Improving children's lives, preventing criminality

Where next?

STEPHEN SCOTT *wraps up the special issue.*

IN the UK, now is a good time to be a psychologist aiming to help families with difficult children. In the last decade there has been a shift from clinic-based services that simply wait to see who turns up at the door, towards efforts to implement a community-wide, population-based approach. Unprecedented resources are being devoted to giving less advantaged children a better start, and the new policy from the government enshrined in 'Every Child Matters' acknowledges that many professions and agencies need to work together to make it happen. I think psychologists have a pivotal role to play.

Good-quality parent–child relationships have been recognised by the government to have a large effect on a multitude of outcomes, from reading and school attainments (Desforges & Abouchaar, 2003) to child abuse and criminality (Sutton *et al*., 2004). Starting early is key – for example the Christchurch longitudinal study found that if a child had substantial antisocial behaviour at seven (worst 5 per cent of children), the chance of criminality by 26 is increased 22-fold (Fergusson *et al*., 2005). As we have seen from the three preceding articles in this issue, there are several effective interventions. But what's new, and where do we go next?

New findings about children

Twenty years ago many believed that the infant was a blank slate or tabula rasa onto whom parents wrote their relating style. Certainly, the coercion hypothesis put forward by social learning theorists has been amply confirmed by studies that show that children are actively, albeit unwittingly, trained up to be antisocial by parents who ignore their social overtures and reward aggression with attention, or by letting them get their way when they create a fuss. From a very different theoretical perspective, studies informed by attachment theory have shown that insensitive responding by the parent leads to insecure attachment and disruptive behaviour in the child.

However, while the influence of upbringing is still recognised as key, nowadays the unique contribution of the child is better understood. Recent behavioural genetic findings show that some children inherit traits that impair their ability to get on with others and understand their feelings. Three typologies are being increasingly recognised as complicating the picture for some antisocial children, and each is highly heritable. Firstly, severe hyperactivity and inattention can lead to such impulsive responding that the child doesn't have time to reflect before acting – such children are easily seen as emotionally illiterate, and their hyperactivity can be missed due to the salience of the antisocial acts. Then children with Asperger's syndrome or autistic-like traits have difficulty reading emotions and engaging in the basic to-and-fro of day-to-day social encounters, and this, coupled with their intolerance of changed routines, means they easily get frustrated and become aggressive, often with screaming tantrums. Finally, there is increasing interest in children who seem otherwise intact but display marked callous-unemotional traits. These children seem to be able to understand most emotions, but not to care about distress in others, or to feel much hurt themselves (Viding, 2004). They can use a superficial charm to make new relationships, but have difficulty sustaining them. They often make excellent bullies, choosing skilfully how best to hurt their victims, without caring about the impact (Sutton *et al*., 1999). Correcting these children is especially hard as they are notably insensitive to punishment. In the extreme, these traits add up to psychopathy, and in adults this is associated with low activity in the amygdala, the brain region associated with the processing of fear (Blair *et al*., 2005).

Not knowing where the adolescent is or what they are up to is strongly associated with worsened criminal activity

Although these three traits are highly heritable, and although each predicts a poorer response to parenting programmes (Hawes & Dadds, 2004; Scott, 2005), this doesn't mean they cannot be improved. Children with moderate autistic traits respond well to rule-governed social skills programmes that enable them to get along with other children in joint activities (Frankl 1999). Callous-unemotional traits in antisocial children are ameliorated by parenting programmes (Hawes & Dadds, 2004). Although these children do not seem to learn from punishment, they do change with rewards, so carefully tailoring these can help. Hyperactivity and inattention in antisocial children improve with structured parenting programmes alone (Scott *et al*., 2001), and in severe cases they respond well to stimulant medication, when remarkable improvements in empathy may be seen. However, careful assessment is essential to ensure that stimulants are not inappropriately prescribed for antisocial behaviour without hyperactivity.

In summary, better characterisation of the nature of antisocial behaviour in childhood is leading to the development of more specific and effective interventions to prevent the young growing up to act criminally.

New findings about parents

The dimensions of parenting that predispose to antisocial behaviour are also better understood. In adolescence, good

supervision has emerged as being central: it is not good enough to have been warm and supportive in the early years. Supervision is particularly important in risky environments such as the inner city. Not knowing where the adolescent is or what they are up to is strongly associated with worsened criminal activity, especially misusing drugs and alcohol and committing crimes in the company of other antisocial youths. In response to this, innovative interventions teach parents how to supervise, and offer the adolescent good rewards for being in known places, and strong consequences for being away without leave. For example in the Oregon model, the young person loses a point for every minute they cannot verifiably account for their whereabouts. This combination of immediate consequences for choosing a risky environment combined with an unrelentingly positive regime developing the young person's strengths has led to reductions in offending of 40–50 per cent (Chamberlain, 2003).

Advances have also been made in the understanding of parenting based on attachment theory. Several studies have confirmed that the core process of sensitive responding by the parent is reliably linked to secure attachment in the child. Insensitive parenting leads to insecure attachment patterns and antisocial behaviour (Deklyen & Speltz, 2001). There are several interventions that improve sensitive responding – the most effective seem to be those that include video feedback, whereby the mother watches footage of herself with her infant. The impact her overtures and responses have on her infant is drawn to her attention, and feelings that get in the way are explored. The meta-analysis from the Leiden group (Bakermans-Kranenburg *et al*., 2003) reviewed over 60 randomised trials, and showed that several interventions increase sensitive responding, and that this is indeed followed by increased attachment security in the young child. The relevance for older children of this way of conceptualising parenting is uncertain, although recent studies show that in six-year-olds sensitive responding in everyday tasks is still strongly related to secure attachment representation (Matias, 2006).

Some parenting programmes that are the most effective in changing child and parent behaviour are showing a convergence of two approaches that have sometimes been seen to be philosophically

SEVEN DEADLY SINS, SEVEN VITAL VIRTUES

There are seven deadly sins society and service providers commit to fail children. Each is backed up by a rationale that seems innocuous, and has a siren-like, beguiling voice:

Deadly Sin One: **Ignore what works**. Rationale: 'We offer what makes sense and what we like doing.' There are over a hundred controlled trials showing the types of programme that work, yet more than half the provision in the UK is of non-evidence-based approaches. Why is this considered acceptable or ethical? Vital Virtue One: **Use proven programmes**.

Deadly Sin Two: **Implement poorly**. Rationale: 'We do the programme our own way.' While it is excellent to choose a programme that can be effective, evidence over the last decade is unambiguous that to get change, programmes have to be delivered as defined in the manual, with good levels of skill and appropriate training and supervision. Failure to do this leads to poorer results often with no change, or even harm (Henggeler *et al*., 1997). Vital Virtue Two: **Promote programme fidelity and staff skill**.

Deadly Sin Three: **Forget non-attenders**. Rationale: 'We can only work with who comes.' In a clinical service, dropouts do worse than attenders; and in a community-based preventive service, only working with those who attend will mean the most in need don't get a service. Knock on their door, be friendly, find out what they want and give them it. Vital Virtue Three: **Pursue non-attenders**.

Deadly Sin Four: **Don't evaluate practice**. Rationale: 'We know how it went – we were there.' Many factors may conspire to give an inaccurate picture of a treatment, from dropouts, parents not wanting to disappoint therapists, to therapists themselves wanting to believe they are effective (or being overly pessimistic). Count who comes and how often, see if you are meeting the needs of the local population and catering well for all groups, including ethnic minorities. Use a questionnaire approved by the CAMHS Outcomes Research Consortium 2005 (see *www.camhoutcomeresearch.org.uk*) to see how you're doing. Vital Virtue Four: **Evaluate outcomes**.

Deadly Sin Five: **Carry on regardless**. Rationale: 'We haven't got the time or the skills to look at the audit, which is academic anyway.' Now that most clinical psychology trainees have to do an audit, many services are evaluated, yet often neither clinicians nor managers act on it (if the managers get to see it at all). If some ethnic groups underattend, what can be done? If changes are seen, what are the elements of successful practice? And if not, what needs to change – more staff training, longer therapy, negotiations with the PCT to see fewer cases, or what? Vital Virtue Five: **Modify in light of the evaluation**.

Deadly Sin Six: **Ignore child outcomes**. Rationale: 'We listen to parents who need to be satisfied as they are the service users.' Yes, the service needs to be accessible and acceptable to parents, but how many services are content to say that 95 per cent of parents were satisfied or very satisfied? This may be politically popular, but it is pretty much a waste of time if child outcomes stay the same. We owe it to the children to see if they improve as a result of what we do. Several plausible interventions were very well-received but did nothing for children, from the Fort Bragg project (Bickman, 1996) to the two years of home visiting, male mentoring, home tutoring and summer camp experiences offered by the Cambridge-Somerville project (McCord, 1992). After all this, recipients carried out more criminal activities than controls. Vital Virtue Six: **Target child outcomes**.

Deadly Sin Seven: **Focus on cost**. Rationale: 'We must stay within budget.' It is better to offer no service at all than a money-consuming service that changes nothing. Examine the service, say on Mondays, and see whether the solo therapist who sees six antisocial children that day for an average of 48 sessions each really gets better outcomes than the pair running a 12-week group for six children. If the child outcomes are the same, then the latter will have been twice as cost-effective. Then discussions can begin about whether the individual therapist could get as good results with say 24 or 36 sessions, whether they are seeing clients with similar levels of difficulty, and so on. Investing in training and new ways of working may be very cost-effective, and can boost staff morale. Oh, and help children. Vital Virtue Seven: **Focus on cost-effectiveness**.

incompatible, and whose proponents have sometimes been downright antagonistic to each other. On the one side have been programmes that take a purely counselling approach based on parental insight and emotional support – they don't offer practical advice on what to do. The problem has been that objective evaluations of such programmes mostly show that although they are well liked by parents, they do not improve child outcomes (Scott, 2002). On the other side have been programmes that teach behavioural skills on how to handle child behaviour but do not explore beliefs. Indeed, several detailed manuals still emphasise skills and the 'how to', with little about what the parent may be feeling (e.g. Hembree-Kigin & McNeil, 1995; McMahon & Forehand, 2003; Sanders & Turner, 2005). Such behavioural programmes have the enormous strength that they have repeatedly been shown to be effective in improving child outcomes (Kazdin, 2005). However, as noted in the previous article, the populations on which they have been proven have often not been the most disadvantaged and 'hard to reach'.

Certainly in clinical practice, it seems helpful actively to solicit what parents are feeling as well as helping them to develop skills to change relationships. For example, not infrequently parents have difficulty setting limits, and fail to follow through despite repeated practice. Sensitive exploration of their beliefs sometimes reveals that they themselves were brought up in a painfully harsh way, so they shy away from almost any discipline at all since the last thing they want to do is make their child suffer as they did. Helping them understand and experience through role-play that gentle but firm parenting is not abusive can then lead to progress.

Some programmes that combine both approaches have been shown to work with the most disadvantaged families. For example, the Incredible Years series have changed from their inception in the early 1980s so it now emphasises parents' beliefs and feelings much more strongly. Likewise the Mellow Parenting programme has a major component exploring how parents feel about themselves, and a behaviourally based practice session with children (Puckering *et al*., 1994).

We now need large trials directly comparing each approach alone and both in combination. To date, it has been shown that explicitly adding an element addressing the understanding of families leads to better enrolment rates (Miller & Prinz, 2003), but trials addressing child outcomes are needed. Further, the group format, whilst cost-effective, may not suit the most crisis-ridden, suspicious families, who may need to be seen in their own homes, with help addressing their immediate concerns (e.g. heating, schooling, adult health, finances) before parenting can be tackled. How best to work with this 'hard end' needs to be better researched.

Disappointing times

Whilst it is indeed exciting that there is the current political emphasis on children coupled with great progress in understanding what causes antisocial behaviour and developing new treatments,

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the pace of implementing and evaluating practice is disappointing. Psychologists and all those concerned to make a difference for the next generation surely have to get the message across about what has worked, what hasn't worked, and what we don't know. We need to bring many senior policy makers and practitioners into the 21st century (or into the early 1980s would do). We know enough about what works in improving child outcomes to make changes, yet these are slow in coming. The culture of children's services is still run along the lines of what sounds plausible rather than what seems to work. Perhaps the most worrying example of this is the SureStart project. Costing around £1.8 billion, 500 centres were set up in the most deprived areas of England and Wales to support children aged 0–3 years, many of whom are at risk of poor outcomes and later antisocial behaviour. Unfortunately the evaluation so far has shown that few if any child outcomes changed (Melhuish *et al*., 2005). Now there may be many reasons for this, and prevention projects in whole populations are notoriously hard to make work. We now need to know whether reconfiguring SureStart centres, by the vigorous application of the principles of effective interventions (avoiding the 'Seven Deadly Sins': see box) that have proved effective elsewhere, would make a difference.

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The future

Principles of effective interventions need to be applied energetically, whether it is for literacy programmes with young men in secure accommodation, teenage mothers with young babies, or primary-age children exhibiting disruptive behaviour at school. The good news is that services already set up can be adapted to achieve this relatively easily, without significant extra cost. Psychologists and all professionals involved can help by disseminating the principles; the government could help by setting up training centres to retrain the workforce and change the culture. Now is a time of great opportunity – we must seize it.

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DISCUSS AND DEBATE

What are the beliefs that stop people using interventions that are effective?

Is it ethical to continue to use non-evidence-based when there are ones that work?

What are the practical barriers to implementing programmes that work?

How can these barriers be overcome?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.thepsychologist.org.uk.