antisocial and criminal behaviour?

Research Question 1, 'How do families benefit, or fail to benefit, from intervention?' was divided into two parts. Table 9.1 and Table 9.2 summarise answers to Research Question 1a:

> What factors amenable to intervention influence family functioning and child behaviour?

They also summarise answers to Research Question 2:

> Which factors revealed as potentially beneficial in the qualitative analysis influence the later antisocial and criminal behaviour of children with primary-school age behaviour problems?

Table 9.3 summarises answers to Research Question 1b:

> What features of intervention help bring about change? Conversely, what features of intervention prevent families benefitting?

Table 9.1 lists factors emerging from the qualitative analysis in Chapter 5, corresponding to the intrapersonal, relationships, community and societal levels of the conceptual framework (Figure 1). The right-hand column summarises the findings from the ALSPAC analysis (Chapter 7) investigating, where possible, longer-term outcomes relating to factors identified in the qualitative analysis. In Table 9.1 and Table 9.2, ALSPAC findings are only included if the association with children's later antisocial and criminal behaviour is statistically significant after adjusting for the level of children's baseline behaviour problems. Where the effect remained significant after additional adjustments for family background characteristics, this is mentioned in the table.

Table 9.1 Summary of findings about intrapersonal, relationship, community and societal factors influencing changes in family functioning and child behaviour, and later antisocial and criminal behaviour (ASB)

The qualitative research found that addressing the following factors could facilitate change	**The ALSPAC analyses found these factors associated with lower chance of age 16-21 ASB***
Intrapersonal factors • Mother's perceived reasons for child's behaviour (e.g. blaming child, or not blaming child at all) • Mother's understanding of role of her, and others', behaviour towards, and in front of, child • Mother's mental health (stress/anxiety/depression) • Legacy of mother's personal history (but not always helpful to address) • Self-regulation of mood (mother and child) • Child's literacy and psychological difficulties, which may be masked by bad behaviour	• Lower maternal depression when child is 10, compared to postnatally, adjusting for background risk factors
Relationships • Maternal hostility towards child • Parenting strategies: Praise Less shouting, walking away from arguments Consistent boundaries, rewards and consequences Spending time together, having fun	• Lower maternal hostility age 8, from high at age 4, adjusting for background risk factors
Community • Social support (networks can be source of support, but also of additional stress) • Relationships with neighbours • Behaviour/influence of peers in the neighbourhood • Moving to new neighbourhood if negative influences cannot be avoided • Activities for children and young people	• Mother thinks neighbourhood is good place to live. But the link with ASB may be due to background risk factors
Societal • Money worries; access to state benefits which recognise mother's burden is helpful • Housing quality and affordability • Employment and study opportunities for mother • Opportunities for young people that are better options than crime and ASB • Non-blaming societal discourses e.g. re young single mothers and benefits claimants	• No difficulty paying the rent, adjusting for background risk factors

* Adjusting for level of children's conduct problems at age 6

Table 9.2 lists the school-related factors found to be important for improving children's behaviour in the qualitative analysis presented in Chapter 6. Again, the right-hand

column shows where ALSPAC findings supported the importance of the factors for long-term outcomes.

Table 9.2 Summary of findings about school-related factors influencing changes in family functioning and child behaviour, and later antisocial and criminal behaviour (ASB)

The qualitative research found that addressing the following factors could facilitate change	The ALSPAC analyses found these factors associated with lower chance of age 16-21 ASB*
Schools • The balance of nurture and independence The disjuncture between primary and secondary schools' approaches Having a one-to-one person (usually a teaching assistant) and weaning off Being known and understood by school staff • Enabling/valuing/facilitating/taking note of supportive relationships	• Child likes their teachers (age 13), adjusting for background risk factors individually
• Consistency AND flexibility in approach to discipline Constantly getting in trouble/blamed for minor/ADHD-related problem behaviours Clear and swift sanctions/allowing a clean slate Danger of segregating/stigmatising punishments; creating anti-school sentiment	• Child enjoys school (age 13), adjusting for background risk factors individually
• Communication Communication between school staff regarding child's difficulties and effective approaches Communication with parents: informed; positive; consistent between staff; not just an additional burden on parents Coordination/communication with other services	• Mother feels kept informed about child's behaviour (age 7)
• School ethos and environment School prepared to make the effort to accommodate difficult children Statement of special educational needs means access to funded activities/resources and alternative provision Attention to non-academic goals	

* Adjusting for level of children's conduct problems at age 6

Table 9.3 summarises findings of the qualitative analysis, particularly from Chapter 8, about features of intervention. These are characteristics and behaviours of individual practitioners and organisations which constitute levers and barriers for change, represented by the Intervention triangle in Figure 1.

Table 9.3 Summary of findings about features of intervention that facilitate change

Behaviour/approach of individual practitioners:
• Building trust before attempting change • Listening; taking parents' views seriously • Not judging; challenging without blaming • Taking time • Ongoing support (where wanted); acknowledging burden on parents • Strength-based approach • Advocacy/empowering approach • Developing shared goals with parent • Working out whether addressing underlying trauma is appropriate/helpful/necessary • Where necessary, dealing with practical, or crisis, support before addressing parenting • Acknowledging wider determinants of parenting capacity and child behaviour
Features of organisations:
Helpful: • Availability of support in-between crises/on-call – many parents wanted support that was not available • Easy, unthreatening, non-stigmatising routes to support • Good coordination of support; communication between agencies/schools; sharing information and strategy • Someone to take responsibility • Services may need to compensate for inadequate social support Unhelpful: • Insufficient time allowed for relationship building • Staff turnover (leads to re-telling of stories; undermines trust) • Dropping most difficult cases • Target-based and managerial approaches can create perverse incentives, e.g. too short-term intervention; focus on issues which may not be the most pressing for parents. Tick-box approach may be inevitable consequence of staff turnover • Focus on risks and surveillance undermines strength-based approach and constrains trust, relationships and help-seeking • Organisational discourses blaming parents are undermining • Cultural assumptions can lead to focus on apparently trivial factors • Difficult for overburdened staff to provide what is needed • Possible misuse of power over parents • Parents who are prepared to fight for resources/services are more likely to get them than those who do not

9.2 Supporting parents, and parenting, in difficult circumstances

The focus of family support services on parenting has been an increasing trend in the UK since 1997 (Klett-Davies, 2016). Positive changes in parenting can be beneficial for families, and the qualitative analysis in the current longitudinal study, showing the longer-term benefits of changes in parent-child relationships, supports existing findings of cross-sectional single timepoint associations (Wyatt Kaminski et al., 2008). In some cases these relationship changes appear to be attributable to the parent developing greater empathy for the child. This is an important outcome because parents' empathy for their child is associated, among other things, with reduced recurrence of abuse (Hindley et al., 2006).

However, the focus on parenting can also undermine parents and be counter-productive. Blame is a recurring theme underlying judgements on the reasons for children's trajectories: parents are blamed by everybody, often including themselves. Children are blamed by parents. Social workers and other professionals are blamed by parents, by the media and by Government (Broomhead, 2013; MacDonald, 1990; White et al., 2009).

The study shows that parents find some aspects of intervention aimed at changing their own behaviour helpful, including techniques for regulating their own emotions and behaviours, such as breathing exercises and mindfulness, and strategies to help address children's difficult behaviour, including consistency, praise and spending time together. However, other parents do not find these approaches helpful. Such intervention implicitly locates blame with the individual if not understood in the context of broader pressures. Findings indicate a vicious circle in parents' experiences of services, with bad (blaming) experiences contributing to suspicion of future services, leading to parental lack of engagement and trust, which in turn leads to lack of effectiveness and a poor experience of services. However, skilled practitioners, and supportive services, can break this cycle.

9.2.1 Changing parenting behaviour

Study parents involved with children's services find themselves criticised for parenting behaviours that, although theoretically 'sub-optimal' are within the normal range, and unlikely to do harm in themselves. The ALSPAC data shows that common experiences of parenting include being irritated with your child, and feelings of resentment. Waylen

and Stewart-Brown (2010), find resentment to be more common among older mothers in owner-occupied housing, a group normally associated with better outcomes. While correlational analyses show many aspects of parenting to be related to a range of children's outcomes, it is not clear that these relationships are causal (see Chapter 2). Evidence from London, for example, counters expected associations with 'parental investment' such as time spent on learning activities with children; Blanden and colleagues (2015) show that London pupils score worse on 'parental investment', but have progressed more than those outside London who have more parental investment and similar levels of disadvantage and school-entry achievement. Practitioners may do more harm than good if they base targets, or assessments of pathology, on a 'middle-class' view of what parenting should look like. These are standards from which stressed and distressed families can easily divert (Walsh, 1995).

Even if parenting factors correlated with children's later outcomes *are* causal, it is another leap of logic, without additional longitudinal evidence, to suggest that bringing about change in such factors in middle childhood can *improve* children's outcomes. However, the analyses of parenting using the ALSPAC longitudinal are based on, and support, findings from the qualitative interview study suggesting that when parents become less hostile towards their child, the child is less likely to have later antisocial and criminal behaviour, even after controlling for the severity of behaviour problems and other family background characteristics. The interview study illustrates a process by which greater empathy for the child, coupled with spending more time on shared activities and ensuring support for the child in other arenas, can lead to improved relationships and behaviour.

A challenge for services, then, is to empower parents to affect their children's behaviour and environment by helping them work out which things they need to change, while conveying an understanding of the wider determinants, both of children's behaviour and of families' resources for dealing with their difficulties. Parents who change their understanding of their children's behaviour, with the help of skilled, non-judgemental intervention, can bring about radical improvements in family relationships. Where parents merely absorb messages of blame, without feeling they have the power to effect change, their engagement with services, and confidence that they can improve their child's life, are negatively affected.

Helping parents believe change is possible and can work

Psychologists have discussed the importance of individuals' belief that they can change in terms of fixed versus growth mindsets (Dweck, 2008) and attribution theory (Wilson & Linville, 1982). Although still debated, evidence suggests that these beliefs are not fixed personality traits and that even telling people that their brains are not fixed and they can learn new behaviours and skills can affect their ability to do so (Bandura, 2014). Research on parents' capacity to change when child protection intervention is being considered has drawn on recognised common stages in processes of behaviour change: resistance, ambivalence, motivation, engagement and action (Ward et al., 2014).

The current study shows that helpful practitioners recognise when time needs to be taken to build trust to get beyond the resistance and ambivalence stages. Lapses take place and professionals need to be aware of their potential to both increase and reduce resistance to change (Forrester et al., 2012). The timing of intervention needs to be right; some parents in the interview study were sent on parenting programmes that seemed ill-matched to their needs or badly timed. It has been suggested elsewhere that assessing 'readiness to change' prior to embarking on challenging intervention to change parenting can be valuable (Barlow, 2015:136; Power et al., 2008:5).

9.2.2 Support networks and family resilience

The interview study shows that parents want professional support, despite being sometimes critical of support received, and wary of getting involved with services that may do nothing to help, may make them feel bad or may even consider removing their children. The 2004 British Child and Adolescent Mental Health Survey (Green et al., 2005) also found high levels of help-seeking by parents of children with a conduct disorder. In the previous year 81% of these parents had sought advice because of concerns regarding the child's mental health. Of these, 76% had approached a professional source, most commonly a teacher (60%), reinforcing the importance of school staff, as shown in the current study. Advice was sought from mental health specialists by 28% of the parents and from special educational services, including psychologists, by 24%.

Parents of children with difficult behaviour evidently want formal support but informal support is also important. Robert Putnam (2015) refers to a 'shrivelled sense of we' describing how the notion that 'it takes a village to raise a child' lost currency from the 1980s onwards. The notion was ridiculed by US Republicans for decades following Hilary Clinton's book of that name, with Bob Dole saying, 'With all due respect, I am here to tell you, it does not take a village to raise a child. It takes a family to raise a child' (1996). The theme was in tune with neoliberal rhetoric, and was preceded by Thatcher's 'no such thing as society' (1987), and also the prolonged trend of placing blame almost exclusively on families and underemphasising the importance of wider support networks and environments.

Social support

The contribution of social support to family resilience has been repeatedly demonstrated (e.g. Lietz & Strength, 2011) and better social support is associated with a range of positive outcomes, including desistance from crime (Sapouna et al., 2011). In the current study the importance of these wider networks is clear. Families in the interview study generally had quite poor levels of social support, although this differed between timepoints. Improvement in family functioning happened in different ways; but enhancement of these wider networks appeared to coincide with better family functioning (for example for Linda and Sue's families where connections were made with others in the community, with the help of services in Linda's case). Where these networks diminished, as in Kathleen's case, outcomes were poorer. For Kathleen a plethora of short-term interventionists may not have contributed much to a long-term solution when her informal support network was so diminished. In the absence of informal support, professional support is important, although if study parents felt obliged to accept intervention they did not want, it was less well received.

Theoretical work on supporting vulnerable families proposes the importance of the quality of a network of family, friends and professionals in promoting family resilience. This view does not seek to merely compensate for poor parenting, but to improve the whole family's resources by strengthening these networks (Walsh, 2002). A review of factors associated with risk and resilience in cases of emotional abuse identifies the need to pay attention to the relevant protective factors in each individual case, and the availability of supportive relationships (Iwaniec et al., 2006). Discussing the strength of

research evidence on the importance of relationships with non-familial adults in promoting resilience, Walsh writes:

> The prevailing narrow focus on parental pathology blinded many to the resources that could be found and strengthened in family relational networks, even where a parent is seriously impaired (Walsh, 2002:2).

Key to the proposed family resilience network is the inclusion of the parent at the centre of the network, whereas attention focussed on building extrafamilial resources often dismisses the family as ‘hopelessly dysfunctional’ (Walsh, 2002:2).

Research on social support often divides informal from formal support, but another divide referred to in the literature is between tangible and emotional support, both of which can potentially be provided within family systems or through external support from ‘outside systems in their environment’ (Piel et al., 2016). While, in the interview study, helpful intervention encourages mothers to make use of their family networks, unhelpful intervention sometimes exacerbates existing family rifts. Sometimes practical (or tangible) support is the overriding need, but is unavailable.

<u>Mothers’ wellbeing</u>

Mothers in the current study expressed a feeling that services were interested only in supporting their child, and not them, with the link between the two ignored. This point has been made elsewhere, with Lister (2006) arguing that the movement of children up a future-oriented policy agenda has indeed demoted the importance of parents. Parents’ wellbeing, however, is highly relevant to their children. The high prevalence of mental health problems among parents of children referred to mental health services is known (e.g. Middeldorp et al., 2016), and was evident in the current study, as is its effect on parenting (Waylen & Stewart-Brown, 2010), and on children’s outcomes (Cunningham et al., 2004; Rutter & Quinton, 1984).

Analysis of the ALSPAC cohort supported the qualitative findings, indicating that improvements in maternal mental health compared to the postnatal period were protective, reducing the chance of children’s later antisocial behaviour. Children were also less likely to display later antisocial behaviour if mothers could afford the rent with no difficulty, and reduced maternal anxiety may have had a role. Both these associations remained statistically significant when controlling for the severity of children’s behaviour problems, and family socioeconomic factors.

The qualitative analysis also pointed to the importance of neighbourhood factors for family wellbeing. At least two families in the study (Amana's and Linda's) had benefitted from moves to a new location. However, services involved with two other study families, Nicole's and Kathleen's, had not facilitated their desired moves to new areas, despite serious risk from local criminal connections. Not moving these families seemed to be turning out to be a costly mistake. The ALSPAC analysis supported the qualitative analysis findings that good social support and positive feelings about the neighbourhood were related to a lower likelihood of children's later antisocial behaviour. However, these relationships seemed to be at least partially explained by pre-existing differences in background factors including children's behaviour.

9.2.3 Therapeutic relationships

Getting the right balance between pushing and listening, between challenging and supporting, requires skill, empathy, and the ability to adjust to the circumstances and networks of each family (Shulman, 2012; see also Sen's 2016 case study of a single family involved with intensive family support). Analysis of discussions with study parents about the aspects of practitioners' intervention they found helpful, identifies many factors which are reflected in the wider literature. Previous research has suggested that the quality of the patient-therapist relationships in psychological interventions is one of the best predictors of treatment outcomes (Karver et al., 2006), and that without this, therapy can do more harm than good (Goldsmith et al., 2015). Arts-related therapies in the current study may be an example of this. Several children received art or similar types of therapy, but whether it is well-received or not depends on the relationship between the child and the therapist and also between the parent and the therapist. Relationships which seem crucial for effective intervention in the study involve providers of services including school staff, social workers, family support and GPs.

<u>Strengths-based approach</u>

Relationships are more beneficial when practitioners focus on strengths, not risks. The family resilience perspective discussed above (Walsh, 2002), as also in the Family Partnership Model (which underpins HFP; Davis & Day, 2010), has practitioners focussing on families' strengths, not deficits. Despite the growing literature supporting this approach, often contrasted with a 'problem-oriented focus' (Allison et al., 2003)

there is much evidence in the current study of parents feeling they are viewed through a deficit-focussed lens. For example, the youngest mothers say they have been repeatedly stereotyped as inadequate parents. A support model focussing instead on strengths will encourage 'key processes for resilience' through which 'members may discover untapped resources and abilities they had not recognised' (Walsh, 2002).

In the current study interactions which focus on parents' (and children's) strengths are noticed and appreciated by parents. Practitioners described as helpful highlight and praise mothers' successes and strengths, which some mothers had not experienced before. They validate parents' wishes regarding life aims outside their parenting responsibilities, such as employment or education for themselves. Mothers find this empowering; it is almost as though some were helped to develop their own discourse about their situation, their own resources that contributed to their families' well-being, including their ability to draw in other support around the family and child.

This question of focussing on strengths is at odds with many aspects of the English child safeguarding system, which is primarily risk-based. Theorists describe two orientations in global child protection systems, one with the primary aim of preventing child maltreatment – a 'child protection' model – and one aimed at promoting child wellbeing – a 'child welfare' model (Gilbert et al., 2009). The English system draws primarily on the former, although it contains elements of the latter (Parton, 2012). The English model has been described as child-centric, focussing on assessing risks posed by caregivers (Featherstone et al., 2014). It is argued that effective implementation of a strengths-based approach, when social workers are 'walking a tightrope between responsibilizing and governing families' demands a broadening of the strength-oriented focus in the social, economic and political contexts surrounding families and those intervening with them (Roose et al., 2014). At present, as found in some parents' accounts here, research on parents' experiences of social work interventions reveal adversarial working processes, difficult parent-practitioner relationships and blaming of mothers in professional discourses (Forrester et al., 2012).

<u>Building trust and taking account of life events</u>

Relationships between study families and practitioners are undermined when practitioners focus on factors that seem unimportant to parents. The Helping Families

Programme, to which study families had originally been referred, had as an explicit part of its approach the need for practitioners to deal with crises, 'firefighting', before meaningful therapeutic work could take place. This involves finding out what matters to families at that moment and may help prevent a focus on trivial factors. However, for stressful life events to be taken into account, relationships have to be good enough for the information to be shared. The analysis suggests practitioners need to build trust, through listening, focussing on strengths and not being judgemental. For some parents this process takes longer than for others. Not all practitioners are in a position to offer such time. Helpful intervention takes note of the life events that can be the reason for set-backs. How families or young people are treated, and supported, at 'critical moments' where choice, chance and opportunity interact, can be critical to these moments' impact on life trajectories (Thomson et al., 2002).

Teaching assistants, or other staff working with study children, often take pains to be in good enough contact with parents, or to take enough time to listen to children, to know about stressful events, and approach the child, and parent, accordingly, perhaps adjusting the level of challenge. In poor intervention, insufficient notice is taken of the role of stressful life events, as in Paula's case where she feels services are putting all the blame on her parenting, and housekeeping, when she is reeling from recent divorce, multiple bereavements in the extended family, and near eviction while parenting children with special needs. A more enlightened approach would assess the impact of the events and explore family members' responses, 'their proactive stance, immediate response, and long-term "survival" strategies' and how these can be bolstered (Walsh, 2002).

Parents will not engage with services if they do not feel listened to, the current study suggests. Times of crisis are not representative of general coping skills, and practitioners should be wary of giving parents the impression they have made such assumptions (Walsh, 1993). A skilled approach is needed, to probe without endangering the relationship. Walsh refers to clinicians using 'respectful curiosity' to ascertain life events as well as past histories which can explain triggers for painful memories or fears (Carter & McGoldrick, 1998; Walsh, 2002).

Stressful life events reported by mothers of ALSPAC children with behaviour problems are strongly associated with children's later antisocial behaviour as well as with mothers' depression. The link between stressful life events and depression is well documented (Kendler et al., 1999; Kessler, 1989). Most, if not all, of the parents in the qualitative study were affected by past traumatic events. While a typical clinical approach identifies these as problematic causal factors, a resilience-based approach focusses instead on the strategies and strengths families use to survive these adversities (Walsh, 2002).

9.2.4 Organisational support for relationship-building or practitioners going beyond the call of duty?

Some of the features of intervention which appear to get in the way of effectiveness are at the level of the organisation, such as availability of services, and these features influence practitioners' capacity to build useful relationships with families. For example, there is little hope of good relationships where social workers are regularly changed, or their workloads leave insufficient time to develop relationships (Chapter 8).

<u>Support when parents want it…for as long as they need it?</u>

While appropriate support during times of crisis is critical, the qualitative analysis indicates that parents also look for support during non-crisis periods, but such support is often not available. It can be speculated, as is the belief of some parents in the study (Kathleen, Sue, Amana and Bella), that lack of support during these non-crisis times may contribute to subsequent crises. A qualitative study following up parents of children judged to be at significant risk of harm during their first year of life found, for most, deterioration in family circumstances over eight years, commonly because of recurrent domestic abuse and maternal mental health problems (Brown et al., 2016). Other factors exacerbating risks are long-term poverty, poor housing, hostile neighbourhoods and poor physical health. The availability and nature of informal support and professional relationships also affect trajectories. While trials continue to show short-term effects of parenting programmes (Jones et al., 2016), the current study indicates that ongoing support may be needed for long-term maintenance of benefits. In the absence of informal (non-professional) support it may be that professional (if relatively informal) on-call support should be available. It can be argued that Sure Start provided one route to such support through children's centres, although this route of access did not suit all disadvantaged parents in Sure Start local areas (National

Evaluation of Sure Start (NESS) Team, 2012). Many of those avenues have now closed (Sammons et al., 2015).

Sometimes contact with support workers carries on longer than study parents want. On the whole though, study parents find long-term relationships useful, though these are not encouraged by the ethos of many services; ongoing involvement is equated with lack of effectiveness. Parents sometimes find support arrangements end before they feel ready, either because the support is time-limited, because others are in greater need, because the practitioner leaves the post or because it is felt insufficient progress is being made. In the latter case, listening to parents about what they are gaining from the contact could lead to reassessment of the aims.

Supportive relationships in the study are formed with a variety of different professionals. It has been acknowledged elsewhere that parents may turn to different practitioners for support, for example, when they are dissatisfied with their social worker, and that this is another reason to support inter-agency communication and collaboration and organisational flexibility (Ward et al., 2014). Services that are flexible and well-informed enough to negotiate roles and endings are helpful.

Partnership

Study families' experiences of social workers support Goodman and Trowler's (2012) observation that:

> Social workers may not feel very powerful but when we knock on someone's door, [to them] we seem very powerful.

Some nominated practitioners are aware of the danger of this perception, and of the temptation to take advantage of this power imbalance despite practitioner training on the importance of empowering parents (Davis & Day, 2010; Trevithick, 2000). There may be implications here for recruitment. For example, concern has been expressed about the current emphasis on recruiting social work students 'from Russell Group universities with high-grade degrees, rather than the shared experience, listening skills and human qualities that service users and carers particularly seem to value' (Beresford, 2015). There are also implications for on-going training, supervision and support that encourage a respectful approach to clients, building on their strengths and their own

wishes. These aspects can be reinforced by the ethos of a supportive practice organisation.

The Helping Families Programme (HFP) (to which all participants were originally referred, although not all engaged with the programme) was designed to provide support combined with 'purposeful' challenge, based on partnership working. Positive feedback was received about HFP practitioners' interaction styles and the relationships built, although some parents regretted that the relationships ended at the end of the 20-week programme. While the HFP workers were dedicated to their task and to helping the families, they did not have to go *beyond* the call of duty as the design (and funding) of the pilot programme allowed time for relationship building and 'firefighting' as well as developing shared purpose.

In contrast there are workers from other services, as shown in Chapters 6 and 8, who are deemed important by study mothers, who often go further than the expected practices of their workplaces, 'beyond the call of duty', in order to provide what they consider to be the right level and manner of help to the child or parent. This has been found elsewhere (Sulimani-Aidan, 2016; Tillard, 2016), and can lead to 'secret' or hidden caseloads (Clark et al., 2015).

Combatting fear of service involvement

Positive engagement with services is, as would be expected, a factor in services' effectiveness, and has been associated with lower recurrence of child maltreatment (Hindley et al., 2006), but parents are not likely to confide in practitioners if they believe signs of weakness may be used against them in a risk-based child protection system. The current study shows parents resisting service engagement, or avoiding help-seeking, because of child protection concerns. Parents often have low expectations (based on past, or others', experiences), and antagonism/antipathy towards services for a number of reasons, including fear of therapeutic intentions (not wanting, for example, to dwell on past traumas). The potential risk to mothers' help-seeking behaviour from the risk-focus of child protection services was highlighted in Lord Laming's (2003) report written following the death of Victoria Climbie. Canvin and colleagues, for example, found that disadvantaged families used hospitals' Accident and Emergency departments

instead of more appropriate services because of child protection fears (Canvin et al., 2007).

A clear finding from the qualitative work is that, despite positive feelings about individual social workers, the general perception of social workers working with families on the Child Protection or Child in Need registers is they are unhelpful and exist largely to surveil parents, children and homes, rather than to offer support. Recent research following a Freedom of Information request showed that one in five young children were being referred to children's services (Bilson & Martin, 2016). Deprivation seems to be increasingly associated with child protection referral rates, with evidence that cases are treated differently according to deprivation levels (Bywaters et al., 2014; Hood et al., 2016). It is perhaps unsurprising, therefore, that the literature shows parents' use of 'false compliance', failure to cooperate and denial when involved in the child protection process (Ward et al., 2014). This resonates with comments made about some mothers in the current study. The consequences of lack of trust seem to recommend approaches which give a degree of control back to families, such as partnership working and motivational interviewing (Barnsdale & Walker, 2007; Forrester et al., 2012).

Culture of blame and the pressure on practitioners

Social workers' focus on risk is understandable given that they are held to account for any harm to children (Parton, 2012). Social workers are required by law to find out as much information as they can that is relevant to a child's situation (Children Act, 2004); they are threatened with prison for 'failing to protect children' (Stevenson, 2015), as are school staff who 'ignore abuse' (Barker, 2016). We have seen that parents are often a focus of blame. However, when a child death occurs, it is social workers who are blamed (MacDonald, 1990), described by Warner (2013) as a mutually beneficial collusion between politicians and the press. The negative effects of a blame culture in social work have been unfavourably compared with changes in the airline industry that have led to safety improvements. Where errors are seen as inevitable, everyone reports mistakes and problems, individuals are not blamed and the information is used to improve safety (Caffrey, 2014).

As had previously been made clear by the Social Work Task Force and the Social Work Reform Board in response to the death of Peter Connelly, Munro's review of child protection highlighted the negative effects of managerialism and bureaucracy on relationship-building and time spent with service users (Munro, 2011). The review advocated a move from a compliance culture to a learning culture, developing social work expertise, and reducing bureaucracy, so that decision-making could rely on professional judgement, not on box-ticking. In youth justice services the use of risk and outcome assessment tools have been similarly described as undermining professional judgement (Briggs, 2013). However, Briggs's interviews with youth justice practitioners found plenty of evidence of practitioners prioritising the welfare needs of young people over the procedures suggested by the prevailing mode of governance; that is, going 'beyond the call of duty'.

The need to make space for reflective practice is the central theme of Dolan and colleagues' book on family support (2006). However, Clark and colleagues point out that austerity (reduced budgets), and payment by results, lead to greater demands for accountability, in turn leading to more rigid outcomes frameworks and less face-to-face time, thus 'dehumanising' and 'distorting the proper aims of professional practice' (Clark et al., 2014:6). Such approaches may not improve longer-term cost-effectiveness; Munro concluded that less prescription and more investment in social workers' training would *save* money in the long term.

Cost savings could of course result from removing unwanted and ineffective intervention. In 2016 the President of the Association of Directors of Children's Services spoke about 'radical non-intervention', saying:

> We intervene too often and sometimes too readily. Children, young people, their families and communities are more resilient than we give them credit for. Social workers and other professionals can on occasions act in a way that is formulaic and reactionary. The most skilled know how to work with, rather than doing unto children and families (Hill, 2016).

The qualitative analysis showed that the ability of services to contribute to change is dependent on practitioners' behaviour. The analysis indicates, and is reinforced by existing literature, that practitioners' behaviours are at least partly dependent on the behaviour and values of organisations. Families can be supported, then, through attention to forming good relationships and networks, both informal and formal, that

can provide practical and emotional help when needed. Parents in these families can be providers as well as receivers of support, and can be advocates for services, as well as for their own children.

9.3 Supporting children in schools

Most of the support provided directly to children in the current study is through schools, and relationships are again key. Parents, and their own relationships with school staff, have a role here. The analysis of interviews with parents over the years, and with practitioners, many of whom are school-based, suggests a number of helpful aspects of school environments for children exhibiting difficult behaviours. These include treating children with consistency in terms of expectations and consequences, but also, school approaches that are flexible enough to allow difficult children sometimes to be treated differently from their peers. Contact with sympathetic adults with whom children have good relationships is important.

As with intervention with parents there are difficult tensions to negotiate. Children sometimes need special treatment, but this can be stigmatising, and approaches which segregate children with difficult behaviour can be problematic. Often, literacy problems are not picked up because children ‘act out’ rather than ask for help. Parents can play an important role in accessing support for their child, and are helped to do so by practitioners and advocacy services, but this begs the question of what happens when parents are not assertive, or not supported. The ALSPAC analyses support hypotheses that children who are ready for the transition to secondary school, and who like their secondary school teachers, are less likely to go on to have antisocial and criminal behaviour. These issues are discussed in relation to the wider literature below.

9.3.1 Positive parent/school relationships

In the interview study, following families over five years showed that most parents had good relationships with school staff at some points and bad relationships at other points. The ALSPAC analysis supports the importance of parent-school communication when it suggests that children of parents who feel they are kept well-informed by their school are less likely to develop antisocial behaviour. Characteristics of practitioners associated with good relationships have been discussed above, and often these characteristics

applied to nominated practitioners. However, other school staff discussed in interviews are often perceived as judgemental and can make parents feel defensive.

Questioning cultural assumptions about parenting

Broomhead (2013) finds that British teachers attribute children's behaviour problems to poor parenting, and that parents feel blamed by teachers. It has been argued that teachers' expectations of parents' behaviour are based on their own cultural, as well as moral, values (Lasky, 2000). Parents could be judged 'bad' by teachers without any knowledge of pupils' home life, financial situation or cultural practices (Crozier, 1998; Gwernan-Jones et al., 2015; Lasky, 2000). Conversely, high-quality relationships with teachers are more likely to be found with those who share their socio-economic, ethnic and class background (Gwernan-Jones et al., 2015; Thijs & Eilbracht, 2012; Waanders et al., 2007).

A systematic review of qualitative research on relationships between teachers and parents of children with ADHD finds that positive relationships can be powerful in helping resolve children's difficulties (Gwernan-Jones et al., 2015). This was also shown in the current study. However, such good relationships were not common in the review, and mothers' attempts to intervene were usually ineffective. The review found, as with many parents in the current study, evidence of parents' 'escalating resistance' over time. Parents in the current study generally want to be kept informed but constant phone calls from teachers complaining about their child without taking account of the child's history, family situations or agreed behaviour plans cause anger and are probably counter-productive.

9.3.2 Awareness of danger of interventions that stigmatise and segregate

The study shows potential risks from interventions for children with difficult behaviour, both in terms of labelling or stigmatising children, potentially giving them an identity which might be unhelpful, and in terms of segregating children together with other difficult children, with potential for negative peer 'contagion' (Dodge et al., 2006). Some of the dilemmas identified when intervening with children with difficult behaviour in schools have parallels in the research on youth justice intervention. In the latter body of work, it has been argued that the labelling and stigma involved in targeting and early identification of problems can mean young people identify with the offered characterisation (Becker, 1963; Lemert, 1967; Smith & McVie, 2003). In a

Scottish longitudinal study McAra and McVie (2007; 2010) find school exclusion to be among the critical events which can send young people down the wrong track. Conversely, diversionary activities appear to promote desistence from antisocial and criminal behaviour, and McAra and McVie therefore advocate minimal intervention, maximum diversion. Qualitative analysis of data in the current study finds that, in the school context, consequences need to follow on swiftly from actions, and be seen to be fair. Curtis notes that, if punishment is considered necessary, it should be focussed on the loss of privileges while ensuring the reason for punishment is understood. Punishment should not be seen merely as a demonstration of anger or strength (Curtis, 2016: 76).

Intervention can exacerbate negative peer influences

The children in the current study did not (by the end of data collection) appear entrenched in any particular trajectory; there were push and pull factors for both worse behaviour and better. Different peers can be influential in different directions; some research, however, suggests that once affiliations are made with peers with more 'deviant' behaviours, a young person can be rejected by more 'mainstream' peers, entrenching allegiance to the deviant group (Dodge et al., 2006). Separating errant youth together, in special interventions or in special schools, can risk this type of effect, with potential for peer effects discouraging desistance from antisocial behaviours (Pardini, 2016). Known as an iatrogenic effect, it is notoriously illustrated by the negative results from 'scared straight' type interventions, which despite these results continue to be used in the US (Petrosino et al., 2013). Changes in peer affiliations are not necessarily an overt choice, and for some children, as with at least one child in the current study, there is little understanding of the social undesirability of certain behaviours; this child happily recounted to teachers exploits for which he had been congratulated by peers. Such 'positive perception of problem behaviour in early adulthood' is one of the risk factors previously found to predict continued involvement in delinquency (Stouthamer-Loeber et al., 2004).

Sampson and Laub (1995) provide a much-used theory of criminal careers over the life course which shows the importance of key transitions highlighting the influence of *informal social control* to account for both stability and change in criminal careers. Life-course transitions are important, they argue, because of their impact on social

control; turning points can occur with changes in links to institutions, such as marriage or employment, which inhibit deviant behaviour (Warr, 1998). However, the theory does not take account of peer effects, and the impact of such transitions on peer relationships. The number of peers with antisocial behaviour that a person knows has long been known to predict criminality and Warr sees theories of delinquency learned from significant others (Sutherland, 1947) or broader social learning theory (Akers, 1985) as opposing Sampson and Laub's view. Peers have been seen as a causal factor because acquisition of deviant peers has been shown to precede deviant behaviour (Elliot & Menard, 1996).

School exclusion is an extreme case, which can result in both labelling and segregating, often with other errant youth. Nearly all the children in the interview study had been moved from mainstream school into alternative provision by the final follow-up. Berridge and colleagues used retrospective data on 343 young people including in-depth interviews with a subset of 28, to consider the effects of having been excluded from mainstream school on young people's offending careers; young people generally come to regret their exclusion (Berridge et al., 2001). While for a small number the exclusion broke problematic affiliations and stopped further involvement in criminal and antisocial behaviour, most young people either began or continued to be involved in crime following exclusion. Qualitative analysis suggested that the exclusions triggered chains of events which severed young people's 'affiliation and commitment to a conventional way of life', including a 're-casting of identity', changing relationships within the family and eroding contact with pro-social peers and adults (p8). Following exclusion young people are more vulnerable to police surveillance and are more likely to associate with other young people involved in crime and antisocial behaviour.

9.3.3 Experiences following transition to secondary school

The current study suggests that the huge disjuncture between the environments, and how children are treated, in primary and mainstream secondary schools means it is very hard for these children to succeed. Difficulties with the balance between nurturing children and promoting their independence is particularly acute because the children tend to have (eventually) found primary schools that could adapt to their behaviours, and where they are supported by key relationships. Bailey and Baines (2012) seem to support this finding; their survey suggests that where factors associated with resilience

are present at primary school, but not at secondary school, pupils with Special Educational Needs are less able to deal with the significant changes at their new schools. A UK ethnographic study of pupil experiences of building relationships with teachers following transition to secondary school notes the importance of 'enabling transition contexts' which give attention to the formation of interpersonal relationships which can then lead to learning relationships (Tobbell & O'Donnell, 2013).

A crucial developmental period

Transition to secondary school occurs when the brain is beginning a period of intense 'refurbishment' (occurring between ages 11 and 25), when children begin seeking to accomplish four crucial developmental tasks: consolidating their identity, achieving independence from their parents, establishing adult relationships outside the family and finding a vocation (Colver & Longwell, 2013). Other research suggests that school transition experiences have the potential to affect long-term trajectories (Chevalier & Feinstein, 2006; Hanewald, 2013) and health outcomes (Roberts, 2015). In the UK, Gutman and colleagues (2009) show decreasing levels of wellbeing for children as they move from primary to secondary school; children with SEN are more likely than others to experience this decline, and emotional and behavioural difficulties are the most common predictors of worsening outcomes (also see Bailey & Baines, 2012). For children with ADHD, with which more than half the children in the current study have been diagnosed, the moment of transition has been shown to be associated with a halt in the decline of symptoms (Langberg et al., 2008). For some children there may be a poor fit between their developmental stage and the appropriateness of their school, as well as home, environments (Eccles et al., 1993).

Whole-school approaches

There has been a great deal of interest in recent decades in school-wide strategies to make school ethos and environment more conducive to wellbeing. These represent non-stigmatising ways to potentially influence behaviour (Wells et al., 2003). A systematic review of bullying interventions, for example, finds little evidence of effectiveness for most approaches, but those that are effective are 'whole-school' approaches. Whole-school approaches see bullying as a systemic problem requiring systemic solutions with complementary components directed at different levels of the school organisation (Vreeman et al., 2007). However, the effectiveness evidence can be difficult to unpick,

perhaps because of the broad-based nature of the intervention and the diverse population of potential beneficiaries (Bonell et al., 2013).

Coffey argues in favour of concentrating on relationships for successful transitions (Coffey, 2013) and Keay and colleagues (2015) show the value of effective implementation of support for peer relationships following transition. Affiliation with particular groups of peers can be significant, as discussed above; a meta-ethnographic review including 19 qualitative studies concurs that aggressive behaviours are often a source of status or bonding when pupils feel educationally marginalised or unsafe (Jamal et al., 2013). The review also finds that positive relationships with teachers appear critical in promoting student well-being, confirming the findings of both the current qualitative and ALSPAC analyses, and that such relationships can limit risky behaviours (depending on other features of the school environment). Sadly, the review finds poor student-staff relationships to be common and as with adult relationships in the current study, trust is important and once pupils feel that staff do not understand them they are unlikely to listen to their messages. Inconsistently-applied discipline contributes to poor relationships, and is found to be harmful in the current study, as was high staff turnover. Again supporting the findings in the qualitative and ALSPAC analyses, Jamal and colleagues (2013) find unhappiness at school leads to risky behaviours associated with 'escape' such as truancy or drug-taking.

Evangelou and colleagues (2009) find that good communication between primary and secondary schools, and with parents and the child; good collection of information about the child; careful consideration of tutor groups; and tracking individual children until they had settled in are features of good practice over transitions. However, while many schools have good transition arrangements in place, the period following transition can be less well-handled (McLellan & Galton, 2015). It is most common for children to arrive in alternative educational provision (AP), not immediately following transition, but in years 10 and 11, at which point it is likely that they have been underachieving for years (Taylor, 2012).

Responses to minor misdemeanours

A report by Young Minds (2016) supports the current study's findings in stating that services, including school staff, can be too focussed on challenging or risky behaviours,

which can stigmatise or even criminalise what may be normal responses to adverse child experiences. As we saw in the current study, such staff responses can unnecessarily escalate problems, with potential impacts on trajectories. Research on psycho-social intervention for ADHD has covered many approaches which chime with the findings of the current study: consistency is advocated with 'watch words "routine, repetition and regularity"' (Steer, 2014); and 'structured and predictable' approaches are effective with clear behaviour rules and consequences, consistently applied (Eiraldi, Mautone, & Power, 2012, p3). The importance of addressing academic deficits is highlighted, and was also a theme in the current research where underlying literacy deficits seemed to exacerbate problems.

9.3.4 Supporting teachers encountering children with mental ill health

The finding in the current study that some schools are very supportive of children with behaviour problems and others are not, echoes the House of Commons Health Committee (2014) description of variation in practice between schools for children and young people with mental health problems. Their report argues teachers should be given training about mental health, and for Ofsted to assess this provision, echoing in turn the Good Childhood Enquiry which calls for better training for non-mental health specialists who work with children, such as teachers and GPs (Layard & Dunn, 2009). The Enquiry's subtitle (*Searching for values in a competitive age*) links to themes in the current research about consequences of judging schools almost exclusively by academic results, a state of affairs considered damaging to mental health by the National Union of Teachers (Hutchings, 2015).

Evidence suggests that teachers' behaviour towards children affects their wellbeing; patience, knowledge of intervention techniques, ability to collaborate with an interdisciplinary team and positive attitude towards children with special educational needs have been shown to have a positive impact on student achievement and/or behaviour (Dawson-McClure et al., 2015; Mason et al., 2015; Sherman et al., 2008; Sibley et al., 2011). Teachers have reported insufficient training in behaviour management and a link between student misbehaviour and burn-out (Kokkinos, 2007). NICE guidance (2009) recommends that those teaching children with ADHD are trained in understanding and managing the associated behaviours. However, Reinke and Herman (2002) report that the behaviour of teachers towards children with conduct

problems too often reinforces problematic behaviours; there is an absence of efforts supporting positive behaviours in these children, and they are often reprimanded even in the absence of negative behaviours.

Thresholds for additional support

The experiences of study children with and without a statement of special educational needs were very different. A statement was needed for entry to a special school or to be allocated a full-time one-to-one Teaching Assistant. The ALSPAC analysis found tentative evidence suggesting that those with high needs, but not high enough to warrant a statement of special educational needs, were most likely to go on to have antisocial behaviour. Similarly, pupils who have identified special educational needs, but are ineligible for support, are more likely to be permanently excluded (58.8%) than those with no special educational needs (34.5%) or those with support (6.7%) (Office for National Statistics, 2015). It makes sense that those who fall just below thresholds for intervention may be more at risk than those just above it, who are receiving additional support. The introduction of Educational Health and Care plans to replace Statements of Special Educational Need (SEN), has reinforced the importance of academic achievement for those with SEN and children who are progressing despite difficult behaviour are unlikely to be eligible (Department for Education & Department for Health, 2015).

Diversionary activities

The interview study found some positive consequences of children's involvement in recreational activities. These are not only diversionary but can also offer identity, purpose and positive peer and adult relationships. While it was common to be excluded from mainstream school activity clubs because of behaviour issues, local funding, or chance associations, meant these opportunities were available for some, but not all, study children. Their potential usefulness in diversion from antisocial behaviour is supported by research; for example, Irwin found involvement in sport or hobbies to be the third most important component leading to men's desistance from crime, after finding a good job, and finding a good relationship with a woman (Irwin, 1970). A UK government report cited strong evidence that involvement in sport improves pro-social behaviour and reduces criminal and anti-social behaviour while increasing social connectedness, although two studies which indicated sports clubs reinforcing social exclusion were also cited (Taylor, Davies, et al., 2015). Putnam (2015) has commented

on the serious implications of the disappearance of free sports activities for children and young people in the US, previously seen as a community resource beneficial to all. The crime desistance literature concurs that there is a role for communities in helping young people ‘grow out’ of gang behaviour by providing ‘social recognition and identity-enhancing opportunities’ (Gormally, 2015).

There are risks, then, involved in intervention aimed at children which stigmatises and segregates them, suggests negative self-identification or encourages affiliations based on antisocial behaviours. Recognition of these risks is important so steps can be taken to provide alternative influences. Parent-school relationships can also suffer if parents perceive negative attitudes towards them. Curtis suggests that the need for programmes aimed at ‘at-risk’ youth could be reduced through improvements in interpersonal relationships; important adults in young people’s lives can promote good behaviour through focussing on the children’s strengths, building self-esteem and engaging the child in enjoyable activities (Curtis, 2016: 76). Attention needs to be paid to the quality of relationships, and any barriers to this such as demands on staff. As with services aimed at parents and whole families, flexibility, in terms of recognising where important relationships exist and potential risks if these are curtailed, could be desirable. In the current study, transition between schools was particularly difficult partly because lost supportive relationships were often not compensated for. In addition, however, supportive working environments which allow and reward relationship-building more generally, not just single relationships, can help compensate for any limitations in informal networks.

9.4 Summary of implications for policy and practice

The thesis examines parents’ experiences of services and has drawn out the implications for what is helpful to families with children with serious behaviour problems. The findings, discussed in this chapter and summarised in Table 9.1, Table 9.2 and Table 9.3 above (pages 286-288), therefore have direct implications for practice and/or policy. Table 9.1 and Table 9.2 set out what factors services can usefully target in order to facilitate change in children’s behaviour, sometimes via maternal wellbeing or family relationships. Table 9.3 sets out the study’s findings in terms of how this can best be done. It shows features of individual practice and of organisations delivering services

which can facilitate change or, conversely, inhibit the effectiveness of service intervention. Key points are summarised below.

9.4.1 Implications for practice

The study shows the types of factors which services can helpfully target, such as changing parents' attitudes towards their child's behaviour problems and improving parents' own wellbeing and support networks. However, for these to be addressed successfully the features of individual practice outlined in Table 9.3 and discussed in section 9.2.3 need to be taken into account. These are in turn affected by characteristics of organisations discussed in section 9.2.4.

<u>Helpful features of individual practice</u>

The findings suggest that practitioners are helpful when they are non-judgemental, which can mean: not focussing on trivial issues which may not be crucial for children's wellbeing; listening; focussing on strengths; and developing purposeful shared goals. Practitioners that can coordinate service responses and reinforce positive informal social support are useful to families. The findings suggest there is value in considering the negative as well as positive influences from social networks and neighbourhoods.

Listening and being non-judgemental can help to build trust which may be necessary before change can be attempted. There may be immediate financial or housing issues, or family crises or dangers in the neighbourhood that need to be addressed, or therapeutic input may be needed. Some parents may need long-term support from a practitioner that has gained their trust before they can help bring about significant changes.

Once good relationships are established it is possible for parenting behaviours to be affected through helping parents see their own role in their child's behaviour and also, even in the absence of such a change, through parents learning strategies that they can witness being effective in dealing with their child's difficult behaviours.

<u>Positive feedback and a strength-based approach</u>

The effect on future engagement with services of unsupportive, belittling or blaming past interactions suggests that all practitioners who come into contact with vulnerable children and parents could benefit from an understanding of the impact of past trauma on behaviour (Young Minds, 2016). A strength-based approach can be empowering and

the long-lasting consequences of supportive intervention is particularly clear for the young mothers in the study. These mothers are supported to fight for their child's wellbeing and this leads to greater engagement with the services they and their children receive and even to accessing more support for their child.

Positive feedback is also important for children in schools, and for parents hearing about their children in school. Conversely, support is undermined where parents feel in fear of having their child removed from their care, or when children, and their parents, feel they are constantly at risk of exclusion from school.

Identify and facilitate supportive relationships

Where schools are aware of the value of particular supportive relationships they can seek to mitigate ill effects when key adults leave. To avoid dependency on a single individual, more attention could be paid to developing supportive relationships between all members of a school community. A promising model following transition to secondary school offers a type of wrap-around care with pastoral contact at the beginning and end of each day.

Organisations, including schools and children's services, could take note of where staff have to go beyond the call of duty to provide the care and support they deem necessary, recognise and reward this effort, and take steps to make such effort a part of normal practice if needed — perhaps adjusting job descriptions where necessary.

Available support

Families have periods of crisis and periods of relative calm. Making support more available when parents feel they need it, rather than only when there is a crisis, could help avert such crises. The findings suggest that a short-term intervention is unlikely to permanently shift a child onto a new trajectory but may nevertheless have long-lasting effects, if support is available when needed in future. It may be cost-effective to provide low-level on-call support in-between crisis points as part of families' support network.

9.4.2 Implications for policy

If family support, social work, CAMHS and school staff need to provide more and longer-lasting support and intervention there are, of course, resource and capacity implications. Prevention efforts may be paid for in government departments (Education,

Health or Communities and Local Government, for example) which are different from those where cost savings will be eventually felt (Justice or Work and Pensions, for example). Joining up policy so that it is easier for long-term cost-effectiveness to be taken into account helps make the case for prevention. This study, however, finds barriers to effective practice which, if addressed, might be cost-saving in the shorter term. Many of the features of organisations listed in the second half of Table 9.3 could be addressed through changes in national, local and organisational policy, as could factors listed in Table 9.1 and Table 9.2. Policy can address factors relating to community (such as funding local activities and making it easier for people in social housing to relocate), schools (such as provision of statements to fund additional support and creation of suitable school environments), and society (such as maintaining welfare benefits at levels that recognise parents' additional burdens, and communicating non-blaming discourses regarding vulnerable families). Policy can also affect training, recruitment and working conditions of practitioners.

Identifying and incentivising 'Soft'/intermediate outcomes

Large-scale evaluations of UK family policy such as Sure Start, the Family Nurse Partnership, and most recently the Troubled Families Programme, have had disappointing results when comparing quantitative outcomes with a comparison group. However, although given little attention, some differences in 'softer outcomes' were found, which might be associated with improvements in the longer term (as discussed in Chapter 2) (Barnes, 2016).

The small-scale but in-depth interview study in the current research shows that important improvements can take place, for example in family and community relationships, and yet not be reflected in 'hard' outcomes such as staying in mainstream school or quantitative measurements of children's behaviour (or, for example, reduction in service use or increased maternal employment). The findings suggest that policy needs to allow for the importance of 'softer' outcomes such as improvements in family functioning, and to be realistic about the short- and medium-term outcomes that can be expected from intervention.

Targets and perverse incentives in children's services

The study's findings suggest potential dangers of some approaches to accountability. Aspects of intervention which may not be easily reflected in performance management

metrics may be discouraged if they are not applauded. Good practice, with the features outlined above, may be undermined when too much focus on meeting targets leads to tick-box approaches to interactions with service users, and the creation of perverse incentives through unrealistic, and perhaps too short-term, outcome measures. The TFP's payment-by-results structure incentivised, for example, entry to paid employment or attendance at a work programme (with no attention to the sustainability of outcomes), which could undermine focus on intermediate outcomes such as maternal mental health or social networks, which might be more important for children's antisocial behaviour in the longer term.

Targets and perverse incentives in schools – are children happy at school?

Similarly, in schools, there are potential dangers if policies privilege academic achievement above all else, particularly when fewer than 60% of pupils achieve government's headline measure of educational success (until recently, five or more A*-C grades at GCSE; only a quarter of children achieved the standard of the new English Baccalaureate) (Department for Education, 2016b).

Policies put into place in schools need to take account of their effect on children's happiness. The study shows there is great variation in primary schools' approaches to children with difficult behaviour, some apparently preferring not to keep these children in their schools while others take pride in providing the nurturing and personalised approach they need. These different approaches are not explicitly stated. Children have often therefore already experienced failure and exclusion even before they arrive at secondary school.

Mainstream secondary schools in the study did not seem well-equipped to deal with these children's needs, leading to children being labelled as difficult, and often segregated. A spiral of continuing identification with antisocial behaviour can follow. It is possible that the current political focus on academic results may undermine provision for those with difficult behaviour and a variety of other needs. Statements of special educational needs are becoming harder to obtain and school leaders consider there to be insufficient funding attached (The Key, 2016). The current system appears to mean that for these children to access a more therapeutic school environment they either have to have experienced multiple failures, or to enter the fee-paying system.

9.4.3 Promoting enabling environments around children, families and practitioners

Rather than implicitly or explicitly blaming parents and practitioners for children's outcomes, policy and practice can instead take more account of the wider network of influences on children, families and practitioners working with them. Psychological perspectives on antisocial and criminal behaviours see healthy emotional development disrupted by interactions between genetics/temperament, early experiences with significant others and social factors which intensify problematic personality traits (Haigh, 2013). However, despite damaging early experiences, later emotional development can occur where the right conditions are created; environments are enabling when they provide such conditions. Haigh argues that where experiences necessary for healthy emotional development have been missing (attachment, containment, communication, inclusion and agency) they can be recreated in therapeutic (or psychosocial) environments.

Much of what has been discussed above in relation to families, schools, communities and practitioners' workplaces, within a broad socio-ecological and developmental framework, is supported by research on key features of 'enabling environments' (Johnson & Haigh, 2011). Haigh has summarised these as: Belonging, Boundaries, Communication, Development, Safety, Structure, Empowerment, Leadership and Openness (Haigh, 2013). The importance of good relationships and feelings of belonging are highlighted, along with clear boundaries (rules and expectations of behaviour) and communication; all behaviour is interpreted as communication. An enabling environment gives attention to people's development, with opportunities to try new things; involvement, so that everyone shares responsibility; and empowerment, so everyone can have their voice heard. Enabling environments should feel safe, with emotional support available for all, and they should provide structured activities in which everyone takes part. Openness, in terms of external relationships, is valued and thoughtful leadership is needed.

Schools need to be enabling environments for children and so do workplaces for staff. Teachers in England report working longer hours than any others in the developed world and, tellingly, the additional hours are spent on marking, lesson preparation and form-filling, rather than contact with pupils (Sellen, 2016). Teachers in England are also

missing out on training and development compared with other countries, and are younger and less experienced (Sellen, 2016). Munro, in an attack on hot-desking workplace culture, spoke about the need for social workers to be able to return to a workplace where they know they can find support from known colleagues (Munro, 2016). Horwath, and White and colleagues (2014), relate workplace environments directly to practitioners' ability to form relationships with families; Horwath talks about a 'toxic duo' of neglected practitioners dealing with parents who are not meeting the needs of their child, and the difficulty of creating healthy workplace cultures when faced by year-on-year budget cuts (Horwath, 2015).

School staff, social workers, and other professionals supporting families and children have a difficult balance to strike between support, reform and surveillance, between challenging (being purposeful) and listening, between nurturing and promoting independence and between providing flexibility and consistency. They are also having to balance demands from their managers and organisations with their own instincts about how families and children can best be supported. Professionals providing these services need their own enabling environments.

9.5 Reflection on the methods and implications for future research

Limitations of the research design were discussed in Chapter 3 (sections 3.3.1 and 3.4) including issues of generalisation and causality and the match between the interview study and ALSPAC study families. Ethical constraints on what could be reported were also discussed. Some further issues are highlighted here along with implications for future research.

9.5.1 Reflections on the methods used for the qualitative interview study

The perspective of children

Children were not interviewed and so their perspective is missing and there is little attention to questions of children's agency. Some information, particularly regarding services only received by the children, was second-hand and children may have presented their views about the benefits or otherwise of relationships differently from parents or practitioners.

Limits to the ecological scope

Some aspects of experience are easier to relate to outcomes than others; neighbourhood influences were sometimes particularly difficult to unravel. While the impact of peers was easier for parents to comment on, the built environment, for example, was trickier, unless two different environments had been experienced affording obvious comparison. Regarding provision of activities, for example, it was not always clear whether activities are not available or whether children, or parents, choose not to participate or do not know what is available. Again, where change had been experienced, for example, the closure of facilities, impact was more obvious, and respondents often made such reflections.

Recruitment; a convenience sample

As described in Chapter 3 recruitment of both parent and practitioner participants was time-consuming. Only one parent contacted declined to participate, the remaining potential recruits could not be traced, and these may on average have more problems, although the reverse is also possible, that they were difficult to trace because they were no longer involved with services. It is not possible to comment on prevalence of the problems encountered, in either phase, because a convenience sample was used. However, this was not an aim of the qualitative study, which was exploratory, aiming to show the types of issues that can affect services' efforts to intervene. Because there was no attempt to claim any representativeness numbers are not systematically reported. Nevertheless, for transparency, an overview of the main themes, and how many families the theme applied to, is included in Appendix 4.

Development of data collection tools

Various versions of the questionnaires used for recording families' service use had been piloted in conjunction with the intervention evaluation of the Helping Families Programme. While this is a strength, that study had different aims and further modifications were needed during the process of the thesis research. Because the tool was developed for the costing of services and not for use in an in-depth interview its original form was sometimes inefficient. Procedures therefore changed during the study so that by the follow-up interviews the process involved the in-depth interview, checklist and ratings sheets. The eventual procedure suited the purpose well.

Participants rated each service mentioned using visual analogue scales. These could only be used very crudely to compare different participants' responses. However, they were useful for comparing individuals' different responses over time. They were perhaps most useful as a heuristic device as they elicited further thoughts about the helpfulness of services. Nevertheless, the scales could also have value in future research with larger samples and a less in-depth interview process.

Reliability of accounts

Mothers were the principal informants in the interview study and had told their stories to services many times. This may have some impact on accounts given. Parents, as well as practitioners, whether or not consciously, are constructing their stories, and their stated understanding of their child's behaviour, in a research interview situation, as they must also in interviews with services. In order to provide some triangulation the analysis compares parents' accounts of similar situations given at different points in the interviews, or in different interviews, as well as comparing different instances of similar phenomena. The accounts of parents and practitioners were also compared, in order to unearth what appeared to be the salient factors affecting parents' ability to manage their children's behaviour.

There was only one coder, which may affect the reliability of the study. Although application of codes was discussed with two supervisors it was felt too complex to make the use of a second coder useful. Accurate coding relied on knowledge of all available data (interviews, background data, field notes) on the family and on other families in the study. Verification efforts involved discussion with participants themselves about previous and current interpretations, and the main conclusions arising from the first set of interviews were discussed with participants at the final follow-up.

Issues in reflecting complexity

The in-depth interviews avoided simplistic accounts with a loose structure enabling adaptation to the themes which appeared important in each case, but could mean some questions weren't asked of all families – as far as possible this was remedied in the second follow-up interviews.

The scope of the study indicated by the conceptual framework (Figure 1) is broad. The research questions could have been addressed in different ways and the purpose of this

study was for investigation to be rooted firmly in parents' experiences. The inductive approach means that the analysis is limited by what emerged from the interviews with parents and practitioners. Practitioners, for example, could only comment on certain aspects of parents' involvement with services.

Because practitioners came from different services, findings specific to particular services had to be very tentative. However, the focus was on features of practice that had relevance across different service types. Future research could investigate the highlighted factors using larger samples of practitioners and users of specific services to examine the extent to which the findings apply.

9.5.2 Reflections on the mix of methods used

There are limitations in the ALSPAC analyses, and the link between the qualitative and quantitative study components, which should be taken into account.

<u>Only a sub-set of hypotheses could be investigated using ALSPAC</u>

The qualitative study was designed to be hypothesis-raising and not all findings could be investigated further in the cohort data, although the number of hypothesised factors which could be approximated with ALSPAC variables was surprisingly high. The wording of the hypotheses was limited by data availability and not purely based on the qualitative results. For example, the importance of good relationships between children and school staff could only be mirrored with a general question about how much children liked their teachers, whereas the interview study showed that relationships with non-teacher school staff may sometimes be the most important. It is also possible that further hypotheses could have been investigated with more time, additional data requests and more sophisticated techniques.

<u>Investigating effects which may be large for individual families but small on average</u>

As indicated previously, the size of effects for individual hypothesised factors were not expected to be large, due to the plethora of influences on children's behaviour. Because of this, an attempt was made to maximise sample sizes, and relatively simple analytic techniques were used to enhance transparency in a complex field of study.

Lack of representation of high need families in cohort data

The ALSPAC behaviour problems subsample is not matched with the type of difficulties faced by the interview study families, who had particularly high needs including family-level risk factors for children's antisocial behaviour, in addition to primary-school-age behaviour problems. In order to retain larger samples for greater statistical power, family-level risk factor variables were instead used as covariates, where possible. However, these are not the same risk factors experienced by interview study families.

The problem of the counterfactual

The current research, as with other research interested in prevention which is not based on controlled trials, wished to address the question of the counterfactual, that is, what would happen in the absence of hypothesised protective factors, or without the intervention, given that a large proportion of children with difficult behaviour will 'recover' without intervention (Gormally, 2015; Holman & Ziedenberg, 2013).

The in-depth nature of the qualitative approach uncovered factors and processes which appeared to explain helpful intervention and be important for children's future trajectories. However, we do not know what would have happened to the young people in the absence of these factors.

The ALSPAC study attempted to investigate the counterfactual through its creation of groups who did or did not experience the hypothesised protective factor. Some of the factors investigated with ALSPAC did not show the hypothesised effects on the summary antisocial and criminal behaviour outcome, when controlling for family background factors. It is possible that some processes and effects might only be detectable through such an in-depth, longitudinal interview study as that conducted here, but it may also be that the apparent benefits will not affect children's antisocial and criminal behaviour in the long-term. From the current study we cannot say which of these is true. It may well be that attention to more than one factor is needed for changes to be apparent in longer-term outcomes, necessitating more complicated analyses.

With additional data, future research could use cohort studies to explore potential causal influences suggested by this and other qualitative analyses. Available techniques

include use of normative 'virtual' control groups (Goodman, 2010), propensity score matching (Austin, 2011) or instrumental variables (DeMaris, 2014).

9.5.3 Future research

The ALSPAC analysis, supporting existing research, shows that not all children with behaviour problems will go on to have problematic behaviour when they are older. The interview study showed that all the high-risk children in these families continued to have serious problems with their behaviour five years after referral to therapeutic family intervention. The fact that positive changes were observed nonetheless is important for future research evaluating interventions. These improvements have certainly made life more bearable for the children, mothers and other family members, but will they translate into long-term benefits? The ALSPAC study attempted to look at this, within the limitations discussed above, and the findings of this mixed methods approach have implications for future research.

<u>Identifying intermediate outcomes</u>

It is important to develop ways of measuring potentially-modifying factors and associated short- and medium-term outcomes so that approaches that may be beneficial are not rejected because timescales are too short to pick up the outcomes of interest or because the wrong intermediate outcomes are measured.

It would be useful to continue this small sample study having had the opportunity to assess these nuanced features and their implications, to look at future outcomes for the children of this interview study. Larger qualitative longitudinal studies which look across intervention types are needed, and the results should feed into cohort studies and intervention evaluations to incorporate assessment of identified potentially-modifying factors. Some such outcomes are likely to be considered 'soft' (parent empowerment for example (Freiberg et al., 2014)) but may have important implications for longer-term outcomes. The 'enabling environments' framework described above could be used as a multi-faceted intermediate outcome measure and a potential mediator between risk factors and later antisocial and criminal behaviour.

Research which can embrace the complexity of lived experiences of at-risk children and their families is needed to counteract the possible dangers of prioritising intervention

approaches just because they are easier to 'manualise' and have easier-to-measure outcomes.

Broad outcome measures

An alternative approach is to develop broad outcome measures to try to pick up unforeseen benefits of intervention. Suggestions include outcomes such as happiness, wellbeing, life satisfaction (Helliwell et al., 2015) or 'cognitive footprint', that is, assessing policies and interventions in terms of whether they enhance or impair cognition (Rossor & Knapp, 2015). These ideas could be useful in capturing a wider range of potential benefits of intervention in quantitative studies.

School experiences

Reasons for the variation in schools' approaches to children with difficult behaviour, and variation in services on offer in different areas, including availability of diversionary activities for youth, could be further researched. Given the diversity in schools, and the obvious (from this study) differences in approach to children with challenging behaviour, future research could compare schools with similar intakes, but different approaches (for example, very different rates of exclusions or different behaviour policies). The processes by which these differences come about, as well as the associated outcomes, could be investigated.

The current research suggests that children's experiences following transition to secondary school could explain non-sustainability of improvements in behaviour often seen during primary school. While there is some research on beneficial and unhelpful aspects of transition experiences this could be enhanced through reference to the current study's conceptualisation of the disjuncture between radically different balances of nurture and independence. In addition, it would be beneficial to follow children for a longer period after transition to secondary school to look at the role of continuing discreet support, or of changes in school ethos and environment.

Thresholds of need

It has already been shown that child protection thresholds differ by area deprivation (Bywaters et al., 2016). Related research could investigate a suggestion of the current research about reasons and choices about ending practitioner involvement, for example in child protection cases. Do the most hard-to-help families have the most changes in

support/social worker? Is this the best use of resources? While this might be the most efficient way of meeting immediate targets it may not be cost-effective in the long-term. The issue of apparent (to parents) prioritisation of trivial aspects of families' lives could be investigated by attending social work training on thresholds where scenarios and decision-making are discussed, analysing discussions and perhaps surveying participants afterwards.

The role of individual practitioners and relationships

Relationships were a recurrent theme in the current research. Future research looking at what works in intervention with children and families could benefit from taking account of the role of individual practitioners. For example, within an overall assessment of 'no effect' of a policy or intervention may be variation based on practitioner qualities or behaviours. Alternatively, key features of practitioners' approaches could be measured, using for example the factors identified as important in the current research. Aspects of policy which detrimentally affect relationships could usefully be researched and adjusted where necessary.

9.6 Conclusion

> Yeah, it was a combination of things but as I said, I can't pinpoint one thing. It could be from him growing up, you know, matured a bit, not such a baby. The sports club helped him, I helped him, family helped. …and all the other help I've had. I think it's just like a combination of things and it's just gelled all of a sudden at this age and time. That's all I think it is. *Sue*

The mothers in the interview study loved their children. Two who initially had very negative attitudes towards their child changed their views, with therapeutic support, becoming great supporters of their child. The mothers of the children who were taken into care also loved their children but were unable to make changes that would keep their children safe. This appeared to be connected to past trauma and/or a lack of belief that they could affect their fate (also appearing to result from past trauma).

Policy and practice should beware of blaming or pathologising parents and children and instead promote approaches, and rhetoric, which take account of the network of different influences on families. The environments around children become more conducive to good behaviour when harmful parenting attitudes or behaviours change and there are supportive informal and formal networks around mothers and other main carers. Therapeutic relationships which focus on parents' strengths and take account of

difficult life events can help empower parents to bring about change, and organisational approaches can make helpful relationships between practitioners and parents more likely.

Children are in different environments at school and attention to good quality relationships between school staff and children, as well as between schools and parents, can help make these settings more conducive to children's wellbeing. However, some school responses to difficult behaviour can exacerbate problems when they stigmatise and segregate children, reinforcing the negative perceptions of peers, staff and children themselves. Children who have been nurtured at primary school may find little opportunity for equivalent supportive relationships following transition to secondary schools. School staff themselves, as with social workers and others supporting families, are working in highly pressured environments with restricted resources and targets which may not always be in line with the provision of the most appropriate support for children.

Despite what is known about risk factors, there is much uncertainty in what happens to people; people need help at different times and this is hard to predict, so routes to support need to be known, easy, unthreatening and non-stigmatising. The qualitative, in-depth interview study following families of eleven children over five years showed many changes in children's trajectories and found no evidence of an inevitable path towards antisocial and criminal behaviour. Instead, the study found moments when there was great motivation on the part of parents to help bring about change. The study uncovered many features of the help available to families and children which did seem to have an influence. The ALSPAC study found evidence that some of the protective factors for children in middle childhood identified in the qualitative work had a long-term impact, reducing the likelihood of antisocial and criminal behaviour when children grew up.

The conclusion of the study therefore is that long-lasting changes are possible, and are more likely where support, and all services encountered by families, is careful and thoughtful, based on respectful relationships and positive feedback. Policy and practice should aim to avoid the harm that can be caused by risk-focussed, blaming rhetoric and interactions, and concentrate on doing more of what can help. This should be

intervening at a variety of different levels of influence, to improve the environments around children, families and those working with them. We live in an unequal society but families and services ultimately want the same thing, to improve the life chances of disadvantaged members of society. The quote at the beginning of this chapter described a young man choosing a new life trajectory, away from gangs and crime. Remembering that we are on the same side may help policy and practice create relationships and environments that can support and respond to parents' and children's desires to bring about change.

> My hopes are for Michael to go to that [college]… to finish college and have a job ... his hope is – you know, to work and earn money. And myself, to go back to work and you know, live as a family, and a happy family, not stressed, no anger, nothing! My fears is just things to go back or to go bad again, you know? Those are my fears, yeah. *Kathleen*

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Appendix 1 Sue and Aaron

BUT SUE FELT AARON WAS NOT LIKE OTHER 9-YEAR-OLDS.
I'D LIKE MORE TESTS.
I INTERVIEWED SUE AGAIN RECENTLY.
AARON WAS 13. THEY WERE STILL GREAT MATES. BUT THE TRANSITION TO SECONDARY SCHOOL HADN'T GONE WELL.
HEY YOU! DO UP YOUR TIE!
***!
HE CAN'T HANDLE THE WAY THE TEACHERS TALK
IF HE'S TACKLED IN FOOTBALL, HE THINKS THEY'RE STARTING A FIGHT!
THE SCHOOL DID NOT PUT IN PLACE THE PLANNED MENTORING AND SUPPORT.
SORRY HE'S LEFT.
SORRY SHE'S BUSY.
WHAT HAPPENED TO THAT FULL-TIME SUPPORT?
AARON WAS EXCLUDED AND SENT TO A PUPIL REFERRAL UNIT. HE WASN'T HAPPY THERE.
HE'S EASILY INFLUENCED.
HE'S SCARED TO GO TO LUNCH.
THE STAFF TRY TO BE THE BOY S' MATES.
THERE'S NO DISCIPLINE.
SHE DIDN'T KNOW WHAT TO DO. SHE THOUGHT THE AREA WHERE THEY LIVED WAS FULL OF BAD INFLUENCES. AND THERE WASN'T ENOUGH FOR CHILDREN TO DO.
THERE WERE NO MORE SERVICES OUTSIDE SCHOOL. SUE HAD TO GIVE UP HER JOB TO LOOK AFTER AARON. SHE SUFFERED FROM DEPRESSION AND ANXIETY. BUT THEY LOVED EACH OTHER. AND AARON HAD FOUND A LOCAL KARATE CLUB, WHERE THE TRAINER HAD TAKEN HIM UNDER HIS WING.
I WANT TO BE A FIGHTER.
I WISH WE COULD HAVE A HOLIDAY.
I THINK THE CLUB HAS SAVED HIM, I DON'T CARE WHAT ANYBODY SAYS. BUT HE'LL HAVE TO STAY AT HOME WITH ME FOREVER.

Appendix 2 Key intervention reviews

Table A2.1: Key intervention reviews

Author	Year	Title
Multiple-intervention reviews		
O'Connor and Waddel	2015	What works to prevent gang involvement, youth violence and crime
Epstein	2015	Psychosocial and pharmacological interventions for disruptive behavior in children and adolescents: comparative effectiveness
De Vries	2015	Practitioner review: Effective ingredients of prevention programs for youth at risk of persistent juvenile delinquency--recommendations for clinical practice
Melendez-Torres	2015	Systematic review and meta-analysis of effects of community-delivered positive youth development interventions on violence outcomes
Hale	2014	A systematic review of effective interventions for reducing multiple health risk behaviors in adolescence
Parsonage, Khan,	2014	Investing in children's mental health: A review of evidence on the costs and benefits of increased service provision
Carr	2014	The evidence base for family therapy and systemic interventions for child-focused problems
Pilling…Scott, NICE Guidance	2013	Recognition, intervention and management of antisocial behaviour and conduct disorders in children and young people
Ross et al	2011	Prevention and reduction: A review of strategies for intervening early to prevent or reduce youth crime and anti-social behaviour
Kilian	2011	Cost-effectiveness analysis in child and adolescent mental health problems: An updated review of literature
Piquero	2010	Self-control interventions for children under age 10 for improving self-control and delinquency and problem behaviors
Cohen, Piquero Jennings	2010	Estimating the costs of bad outcomes for at-risk youth and the benefits of early childhood interventions to reduce them
Bayer	2009	Systematic review of preventive interventions for children's mental health: what would work in Australian contexts?
Lipsey	2009	The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview
Welsh, Sullivan, Olds	2009	When early crime prevention goes to scale: a new look at the evidence
Wadell	2007	Preventing mental disorders in children: a systematic review to inform policy-making
Tennant, Goens, Barlow, Day, Stewart-Brown	2007	A systematic review of reviews of interventions to promote mental health and prevent mental health problems in children and young people
Farrington and Welsh	2003	Family-based crime prevention approaches
Woolfenden	2001	Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10- 17
Greenwood; RAND	1998	Diverting children from a life of crime

School-based interventions		
Lima-Serrano	2014	Impact of school-based health promotion interventions aimed at different behavioral domains: a systematic review.
Evans	2014	The effectiveness of school-based bullying prevention programs: A systematic review
Ttofi and Farrington	2011	Effectiveness of school-based programs to reduce bullying: a systematic and meta-analytic review
Hahn, Fuqua-Whiteley et al	2007	School-based programs to prevent violent and aggressive behavior: A systematic review
Vreeman	2007	A systematic review of school-based interventions to prevent bullying
Garrad and Lipsey	2007	School-based conflict resolution education
Mytton	2006	School-based secondary prevention programmes for preventing violence
Wilson and Lipsey	2005	School-based violence prevention programmes
Wilson & Lipsey	2003	The effects of school-based intervention programs on aggressive behaviour: a meta-analysis
Specific intervention reviews		
Taheri and Welsh	2015	After-school programs for delinquency prevention: A systematic review and meta-analysis
Furlong et al	2012	Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years
Tolan et al	2013	Mentoring interventions to affect juvenile delinquency and associated problems: A systematic review
Reyno & McGraph	2013	Predictors of parent training efficacy for child externalizing behavior problems; a meta-analytic review
Turner	2011	Treatment foster care for improving outcomes in children and young people: a systematic review
Farruggia	2011	The effectiveness of youth mentoring programmes in New Zealand
Zwi	2011	Parent training interventions for attention deficit hyperactivity disorder (ADHD) in children aged 5 to 18 years
Dretzke	2009	The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials
Piquero, Farrington etc	2009	Effects of early family/parent training programs on antisocial behavior and delinquency
MacDonald & Turner	2008	Treatment Foster Care for improving outcomes in children and young people
Wyatt Kaminsky	2008	A meta-analytic review of components associated with parent training program effectiveness
Reyno	2006	Predictors of parent training efficacy for child externalizing behavior problems; a meta-analytic review
Little	2005	Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17: A systematic review
Losel	2003	Effects of child skills training in preventing antisocial behavior: A systematic review of randomized evaluations

Appendix 3 Interview study materials

Information sheets and consent forms

Copies of the following are pasted below:

Information sheet for study participants - parents

Consent form for study participants - parents

Practitioner information sheet

Practitioner consent form

Information sheet for follow-up participants 12th September 2013

Information about the research

Support for families with children: What services are useful for families?

Hello, my name is Madeleine Stevens and I am trying to find out what services families use and if they find them useful. I and my colleagues Jennifer Beecham and Anne Power work at a university in London called the London School of Economics and Political Science.

Why are we doing this study?
Parents often need help from friends and families but also from other places like schools or social services. Sometimes these services can be helpful, and sometimes not. We would like to know what parents think about these services.

Why have you been invited?
Because in the past you were offered the Helping Families Programme to help with a child who had difficult behaviour. You can still take part if you didn't use the Helping Families Programme.

Do I have to take part in the study?
No, it is entirely voluntary. If you decide to take part I will ask you to sign a consent form but you can change your mind at any time.

What does taking part involve?
If you think you would like to take part I will arrange to meet with you at your home, or another place where you would feel comfortable. I will ask you some questions about your child's behaviour nowadays and about anybody you have seen from school, health services, social work or other services over the last few months. I will ask how helpful they were and if there is any other help you would like. I would also like to hear anything you have to say about things like your neighbourhood or housing. The interview might take up to an hour and a half and I would like to record our conversation. I would like to find out how your child is doing at school so I will ask you if I can speak to their teacher. I would also ask to interview you again in a couple of years to see what has changed.

What are the possible disadvantages and risks of taking part?
Sometimes people find it upsetting to talk about their experiences. You can stop our discussion any time you want and you don't have to answer any questions you don't want to.

What are the benefits of taking part?
We hope that by finding out about parents' experiences we can tell services how to support families better. We will give you £20 each time you take part in an interview to thank you for your time.

Will my taking part in the study be kept confidential?
Yes. The things you tell me will not be shared with anyone outside the research team. The recordings, completed forms and any written notes will be labelled with a number and won't be stored with any names or other identifying information.

What will happen to the results of the study?
At the end of the project we will send you a leaflet explaining what we found. We will also write papers for academic journals and conferences. Nobody will be identifiable in any of these reports.

What if there is a problem?
If you have any concerns about the research and the way you have been approached or treated, please contact me. If you remain unhappy or have a formal complaint, contact Professor Jennifer Beecham on 020 7955 6087 (email J.Beecham@lse.ac.uk) or leave your name and telephone number at 020 7955 6238 and Professor Beecham will return your call as soon as possible.

Who is organising or funding the research?
The research is funded by the National Institute for Health Research as part of a PhD Fellowship Grant. It has been reviewed by the LSE Research Ethics Committee: Identification Number 120521.

Please feel free to contact me if you would like to hear more or have any questions
Madeleine Stevens, PSSRU, LSE, Houghton Street, London WC2A 2AE
Email: m.stevens@lse.ac.uk. Telephone: 020 7852 3773

Thank you for taking the time to read this information sheet

CONSENT FORM

Thank you for taking part in this research. If you have any questions please ask.

Title of Project: Support for families with children: What is useful for families?

Name of Researcher: Madeleine Stevens

1. I confirm that I have read and understand the information sheet dated September 12th 2013 for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my care or legal rights being affected. ☐

3. I agree to the interviews being recorded so that my comments can be typed up and used as research data. ☐

4. I consent to the processing of personal information about myself and child for the purposes explained to me. ☐

5. I agree to my child's school teacher being asked to complete questionnaires relating to my child's behaviour and attendance. ☐

6. I agree to take part in the study. ☐

____
Signature

____________________ ________________
Name of Participant (please print) Date

____________________ ________________
Name of person taking consent Date

The London School of Economics and Political Science Research Ethics Committee Study number: 120521

Practitioner Information Sheet MS LSE 18/12/2013

Information about the research
Support for families with children with difficult behaviour: What is useful for families?

My name is Madeleine Stevens and I am researching support for high need families. This information sheet is for practitioners who I am inviting to take part in an interview. Practitioners have been nominated by families participating in the research.

Why are we doing this study?
The research looks at support for high need families where a child has behaviour problems. The aim is to look at how services can help children who are at risk of longer-term disruptive, antisocial and criminal behaviour. We are not evaluating particular services, but rather looking at general themes to help find the best ways of helping these children. We are following families for 4-5 years to find out how they use helping services, and how their attitudes and the child's behaviour change over time.

Which families are taking part?
The families in this study were initially involved in a pilot of the Helping Families Programme in 2010-11. This was run by the Centre for Child and Parent Support (www.cpcs.org.uk), collaborators on the current project. The families were originally selected because they met certain criteria: behaviour problems in the child, risk of exclusion from primary school, and additional problems in the family considered to be risk factors for poor outcomes in terms of the child's behaviour.

What does taking part in the study involve?
When I interview families I ask them to nominate a key support person that I could interview, someone from any service, who knows the family and has been helpful. If you have been nominated I am inviting you to take part in a brief interview about: your involvement with the family, other services you know the family is involved with, and any barriers to the family making best use of services. The sorts of questions I will ask are listed in the topic guide outline below. The interview will take about 30-45 minutes and I can come to wherever is most convenient for you.

Will my taking part in the study be kept confidential?
Yes. The things you tell me will not be shared with anyone outside the research team. The recordings, completed forms and any written notes will be labelled with a number and won't be stored with any names or other identifying information.

Practitioner Information Sheet MS LSE 18/12/2013

What will happen to the results of the study?
The study continues until 2016. We will write a summary for participants in the research and would welcome feedback on initial findings. At the end of the project we will write papers for academic journals and conferences. Nobody will be identifiable in any of these reports.

What if there is a problem?
If you have any concerns about the research please contact me. If you remain concerned contact Professor Jennifer Beecham on 020 7955 6087 (email J.Beecham@lse.ac.uk) or leave your name and telephone number at 020 7955 6238 and Professor Beecham will return your call as soon as possible.

Who is organising or funding the research?
The research is funded by the National Institute for Health Research as part of a Doctoral Fellowship Grant. It has been reviewed by the LSE Research Ethics Committee: ID Number 120521.

Topic guide outline for interview with nominated practitioner

- Could you tell me about your involvement with this family?
  - Which members do you see? How often and for how long?
  - What support do you give this family?
  - How much non-contact time do you spend on this family?
  - Have you been involved with/in contact with other services regarding this family?

- How important do you think this support is to the family?
  - How does the primary carer respond to the support given?

- What other services do you know that this family is involved with?
  - How useful do you think each contact is for the family?

- What other aspects of their lives do you think affect how easy or hard it is for the primary carer to look after the family? (e.g. personal factors, housing, neighbourhood, employment)

- Can you think of any other help this family might find useful?
  - If yes, what are the barriers to the family getting this help?

Please feel free to contact me if you would like to hear more or have any questions
Madeleine Stevens, PSSRU, LSE, Houghton Street, London WC2A 2AE
Email: m.stevens@lse.ac.uk. Telephone: 020 7852 3773

Thank you for taking the time to read this information sheet

CONSENT FORM

Thank you for taking part in this research. If you have any questions please ask.

Title of Project: Support for families with children with difficult behaviour: What is useful for families?

Name of Researcher: Madeleine Stevens

1. I confirm that I have received and understood the information sheet about the research study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. ☐

3. I agree to the interviews being recorded so that my comments can be typed up and used as research data. ☐

____

Signature

____________________ ________________

Name of Participant (please print) Date

____________________ ________________

Name of person taking consent Date

The London School of Economics and Political Science Research Ethics Committee Study number: 120521

Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire P 4-16

Child's name: Click here to enter text. Male ☐ Female ☐

Date of birth: Click here to enter text.

For each item please mark the box for Not True, Somewhat True or Certainly True. It would help if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils, etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Click here to enter text.

Overall, do you think that the child has difficulties in one or more of the following areas: emotions, concentration or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - Severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Name: Click here to enter text. Date: Click here to enter text.

Mother ☐ Father ☐ Other (please specify): Click here to enter text.

Thank you very much for your help

Services checklist and Adapted Client Service Receipt Inventory

USE OF SERVICES AND SUPPORTS (CSRI)
Support for families with children

We would like to find out about the services used by your child in the past 6 months. This information will be used anonymously in our research and not passed to any other organization.

Date completed

ID

Please tick the box next to the services your child has used in the last 6 months

Services your child has used

Education

Type of schooling

- Registered Child-minder ☐
- Mainstream primary school ☐
- Mainstream secondary school ☐
- Pupil referral unit ☐
- Special school ☐
- Residential school ☐
- Other ☐
- School exclusion services ☐

Type of class attended

- Mainstream classes ☐
- Exclusion classroom ☐
- Other separate classroom ☐

Other support for school

- Some lessons in small classes ☐
- Learning support assistant ☐
- Classroom assistant ☐
- Individual help in some classes ☐
- Individual tuition at home ☐
- Educational Psychologist ☐
- Welfare Officer ☐
- Special educational needs coordinator (SENCO) ☐
- Home/school liaison officer ☐
- Truancy officer ☐
- School police ☐
- Other ☐

Community and social services

- Child's Family Intervention Project (FIP) worker ☐
- Child's social worker ☐
- Children's or Family Centre (e.g. Sure Start) ☐
- CAMHS team member (e.g. psychologist, Psychiatrist, therapist, nurse, etc.) ☐
- Child mentor ☐
- Disability or key worker ☐
- Other support worker e.g. Head's Up ☐
- Any other groups or activities provided by local authority or voluntary services (e.g. playgroups, sporting or cultural activities) ☐

Any other community or social care services? ☐

Youth justice services

Youth offending team (YOT) member ☐
Challenge and support worker ☐
Gangs' liaison worker ☐
Mentor ☐
YIS panel ☐
Other Youth Justice worker ☐
Police ☐

Any other youth justice services? (e.g. court appearances, probation officer) ☐

Health services

GP ☐
Community nurse ☐
Nurse at GP practice ☐
Dentist ☐
Optician ☐
Hospital outpatient clinic ☐
A&E or minor injuries unit ☐

Any other health services? (specify) ☐

Staying away overnight

Hospital ☐
Children's home ☐
Foster carer ☐
Other residential placement ☐
Other ☐

Services you have used to help you with your family

Please tick the box next to the services you have used in the last 6 months

Family Intervention Project Worker ☐
Community support worker ☐
Home care/support worker ☐
Social worker ☐
Housing officer ☐
Alcohol and drugs worker ☐
Parenting practitioner ☐
Parenting programme ☐
Other support worker e.g. Heads Up ☐
GP ☐
Practice nurse ☐
Counseller ☐
Self-help or support group ☐
Complementary therapist (e.g. shiatsu, reflexology, massage, etc) ☐

Any other services? ☐

USE OF SERVICES AND SUPPORTS (CSRI)
Project: Support for families with children

We would like to find out about the services used by your child in the past 6 months. At the end we will ask if you have any comments you would like to make about services you may have received longer ago than 3 months. These questions are about services for the child in the Helping Families Programme. This information will be used anonymously in our research and not passed to any other organization. [This form should be completed in conjunction with the list of services, which can be given to families in advance]

Family ID	Child's sex	Child's age	Child's date of birth	Date completing this form

1. Does your child attend school or receive any other education or day care services? **Yes** ☐ **No** ☐

If yes complete the table below to show how many half-days (morning or afternoons) per week s/he attends each type of service.

Type of day care or education	Attends? (please tick)	No. half-days/week	Comments
Registered Child-minder			
Mainstream primary school			
Mainstream secondary school			
Pupil referral unit			

Type of day care or education	Attends? (please tick)	No. half-days/week	Comments
Special school			
Residential school			
Other (describe)			

How helpful is this service in dealing with your child's difficulties?

I---I

Not at all helpful **Very helpful**

2a. Has your child missed any class time at school in the last 3 months (excluding holidays) due to his/her behaviour? Yes ☐ No ☐

2b. Please complete the table to show where the child was sent, and how often this occurred in the past 3 months.

Time out of class sent home	**Occurred?**	**Frequency and typical length (e.g. No. half-days in past 3 months)**	**Comments**
Sent home			
Officially excluded			
Time out of class at school		**Frequency and typical length (e.g. minutes per day, times per week)**	**Comments (e.g. what staff were involved? Any changes in past 3 months)**
Exclusion classroom			
Other time removed from lessons (Please give details of where child was sent, and who was present)			

3. Please tell us about any other education-related services your child currently receives. [Refer to the list of services]

Service (please add any additional identifying information)	**How much contact? (How often? e.g. times per week or per month / Typical length of contact?/Since when?)**	**Any additional comments**
How helpful is this contact? **Not at all helpful** I---I **Very helpful**		
How helpful is this contact? **Not at all helpful** I---I **Very helpful**		
How helpful is this contact? **Not at all helpful** I---I **Very helpful**		

[additional sheets as needed]

4. We would like to know about any community, social, health and youth justice services your child has used in the <u>past 3 months</u>. [Refer to services list]

Service (Add name and/or job title/service title of contact)	**How many contacts face-to-face**	**Usual location of contact**	**Typical duration** (mins)	**How many contacts by phone**	**Typical duration** (mins)	**Do you feel that you had a choice about seeing this contact?** (Yes/No/any comments)	**Additional comments**
Service:							
How helpful is this contact? **Not at all helpful** I---I **Very helpful**							

Service:							
How helpful is this contact? **Not at all helpful** I---I **Very helpful**							

Service:							
How helpful is this contact? **Not at all helpful** I---I **Very helpful**							

[additional sheets as needed]

7. Has your child stayed away overnight, other than with friends or family, in any of the following places <u>in the past 3 months</u>? (please tick)

In hospital ☐ How many days in total? …..………..Reason?...

In a children's home ☐ How many days in total? ………….. Reason?...

With a foster carer ☐ How many days in total? ………….. Reason?..
Any other residential placement ☐ How many days in total?…….…….. Reason?..
Any other place? ☐ How many days in total?.................... Reason?..

8. Do you think your child has affected your health? Yes ☐ No ☐

We would like to ask about any services that *you* have been involved with for your own needs. [*Refer to the list of services*]

[Please complete the table below to show parent's contacts with health and social care staff for own needs]

Service (Add name and/or job title/service title of contact)	**How many contacts face-to-face**	**Usual location of contact**	**Typical duration** (mins)	**How many contacts by phone**	**Typical duration** (mins)	**Do you feel that you had a choice about seeing this contact?** (Yes/No/any comments)	**Additional comments**
How helpful is this contact? **Not at all helpful** I---I **Very helpful**							

How helpful is this contact? **Not at all helpful** I---I **Very helpful**							

[additional sheets as needed]

Topic guide for parent interviews

In-depth qualitative discussion will take place during completion of the CSRI around discussion of services received. Responses will be probed and explored in order to elicit information relevant to the research questions. Respondents give each service a rating, then the appropriate questions will be asked from those listed here:

How did you feel about this service/person?

How do you think it helped you?
Did you/your child/other family member change how you acted or thought about things as a result? In what way?
What sort of changes did you notice?
Did the changes last?
Why do you think it wasn't helpful?
What do you think [the person/service] was trying to achieve?
How would that help?
What do you think you/your child needed and why?
What sort of changes did [the person/service] want you/your child to make or hope to see?

These further questions follow the discussion around the CSRI and SDQ, but some aspects may have already been discussed where the opportunity arises during CSRI discussion and completion.
[Numbering continues from CSRI]

9. Are there any other services that your child (or you on your child's behalf) have been in contact with in the past 3 months?

S*pecify services and discuss helpfulness as above; add to CSRI where appropriate*

10. Is your child on any medication to do with her/his behaviour?

11.What about services you have received longer ago? Tell me about those.

Probe: as above

12. Do you get other important help from family, friends or neighbours? For example with babysitting, DIY, lifts, shopping, housework, moral support etc

Probe for description and usefulness

13. Is there any help you would find useful which you are not receiving?

Prompt: For yourself; For your child; For your home; In your local area; Financially

How would this help? How do you think this might make a difference for your child?

14. Is there anything preventing you from seeking more support?

Prompt: Don't know what's available; Don't think it would be helpful; Worried people might think badly of me; attiudes to social services.

15. Now could we talk some more about other aspects of life which affect how easy or hard it is to look after your child and your family and what changes you think would help?

a) I'd like to know whether there are aspects of your life and surroundings which make it more difficult to parent your child, or things you could mention which actually help, or changes you would like to see to make things easier.
   Prompts: housing, neighbourhood (eg. play areas, activities, roads & traffic, neighbours, crime), employment, school, family and friends

b) Is there anything else important that you would like to add?

16. If you were free to spend the money spent on services supporting your family in any way you saw fit, what would you spend it on?

Adapted self-completion CSRI for school staff

(next page)

Practitioner Questionnaire
Support for families with children with difficult behaviour: What is useful for families?

We would like to know about the support offered to the child and his family by your

Family ID	Date completing this form	Form completed by	
		Name	Job title

institution. Please answer the following questions. The space available for responses will increase as needed.

1. **What support has been given to this child and his family?**

Please complete the table below to tell us about the type and amount of support provided recently. Please choose a number in the **Helpfulness** column to indicate how helpful the contact has been for the child and/or the family where **0 indicates 'not helpful' and 10 indicates 'very helpful'**. Any additional comments on how the support was useful will be gratefully received.

Service/support Please mark box if this type of support was received		**Approximate amount of contact** (e.g. full-time; 30 mins/week; 1 hr/ week for a month)	**Helpfulness rating 0 - 10**	**Additional comments**
One-to-one learning support/teaching assistant	☐			
Classroom assistant shared with others	☐			
Some lessons in small classes	☐			
Individual help in some classes	☐			
Individual tuition at home	☐			
Educational Psychologist	☐			
Welfare Officer	☐			
Special educational needs coordinator (SENCO)	☐			
Senior Leadership Team	☐			
Home/school liaison officer	☐			
Truancy officer	☐			
School police	☐			
Other *(please specify, box will expand for as many entries as necessary)*	☐			

2. **Have you been involved with other services regarding this child and his family or do you know about other services that have been involved?**
Please could you complete the table below to let us know which other services were involved and your view about how helpful they have been for the child and/or the family, where **0 indicates 'not helpful' and 10 indicates 'very helpful'**.

Service/support Please mark box if you know this type of support was received		**Approximate amount of contact** (e.g. one hour meeting every 3 months; twice a week after school)	**Helpfulness 0-10**	**Additional comments**
Social worker	☐			
Family support worker	☐			
Out of school group provision	☐			
Other social or community services (please specify)	☐			
Child and Adolescent Mental Health Services	☐			
Youth Justice services e.g. YOT worker, mentor	☐			
Police	☐			
Health services e.g. GP, hospital	☐			
Other (please specify as many as needed)	☐			

Additional questions: please use more paper if needed!

3. **Can you think of any other help this child and/or his family might have found useful?**

    a. **If yes, what are the barriers to them getting this help?**

4. **Could you comment in general on any changes you have seen in the child's behaviour and the role of individuals, interventions, services, or other factors, in bringing about any change?**

5. **What factors appear to hold back positive change?**

6. **Is there anything else you would like to add?**

Thank you very much for helping with this research

Topic guide for practitioner interviews

Support for families with children with difficult behaviour: What is useful for families?

If you don't mind I will record my explaining the study to you and then I'll ask if you're happy for me to record the interview [give practitioner letter].
You were identified by the named study participant as a key practitioner who supports, or has supported this family. I interviewed the participant about what services the family is involved with, whether or not they are helpful in dealing with their child's difficult behaviour, and what else makes it harder or easier to deal with their child. The study participant has given consent for you to be interviewed about your involvement with the family and other services you know them to be involved with. All the information you give me will be kept strictly confidential, stored securely with an ID number rather than names. No identifying information will be used in reports.

We are interested in what services or other influences affect the chances of poor outcomes for at-risk children, particularly in terms of later antisocial and criminal behaviour.

Are you happy for me to record the interview? This is only for my own use, so that I don't have to take too many notes while we're talking.

1. Could you tell me your job title and main responsibilities
    a. To what extent is supporting families an official part of your job?

2. How long have you known this family?

3. Could you tell me about your involvement with this family?
    a. Which members do you see? How often? For how long? When did you last see the primary carer?
    b. What support do you give to this family?
        Why? [ask about decisions made and reasons for them]
        How much of your approach is down to you and how much is down to your institution?
        Do you ever have to go beyond official expectations of your role?
        To what extent is this voluntary on your part?
    c. How much time do you spend on this family that isn't direct contact? (how long in last 3 months)
    d. Have you been involved with/in contact with other services regarding this family?
        - Can you tell me about that?
        - When there are lots of different services involved, who holds responsibility for making sure things get done?

4. How important do you think the support is to the family? What do you think the impact is?

a. How does the primary carer respond to the support given? (*attitude to help*)

5. How does providing this support fit in with the rest of your job?
   a. Is there anything that makes it easier or more difficult for you to provide support to this family? (Sufficient time? Resources? Missed appointments? Support from managers?)

6. What other services do you know that this family is involved with?
   For each service that you are aware of please can you tell me, if known:
   a. Frequency and typical duration of contact
   b. How useful you think the contact is for the family and why
      (Ask for a rating to be marked on the separate sheet)
   c. Any factors that help make the contact useful, or prevent it being useful

We would like to know about:
Social services, including youth justice services
Community and voluntary services
Education services
Youth justice services
Health services

7. Do you think there is any other support which the family receives e.g. from family, friends and neighbours? (For example with babysitting, DIY, lifts, shopping, housework etc.)
   a. How important is this support?

8. Do you think there is any support/services/intervention they are getting which is not helping? Can you tell me about it?

9. What other aspects of their lives do you think affect how easy or hard it is for them to look after their child and family? (e.g. income, personal factors, housing, neighbourhood, employment etc.)

10. Can you think of any other help this family might find useful?
    a. If yes, what are the barriers to the family getting this help?

11. How does this family's experiences with services compare to the experiences of other families with similar types of difficulties?
12. *(If not already covered)*

Have there been any particular parenting tips this family has needed to take on board?
What about with other families? What are the main parenting tips that are useful for parents to learn?
Can they be taught?

Appendix 4 Additional interview study results

Full SDQ scores for interview study families

Table A4.1shows which study children scored in the 'probable' or 'possible' disorder range for each of the SDQ's subscales (next page).

Table A4.1 Strengths and Difficulties Questionnaire predictions for interview study families, combined parent and teacher report

	Timepoint	Shaun	Jamie	Tyler	Joe	Ryan	Michael	Aaron	Palani	Ben	Darius	Harriet
SDQ hyperactivity disorder	Pre HFP	2	2	1	1	1	2	1	2	1	2	
SDQ conduct disorder	Pre HFP	2	2	2	2	2	2	2	2	2	1	
SDQ emotional disorder	Pre HFP	1	0	0	0	1	1	0	1	1	1	
SDQ any psychiatric disorder	Pre HFP	2	2	2	2	2	2	2	2	2	2	
SDQ hyperactivity disorder	Post HFP		0			0	0	0		1	2	
SDQ conduct disorder	Post HFP		1			1	0	0		2	0	
SDQ emotional disorder	Post HFP		0			0	0	0		0	1	
SDQ any psychiatric disorder	Post HFP		1			1	0	0		2	2	
SDQ hyperactivity disorder	T1	0	1	0	2	2	2	1	2	1	0	2
SDQ conduct disorder	T1	1	1	1	1	2	1	2	2	2	0	1
SDQ emotional disorder	T1	0	1	0	0	0	1	1	1	0	1	1
SDQ any psychiatric disorder	T1	1	1	1	2	2	2	2	2	2	1	2
SDQ hyperactivity disorder	T2	0	1		2	1	1	2	2	1	0	2
SDQ conduct disorder	T2	1	2		2	2	2	2	2	2	1	0
SDQ emotional disorder	T2	0	0		1	1	1	1	1	0	0	1
SDQ any psychiatric disorder	T2	1	2		2	2	2	2	2	2	1	2

2=Probable, 1=Possible, 0=Unlikely

More detailed breakdown of services received by interview study families

Table A4.2 Number of services families are in contact with at each timepoint

ID	School-related	Social/ community /mental health	Activities, sports	Health	Total
Pre HFP					
1	2	2			4
2			2		2
3	1	1			2
4		2			2
5	1	1			2
6	3	4	1	1	9
7	2	2			4
8					0
9	6	1		1	8
10	1	2		3	6
11					0
Post HFP					
2	1	5	2		8
5	1	2	1	1	5
6	3	6		1	10
7	3	3		1	7
9	2	3			5
10	3	5		2	10

T1	School-related	Social/ community / mental health	Activities	Health	Total	Additional School-reported	Additional Practitioner-reported	Total including school/ practitioner-reported
1		5	1	1	7	6	1	14
2	5	1			6			6
3					0	4	3	7
4	1	2			3			3
5	1	1		1	3	9		12
6	2	1	1		4	3		7
7	5		1	3	9			9
8	2	3			5	2	1	8
9	6	5	1	1	13			13
10	2	2	1	1	6			6
11	2	4		1	7			7
T2								
1		6		1	7	4[a]		11
2		4	1		5	[b]		5
3								0
4	5		1		6	5		11
5	6	3	1		10	2		12
6	1	9		1	11	1		12
7	5	4		1	10	3		13
8	3	1			4			4
9	4	6	3		13	1		14
10	5	1			6			6
11	1	4		2	7	1		8

Notes:
[a] reports were received from both Shaun's primary and secondary schools at T2, this is secondary school response (primary n=5)

[b] 4 specific teachers were mentioned as being a particular help, but not mentioned as not additional services

Principal themes from interviews with parents

Theme/factor	Number of families (not incidences) where factor was present
Intrapersonal-mother	
Stress	10
Mental ill health (e.g. depression, anxiety)	7
History of trauma effects current behaviour	10
Does not want to address psychological and historical issues in therapy	4
Parent taught or learnt emotional self-regulation techniques	7
Relationships-see also table in Chapter 5	
Family relationships improved when parent acknowledged own role in child behaviour	4
Parent discovers value of quality time with child	6
Community-see also table in Chapter 5	
Parents want more local activities for children	5
Child vulnerable to negative peer influences	8
Parents fear peer influence in local activities	5
Moved away from, or wants to move away from source of trouble	6
Good relationships with neighbours	4
Schools - see also table in Chapter 6	
Transition to secondary was problematic	8
Child literacy difficulties	8
School calls nearly every day	6
Child has or had beneficial relationship with 'significant other'	7
Societal	
Family receives supplementary welfare benefits which recognise additional burdens	6
Experienced prejudice (for being young mother, or racism; excludes prejudice regarding family background)	3
Individual practitioner	
Family benefitted from contact with an individual practitioner	11
Practitioner praised for being non-judgemental	8
At least one practitioner went beyond the call of duty	7
Made a personal connection with a practitioner	8
A practitioner earned parent's trust	8
Organisational	
Having a long term relationship was beneficial	6
Having a long term relationship had possible drawbacks	4
Experienced many changes of practitioners/Retelling stories	8
Parent often has to fight for services	5
Parent wanted ongoing support not offered	6
Parent has surveillance concern regarding Child Protection	8
Social workers focus on trivial issues	5

Appendix 5 ALSPAC additional explanatory material

Items in component scale of the antisocial and criminal behaviour outcome measure (ASB)

Parent-reported antisocial behaviour at age 16.5

I derived this variable by summing responses to 25 variables asking the following questions:

Number of times study teenager has travelled on a bus or train without paying enough money or using someone else's pass in the last year
Number of times study teenager has written things/sprayed paint on property in the last year
Number of times study teenager has stolen something from a shop/store in the last year
Number of times study teenager has sold an illegal drug to someone in the last year
Number of times study teenager has ridden in a stolen car/van or on a stolen motorbike in the last year
Number of times study teenager has broken into a car/van to try and steal something out of it in the last year
Number of times study teenager has ignored someone on purpose or left them out of things in the last year
Number of times study participant has said nasty things to someone she knows
Number of times study teenager has threatened to hurt someone she knows
Number of times study teenager has hit, spat or throw n stones at someone she knows
Number of times study teenager has got other people to do any of the above four items
Number of times study teenager has broken into a house or building to try and steal something in the last year in the last year
Number of times study teenager has hit, kicked or punched a sibling on purpose
Number of times study teenager has hit, kicked or punched someone else with the intention of really hurting them
Number of times study teenager has deliberately damaged or destroyed property on purpose in the last year
Number of times study teenager has sold something that didn't belong to them or that they know was stolen in the last year
Number of times study teenager has stolen any money or property that someone else was holding, carrying or wearing at the time in the last year
Number of times study teenager has used force, threats or a weapon to steal money or something else from somebody in the last year
Number of times study teenager has hit or picked on someone
Number of times study teenager has hurt or injured animals
Number of times study teenager has set fire or tried to set fi
Number of times study teenager has carried a knife or other weapon for protection or in case it was needed in a fight in the last year
Number of times study teenager has been rowdy or rude in
Number of times study teenager has stolen money or something else from school/college/work in the last year
Number of times study teenager has stolen money or something else from home in the last year

Self-reported (in clinic) offending behaviours age 17

A similar set of questions were asked of a subset of the young people themselves. The subset of young people were asked to attend a clinic where a range of measures were taken. These questions were asked via a computer.
The individual items were recoded and summed as with the parent report measure.
There were 18 questions with possible answers 0-3. Two of the items did not ask number of times so could only contribute a maximum of 1 point.
Therefore the potential score range was 0 to 50.
YP = Young Person

Number of times during last year YP bought something that they knew or suspected was stolen Number of times during last year YP stole something from a shop or store
Number of times YP damaged or destroyed property that did not belong to them in last year
Number of times YP hit or picked on someone because of their race or skin colour in last year
Number of times YP broke into a car or van to try and steal something out of it during last year
Number of times YP took or drove a vehicle without the owner's permission last year
Number of times YP sold an illegal drug to someone during last year
Number of times YP broke into a house or building to try and steal something in the last year
Number of times last year YP hit, kicked, punched or attacked someone with the intention of really hurting them
YP started fight
Number of times during last year YP sold something that didn't belong to them or knew was stolen
Number of times last year YP stole money or property that someone was holding, carrying or wearing at the time
Number of times during last year YP hurt or injured any animals or birds on purpose
Number of times during last year YP set fire or tried to set fire to something on purpose
Number of times during last year YP carried knife or other weapon for protection or in case it was needed in a fight
YP actually used a weapon against somebody in the last year
Number of times during last year YP was loud, rowdy or unruly in a public place so that people complained or YP got into trouble
Number of times last year YP used a cheque book, credit card or cash point card they knew or suspected to be stolen to get money out of a bank account or to purchase something

Self-reported criminal sanctions-clinic

At the clinic young people were asked about their contacts with police and the criminal justice system. Here only the items which imply the young person had actually done something wrong were used – those where the young person was told off, stopped or taken home by police were excluded as this may not have been due to any problematic

behaviour of the young person. Also excluded 'number of times got in trouble with police'.

YP was given a fixed penalty notice by the police
YP was charged by the police for committing a crime
YP received an official police caution
YP received a fine from the Court
YP was given a Community Service Order
YP was given an ASBO
YP spent some time in a Secure Unit
YP spent some time in a Young Offenders Institution or in prison

Self-reported offending behaviours age 18 – self-report by questionnaire

Made by summing these 12 items with scale range 0-36

Frequency in last year respondent: been rowdy or rude in public place so that people complained or respondent got into trouble
Frequency in last year respondent: stolen something from shop or store
Frequency in last year respondent: bought something that respondent knew or suspected was stolen
Frequency in last year respondent: broken into a car or van to try and steal something out of it
Frequency in last year respondent: taken and/or driven vehicle without owner's permission
Frequency in last year respondent: broken into a house or building to try and steal something
Frequency in last year respondent: stolen money or property that someone was holding, carrying or wearing at the time
Frequency in last year respondent: hit, kicked or punched someone else on purpose with the intention of really hurting them
Frequency in last year respondent: deliberately damaged or destroyed property that did not belong to respondent
Frequency in last year respondent: hurt or injured animals or birds on purpose
Frequency in last year respondent: carried a knife or other weapon for protection or in case it was needed in a fight
Frequency in last year respondent: used cheque book, credit card or cash point card which respondent knew or suspected was stolen to get money out of bank or purchase something

Self-reported (by questionnaire) offending behaviours age 21

12 items.
In past year, frequency been rowdy or rude in a public place so that people complained or they got in trouble
In past year, frequency: stolen something from a shop or store
In past year, frequency: bought something that they knew or suspected was stolen
In past year, frequency: broken into a car or van to try and steal something out of it
In past year, frequency: taken and/or driven a vehicle without the owner's permission

In past year, frequency: broken into a house or building to try and steal something
In past year, frequency: stolen any money or property that someone was holding, carrying or wearing at the time
In past year, frequency: hit, kicked or punched someone else on purpose with the intention of really hurting them
In past year, frequency: deliberately damaged or destroyed property that did not belong to them
In past year, frequency: hurt or injured animals or birds on purpose
In past year, frequency: carried a knife or other weapon with you for protection or in case it was needed in a fight
In past year, frequency: used a cheque book, credit card or cash point card which they knew or suspected to be stolen to get money out of a bank account or to purchase something

Missing data in ALSPAC

I compared cases with an available outcome measure for antisocial/criminal behaviour (7518; 48.68% of originally-enrolled ALSPAC sample) with cases with no antisocial and criminal behaviour (ASB) outcome data (which could therefore not be included in the study (7927; 51.32%)). I looked at differences in the main covariates of interest. There were statistically significant differences between groups on all variables. Those with missing ASB outcome data were likely on average to be younger mothers, of lower social class, with lower incomes, less highly educated, in less secure housing, and their children were more likely to be boys and to have higher levels of behaviour problems. The comparisons were made using ttests for continuous variables and chi square tests for categorical variables. To investigate this further I entered all these key covariates together into a logistic regression predicting whether or not there was ASB outcome data (Table A5.1). The sample size is smaller than 7927 because of missing data on the included covariates.

Table A5.1 Regression looking at key covariates, entered together, as predictors of having, or missing, outcome data on antisocial and criminal behaviour (ASB), n=6,312

Predictors of ASB age 16-21 data availability	Odds Ratio	p	95% CI
Conduct problems age 6	0.96	0.057	0.92, 1.00
Social class	1.31	0.000	1.15, 1.49
Mother's highest level of education	1.74	0.000	1.52, 2.00
Child's sex	1.79	0.000	1.59, 2.02
Mother's age	1.02	0.002	1.01, 1.04
Income age five	1.11	0.001	1.04, 1.17
Housing	1.46	0.000	1.24, 1.72

The regression confirms the significance of all these covariates in the prediction of availability of outcome data for antisocial behaviour. Children with fewer behaviour problems, higher social class, that are girls, and have older mothers, with higher income and owned housing, are less likely to be missing antisocial behaviour outcome scores. The approach taken to missing data is discussed further in Chapter 3.

ALSPAC sample characteristics including investigations for choice of covariates to use in regression analyses

There were 1249 ALSPAC children born in 1991-1993 who had difficult behaviour at primary school and who have a measure of antisocial behaviour available between the ages of 16 and 21. Section 5.3.1 examines continuity in problem behaviours in this sample over time. In section 5.3.2 characteristics of families where the child does and does not go on to have antisocial behaviour are compared. These characteristics were investigated to inform the choice of covariates used in the ALSPAC analyses in Chapter 7.

Continuity and discontinuity of behaviour problems between primary school and late adolescence

Most of the ALSPAC analyses use only the sample of children with behaviour problems identified at primary school age (defined as explained in Chapter 3) and for whom there is data available on their antisocial behaviour between the ages of 16 and 21.There were 1249 such children. Of these, 27% went on to display antisocial behaviour in late

adolescence, compared to 13% of those without baseline behaviour problems. It is worth comparing this figure with the literature on continuity of behaviour problems over time. For example a review of the evidence suggested that 50% of children with conduct disorders at age 3 retained problematic behaviours in adulthood (Farrington, 1989) and an estimate extrapolating from these findings estimated that 59% of children who still had difficult behaviour at age 5 would retain problems after age 16 (Bonin et al., 2011). However, these estimates are for those with the most severe levels of conduct disorder (approximately 5% of the population) whereas the current ALSPAC sample of children with primary school-age behaviour problems includes 17% of the population. For the current sample, expressing the percentages as precursors instead, 31% of those who displayed antisocial behaviour at ages 16-21 had behaviour problems at primary-school age, compared to 15% of those who did not display antisocial behaviour at follow-up.

As described in Chapter 3, the ASB variable is a composite binary measure indicating whether young people or their parents had recorded antisocial behaviour on any of five different measures between ages 16 and 21. Four are self-report measures but the variable with the largest number of responses is the parent-report measure at age 16. Table A5.2 shows the number of times young people scored positive for antisocial behaviour on one of the constituent ASB or criminal behaviour measures.

Table A5.2 Number of antisocial or criminal behaviour scores on which young people in the behaviour problems sample scored above cut-off for problems between ages 16 and 21

Number of ASB score above cut-off	n	%
0	911	73
1	278	22
2	47	4
3	13	1
Total	1249	100

Table A5.3 shows the correlations between the SDQ conduct problems scale at age 6 and later measures of behaviour problems (first column). As well as the ASB scales at ages 16, 17, 18 and 21, the table includes a troublesome behaviour scale at age 13 and a repeat of the SDQ conduct problems scale reported by parents at age 16. The ASB and

SDQ scales are described in Chapter 3. The troublesome behaviour scale is derived from the following items:

Troublesome behaviour scale items:

Child told lies to get things/favours from others/to get out of things supposed to do over past 12 months

Child often started fights other than brother's & sisters over past 12 months

Child bullied/threatened people over past 12 months

Child stayed out much later than supposed to over past 12 months

Child has stolen things from house/other people's houses/shops/school over past 12 months

Child has run away from home/ever stayed away all night without respondent's permission over past 12 months

Child often played truant (bunked off) from school over past 12 months

Table A5.3 Correlations between age 6 Strengths and Difficulties Questionnaire Conduct Problems scale (SDQ CP) and later measures of behaviour problems and antisocial behaviour (ASB), behaviour problems sample

	SDQ CP age 6	TB score age 13	SDQ CP age16	ASB parent report age 16	ASB self-report age 17	ASB self-report age18
SDQ CP age 6	1					
Troublesome behaviour score (TB) age 13	0.11**	1				
SDQ CP age16	0.19**	0.40**	1			
ASB parent report age 16	0.12**	0.43**	0.50**	1		
ASB self-report age 17	-0.02	0.34**	0.16 *	0.07	1	
ASB self-report age18	0.07	0.23**	0.19**	0.20**	0.54**	1
ASB self-report age 21	0.02	0.27**	0.20**	0.18**	0.41**	0.45**

**<.001 * p<.1 ; ASB. All measures are parent-report where not specified.

SDQ CP Strengths and Difficulties Questionnaire; TB Troublesome Behaviour

All the correlations between age 6 conduct problems and the later measures are low, although correlations with parent-reported later measures are statistically significant. The variable most closely correlated with SDQ conduct problems at age 6 is the same

measure taken ten years later, at age 16. SDQ conduct problems score at age 16 is also moderately correlated with other later parent-reported measures of difficult and antisocial behaviour, at ages 13 and 16. Parent's report of ASB at age 16 is only very mildly, if at all, correlated with the reports of antisocial behaviour given by the young people themselves at ages 17 – 21. However the age 17, 18 and 21 self-reported antisocial behaviour scores are all relatively highly correlated with each other. The measures used here to identify antisocial behaviours are not identical to each other and data were collected at different times, which may contribute to explaining the low correlations. The data above suggest that using the composite measure identifies a wider sample of young people engaging in antisocial and criminal activities, including those whose parents may not recognise or be aware of these behaviours. Previous research has shown similarly low correlations between different informants, particularly between the subject and another informant (.22) and that agreement is lower for adolescents than for younger children (Achenbach et al., 1987; Verhulst & Ende, 1992).

Characteristics of ALSPAC children with behaviour problems (at ages 6 to 10) who do or do not go on to have antisocial behaviour at ages 16-21

Young people who had behaviour problems at primary school age and who either do or do not go on to exhibit antisocial or criminal behaviour were compared on key childhood characteristics. These characteristics were chosen for examination because of their known relationship to behaviour outcomes, based on previous research looking at associations between childhood variables and later antisocial behaviour, discussed in Chapter 2 (e.g. Barker & Maughan, 2009; Kretschmer et al., 2014; Salt, 2013; Trentacosta & Shaw, 2008). These covariates are potential confounders of the relationship between predictors and antisocial behaviour and a subset are used in the regression models in Chapter 7.

The life events score is based on responses to an inventory of items, derived for ALSPAC based on previous inventories (Barnett et al., 1983; Brown & Harris, 1978). For each item there are five possible responses based on how much the event affected the respondent:

No did not happen

Yes, but did not affect me at all

Yes, mildly affected

Yes, moderately affected
Yes & affected me a lot
The items refer to stressful life events and whether they have occurred in the preceding period including deaths, illness, troubled with the law, divorce, work and relationship (including cruelty), housing, money problems, accidents, victims of crime. A few of the items are potentially stress-inducing but not necessarily negative (married, moved house, new job, partner new job, returned to work, took an exam, pregnancy) the remainder are negative. Weighted life events is a scale from 0 to 59 at 8 weeks, 0 to 81 at 21 months and 0-79 at 47 months.

Tables A5.4 and A5.5 summarise the data examined when deciding on covariates to include in the subsequent analyses. A great many of these background factors are related to ASB. Variables that were not significantly ($p < 0.05$) associated with antisocial behaviour in the behaviour problems subsample were not examined further unless there was an overriding theoretical reason and it would allow more clarity to do so.

Table A5.4 Comparison of key pre-baseline covariates (categorical variables) for children with behaviour problems at baseline, comparing those who go on to have antisocial behaviour with those who do not

Variable	Child age		No ASB		ASB		
			n	%	n	%	p *
Child's sex	birth	1 Male	472	51.8%	193	57.1%	0.096
		2 Female	439	48.2%	145	42.9%	
Mother's social class	gestation	1 I	45	6.1%	13	4.9%	0.09*
		2 II	264	35.6%	76	28.9%	
		3 III (non-manual)	304	41.0%	123	46.8%	
		4 III (manual)	42	5.7%	18	6.8%	
		5 IV	69	9.3%	25	9.5%	
		6 V	16	2.2%	8	3.0%	
Father's social class	gestation	1 I	117	15.1%	23	8.3%	<0.001
		2 II	278	35.8%	91	32.9%	
		3 III (non-manual)	90	11.6%	28	10.1%	
		4 III (manual)	210	27.1%	89	32.1%	
		5 IV	62	8.0%	32	11.6%	
		6 V	16	2.1%	13	4.7%	
Social class (2 level)[1]		0 III (manual) to V	300	36.9%	140	47.3%	0.002
		1 I to III (non-manual)	513	63.1%	156	52.7%	
Mum’s highest educational qualification	gestation	1 CSE	130	15.4%	54	16.8%	ns
		2 Vocational	83	9.8%	28	8.7%	
		3 O level	272	32.2%	127	39.4%	
		4 A level	223	26.4%	73	22.7%	
		5 Degree	136	16.1%	40	12.4%	
Mum's highest ed qual (2 level)		0 pre16	485	57.5%	209	64.9%	0.021
		1 post16	359	42.5%	113	35.1%	
Marital state	gestation	1 Never married	128	14.8%	69	21.8%	
		2 Widowed	2	.2%			
		3 Divorced	32	3.7%	17	5.4%	
		4 Separated	11	1.3%	6	1.9%	
		5 1st marriage	625	72.3%	204	64.6%	
		6 Marriage 2 or 3	66	7.6%	20	6.3%	
Married at gestation (vs not)	gestation	Married	691	80%	224	71%	0.001

Variable	Child age		No ASB		ASB		
			n	**%**	**n**	**%**	**p ***
Biological Father Lives With Child	47 mnths	1 No	95	11.8%	54	17.9%	0.008
		2 Yes	710	88.2%	247	82.1%	
Housing owned or not	33 mnths	0 not owned	133	16.5%	104	33.4%	<.001
		1 owned	671	83.5%	207	66.6%	
Family income per week	33 mnths	1 <100	51	6.9%	48	16.2%	<.001*
		2 100 to 199	121	16.5%	67	22.6%	
		3 200 to 299	193	26.3%	81	27.4%	
		4 300 to 399	159	21.6%	52	17.6%	
		5 >400	211	28.7%	48	16.2%	
Family Income per week	47 mnths	1 £100	46	6.3%	37	12.9%	<.001
		2 £100 to 199	108	14.7%	55	19.2%	
		3 £200 to 299	183	24.9%	79	27.5%	
		4 £300 to 399	151	20.5%	52	18.1%	
		5 >£400	247	33.6%	64	22.3%	
Average weekly take-home family income	85 mnths	1 <£100	28	4.0%	21	7.7%	<.001*
		2 £100 to 199	85	12.0%	44	16.1%	
		3 £200 to 299	140	19.8%	66	24.1%	
		4 £300 to 399	146	21.0%	55	20.1%	
		5 >£400	308	43.6%	88	32.1%	

* p value is from chi square with test for trend where marked*; ns p>.1;
[1]Social class (2 level) is based on father's social class where available, and mother's social class where not available (following Propper & Rigg, 2007).

In table A5.4 some categories are collapsed for use as binary variables in later analyses. In the case of social class a new 2-level variable uses father's social class where available, and mother's where father's social class is not available. The chi square of mother's educational level became significant when responses were collapsed into two categories, and a binary variable indicating whether the mother was married or not at the time of preganancy was significantly associated with ASB.

Table A5.5 Background characteristics (scale variables) for the sample with data available on ASB outcomes, baseline behaviour problems group, and full sample; valid n and significance of relationship to ASB

Scale variables **Measure**	**Age**	**No ASB** **Mean (sd)**	**ASB** **Mean**	**p**	**95% CI of difference**	**n**
Mother's age	Birth	29.0 (4.6)	28.2 (4.9)	.005	0.25, 1.43	1209
Child communication score	15 months	120.6 (50.1)	125.5 (50.4)	.150	-11.45, 1.76	1126
School entry ability score	school entry	13.2 (3.2)	12.6 (3.4)	.009	0.16, 1.14	850
Life events score	8 weeks	9.4 (8.1)	11.1 (9.1)	.002	-2.86, -0.67	1145
Life events score	21 months	12.4 (9.2)	15.6 (10.9)	.000	-4.59, -1.82	1127
Life events score	47 months	13.6 (10.7)	17.1 (12.0)	.000	-4.96, -2.05	1119
Financial difficulties	33 months	3.3 (3.7)	4.6 (4.3)	.000	-1.91, -0.82	1110
Child IQ	8 years	103.3 (17.3)	101.7 (16.9)	.197	-0.83, 4.01	985
Reunion warmth (attachment)	3.5 years	5.6 (0.8)	5.6 (0.8)	.772	-0.12, 0.09	1116
Mother parenting score	38 months	24.9 (3.4)	24.5 (3.3)	.104	-0.08, 0.81	1127

Gender

Other studies have found bigger differences between males and females in antisocial behaviour. Bowen for example, found 41% of males involved in some sort of antisocial behaviour at ages 8 and 10, compared to 20% of females, while others have reported ratios of 4:1 (Fergusson et al., 2000). However, MacArthur found little difference in numbers of risky behaviours between girls and boys, and although antisocial behaviours were more prevalent among boys, these differences were not marked for rowdiness or theft (MacArthur et al., 2012).

Looking at each of the outcome measures making up the composite ASB measure, for the behaviour problems sample only, the age 16 parent report measure of anti-social behaviour shows a slightly higher proportion of girls (9.97%) than boys (8.5%) with antisocial behaviour (Chi square (1) = 3.65, p=.056). On all the other measures (self-report) boys were significantly more likely to have antisocial or criminal behaviour.

Further investigation showed that girls were significantly more likely than boys to have carried out three of the behaviours “travelled on a bus or train without paying”, “ignored someone on purpose or left them out of things” and “Said nasty things, slagged them off or called them names”. Boys were significantly more likely than girls to have “threatened to hurt someone”, “hit, spat or thrown stones at someone”, “got other people to do” any of the previous four items just listed, “Hit, kicked or punched someone else on purpose with the intention of really hurting them”, “deliberately damaged or destroyed property on purpose”, “Set fire or tried to set fire to something on purpose” and “Carried a knife or other weapon for protection or in case it was needed in a fight”

Choice of covariates to include in analyses

Variables were chosen to be used as covariates in the analyses in chapters [four to six] if they were likely to be alternative predictors of the outcome which may be underlying spurious relationships between the hypothesied predictors and the outcome. Variables were not included if they were considered mediators, that is that they represented merely the mechanism by which the predictor variable affected the outcome.

A set of potential covariates to include in analyses was chosen based on their relationship to ASB in the behaviour problems sample as set out above. For each analysis decisions about which covariates to include were made based on theoretical considerations, as well as considerations of statistical power. For variables that were very similar to each other a single variable was chosen, usually the one occurring at the timepoint closest before the youngest behaviour problems baseline age of 6 years, although the impact on the sample size also needed to be considered.

ALSPAC has a number of variables related to financial circumstances and all were significantly associated with future antisocial behaviour. To decide whether to use financial difficulties score or family income score, correlations were examined. Financial difficulties score at 33 months was highly correlated with family income at the same timepoint (correlation coefficient = -.6 for the behaviour problems group, $p<0.001$); slightly lower at 44 months (-.49, $p<0.001$) and 85 months (-.3, $p<0.001$). In Table A5.4 I used Chi square to look at the relationship between the income brackets and the antisocial behaviour outcome. As the five levels of income constitute a type of

scale the relationship can also be looked at using t-tests which gives clearer results when comparing the different measures (Table A5.6).

A single variable at age 7 'degree of difficulty paying rent' also differentiated significantly between groups (p=0.001). Table A5.6 shows that the income difference between the ASB and non-ASB groups, highly significant at each timepoint, got slightly smaller over time. As all the variables were similarly related to ASB, financial difficulties was chosen a covariate to represent financial disadvantage, as it was a more theoretically defined measure; the raw income questions do not take account of outgoings, so it is felt that financial difficulties better represents disadvantage. In addition the variable was preferable as it was a scale measure, rather than a categorical measure.

Table A5.6 Comparison of income variables by antisocial behaviour outcome

		No ASB			ASB			Difference		
Measure	**Age**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**p**	**95% CI**
Financial difficulties (0-15)	33 m	3.26	3.74	801	4.62	4.26	309	1.36	<.0001	0.23, 0.81
Family income per week (1-5)	33 m	3.49	1.25	735	2.95	1.30	296	.54	<.0001	-1.87, -0.85
Family Income per week (1-5)	47 m	3.61	1.26	735	3.12	1.32	287	.42	<.0001	0.37, 0.71
Average weekly take-home family income (1-5)	85 m	3.88	1.21	707	3.53	1.30	274	.35	0.0001	0.25, 0.60

The potential variables to be used as covariates in subsequent analyses were therefore: child's sex, mother's age, father's social class (2 level), or mother's social class where father's was not available, mother's highest educational qualification (2 level), biological father lives with child at 47 months, housing tenure, financial difficulties, child's school entry ability score, Life events score at 47 months and conduct problems age 6. These variables are all either scales or are dichotomous.

When all these background characteristic variables are used, the sample, for the behaviour problems at baseline group, is very much reduced, to 573. What is more, when all are entered together in a logistic regression predicting ASB, half become non-statistically significant predictors (partly because of their interrelatedness) (Table A5.7). Therefore in subsequent analyses a parsimonious approach is taken, choosing a small number of covariates for each analysis, and basing the choice on theoretical relevance to the predictor under investigation.

Table A5.7 Logistic regression entering all potential covariates as background factors predicting antisocial behaviour at ages 16-21 (ASB), behaviour problems sample, n=573

Predictors of ASB	Odds Ratio	p	95% CI
Child behaviour age 6	1.160	0.016	1.03, 1.31
Child's sex	0.604	0.014	0.40, 0.90
Housing	0.590	0.052	0.35, 1.00
Mother's age	0.979	0.368	0.94, 1.03
Social class	0.761	0.216	0.49, 1.17
Mother's highest level of education	0.753	0.226	0.48, 1.19
Biological father lives with child	0.889	0.712	0.48, 1.66
Family income at 47 months	0.816	0.050	0.67, 1.00
School entry scores	0.983	0.592	0.92, 1.05
Life events	1.019	0.033	1.00, 1.04

Exploration of different combinations of variables showed those that remained most significant as predictors of future ASB were:

Children's conduct problems at baseline

Child's sex

Housing tenure

Financial difficulties

Stressful life events

Table A5.8 shows the statistical significance of these shortlisted background characteristic variables when entered together in a regression predicting ASB. All the variables remain significant predictors of antisocial behaviour, and so can usefully be employed as covariates in subsequent analyses.

Table A5.8 Logistic regression with selected background characteristics as predictors of ASB, entered simultaneously, behaviour problems sample, n=1002

Predictor of ASB	Odds Ratio	p	95% CI
Children's conduct problems at baseline	1.16	0.001	3.24, 0.00
Child's sex	0.70	0.019	-2.35, 0.02
Housing tenure	0.46	0.000	-4.34, 0.00
Financial difficulties	1.05	0.011	2.53, 0.01
Stressful life events	1.02	0.002	3.11, 0.00

Additional covariates from the longer list are used in analyses where they are important for theoretical reasons. The correlation matrix below (Table A5.9) includes all the covariates (other than the measures of conduct disorder) used in the analyses in Chapter 7.

Covariates correlation matrix

Table A5.9 Correlation matrix for covariates used in analyses

	Financial difficulties	Housing	Biological father lives with child	Mother's age	Stressful life events	Child's sex	Mother's education
Financial difficulties	1						
Housing	-0.31*	1					
Biological father lives with child	-0.28*	0.35*	1				
Mother's age	-0.15*	0.31*	0.21*	1			
Stressful life events	0.19*	-0.10*	-0.18*	-0.06*	1		
Child's sex	-0.00	-0.01	-0.00	-0.02*	-0.00	1	
Mother's education	-0.18*	0.20*	0.10*	0.30*	0.06*	0.01	1
School entry score	-0.16*	0.23*	0.09*	0.17*	0.00	0.16*	0.24*

* significant at the $p<0.05$ level

The correlation matrix shows the relationships between pairs of potential covariates. Relationships between continuous variables are Pearson correlations, between binary variables they are phi coefficients and for binary-continuous pairs they are point-biserial correlations. Because binary and continuous measures are used caution is necessary in making direct comparison of coefficients, however the significance levels can be compared.

Risk factors

In the *interview study*, families who came into contact with the original (pre-PHD) study had difficulties which were additional risk factors for future antisocial behaviour, as well as the child's behaviour problems. These included mother's substance misuse, difficulty maintaining a stable mood, lack of supportive network, frequent crises and events and interpersonal conflict with the child. Where possible, equivalent data are presented in Table A5.10 for ALSPAC mothers. Although questions about substance abuse, alcohol problems and serious mental illness such as schizophrenia are asked in ALSPAC, numbers reported in the behaviour problems sample were too small to look at differences between groups. However there are variables available to measure alcohol consumption, social support, social network and anxiety and depression. ALSPAC's anxiety and depression measures have been used elsewhere to reflect mood disturbance (e.g. O'Connor et al., 2007). The variables below were not used to limit the ALSPAC sample because the sample size would become too small.

Table A5.10 Presence of known risk factors for future antisocial behaviour in behaviour problems and antisocial behaviour groups

Mother's mental health and alcohol intake at child age 5	% (n/total) with behaviour problems ages 6-10	% (n/total) with ASB, behaviour problems sample	% (n/total) with ASB, full sample
Anxiety in the past year			
No	18% (1197/6,672)	28% (206/739)	15% (699/4,772)
Yes	26% (504/1,933)	27% (88/329)	18% (235/1,283)
Sig	p<.001	ns	p=.001
Depression in the past year			
No	17% (1,135/6,620)	26% (189/719)	14% (681/4,768)
Yes	29% (572/1,995)	29% (104/356)	20% (253/1,294)
Sig	p<.001	ns	p<.001
Drinks more than 4 units of alcohol at least 10 times per month			
No	20% (1,575/8,069)	28% (275/997)	15% (876/5,720)
Yes	23% (132/569)	23% (18/77)	17% (62/371)
Sig	p=.033	ns	ns

Construction of scales used as hypothesised predictors

Social support and social network scales

The social support scale was constructed for this thesis for ages 5, 6 and 12 from the items listed below but has been used in other studies (e.g. Thomson et al., 2014) Dunn and colleagues computed internal consistency (Cronbach's alpha) for the social support scale at .58 (using ALSPAC responses at 21 months postnatal), explaining that this relatively low value is due to conceptual differences in the various types of support included in the scale.

Social support scale items
Mother feels she has no-one to share feelings with
Mother feels her partner provides the emotional support she needs
Mother can share experiences with other mothers
Mother feels her neighbours would help in moments of difficulty
Mother is worried that partner might leave
Mother always has someone to share happiness about child
Partner will take over from mother if she is tired
Mothers family would help in financial difficulty
Mothers friends would help in financial difficulty
Mother feels if all fails state would support her financially

A separate measure, social network, was also derived as used previously in ALSPAC from responses, in the same questionnaires, to the following items:

Social network scale items
Number of mothers/partners relatives seen at least twice a year
Number of friends mother has
Mother belongs to a close circle of friends
Number of people including partner mother can talk to about problems
Number of people who talk to mother about their problems
Number of people mother can discuss important decisions with
Number of people mother can borrow £100 from
Number of people who would help mother in times of trouble
Number of times mother got together with friends in last month
Number of times mother got together with relatives in last month

While most analyses used the full scale, ‘low social support/social network’ groups were also identified. Following the previous approach, a cut-off which identified approximately 15% of the population with the lowest social support and social network scores was used.
For Social Support this was a score of less than 14 on a scale of 0-27
For Social Network this was a score of less than 19 on a scale of 0-29.

School enjoyment scale

The school enjoyment scale is derived from summing parents’ responses to seven items, to which possible responses were Always (4), Usually (3), Sometimes (2) or Not at all (1):

School enjoyment scale items
Frequency looks forward to going to school
Frequency child enjoys school
Frequency child is stimulated by school
Frequency child is frightened by school (reverse scored)
Frequency child talks about school friends
Frequency child is bored by school (reverse scored)
Frequency child likes teachers