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# Literature Review on the Support needs of Parents of Children with Behavioural Problems

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**LITERATURE REVIEW**

**ON**

**THE SUPPORT NEEDS OF PARENTS**

**of**

**CHILDREN WITH BEHAVIOURAL PROBLEMS**

For

BARNARDOS, CARLOW

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2007



## Foreword

*...despite the fact that partners have been having babies for millennia, contemporary parents are journeying into uncharted terrain, which appears to hold unexpected risks to their own and their children's development.*

(Skolnick & Skolnick, 2005, p.271)

It is widely accepted that the task of child rearing is exceedingly difficult in a context of rapid societal change which is reflected in the complexities of changing family structures, the challenge of work life balance and the social and environmental issues effecting communities.

Barnardos Family Support Project in Carlow is supported and informed by a multi-agency advisory group representing voluntary and statutory agencies and the local community.

The collective experience of the member agencies of this group and that of the local community coupled with increasing anecdotal evidence, suggests that an increasing number of parents in the general population are experiencing difficulty with regard to managing and responding to their children's behaviour.

With consideration of the specific roles, responsibilities and limitations of existing service providers both statutory and voluntary it was agreed that further information was required in order to establish on one hand the extent to which families in Carlow are 'under pressure' trying to respond to problematic behaviour i.e. maintain adequate boundaries with their children and on the other models of good practice in parent support. Primary research will be undertaken in relation to the needs of parents who have not yet accessed existing services and will be informed by the findings of this report.

This literature review was commissioned to identify models of good practice and subsequent learning in order to inform current service provision and the development of new services where relevant. This study, commissioned by Barnardos was funded by Carlow Area Network Development Organisation (CANDO) and RAPID. Research was carried out by Siobhan Bradley of the Centre for Social and Educational Research (CSER) at DIT.

Marian Dowd  
Project Manager  
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## SECTION ONE:

### INTRODUCTION

#### 1.0 Introduction

*"The toughest thing anyone faces in their personal life is bringing up a child."*

(Tony Blair, 21 November, 2006, on announcement of the UK Supernanny Scheme)

*"A little help at a particularly difficult time for parents can be hugely effective."*

(Claire Tickel, National Children's Charity, UK on announcement of the Supernanny Scheme)

*"It's very difficult the older the children get to actually rein them back in."*

(Single Mother, Natalie).

The experiences of Ireland's children now are considerably different to those experienced by Ireland's children even fifteen years ago. An increasing number of children live in one parent households, in dual income families and in migrant and refugee households. The unprecedented economic growth which Ireland has experienced from the mid 1990s and the benefits of our economic affluence have not been equitably shared and the longstanding promise of successive Irish governments that the 'rising tide lifts all boats' has not materialized (Callan and Nolan, 2002; Reynolds, 2005). It is now estimated that one in every seven children in Ireland live in poverty<sup>1</sup>. Disadvantage experienced by children is likely to impact on their behaviour, life style and opportunities. Recent years have witnessed and increased emphasis on parenting and the vital and pivotal role parents play in providing for and in supporting their children. Policy documents such as *The Report of the Commission of the Family* (1998), *Children First* (1999) and *The National Children's Strategy* (2000) all emphasise the States commitment to supporting parents in their parenting role.

The risk factors of disadvantage, and the increasing attention to growing behavioural problems (or at least, recording and reporting of such problems) has accelerated public debate around the support needs of parents, and what works best, in terms of service provision and supports for parents in raising their children. Daily media reports and academic research highlight the growth in youth anti-social behaviour, crime rates and indeed the growing intensity of youth crimes. However, while research and reviews of anti-social behaviour amongst children are long documented, a more extensive focus on the behavioural problems of children, to include emotional and mental health problems, such as ADHD, have only recently come under the research and policy microscope, largely fuelled through the Department of Health's *Vision for Change* and the Health Service Executive's *Child Mental & Emotional Health*. Both reports brought attention to the growing behavioural and mental health problems experienced by Ireland's youth and the scarcity of resources, and often, the difficulties experienced by parents and children in accessing appropriate professional support and treatment.

In the UK, growing levels of anti-social behaviour led to the introduction of a number of policy measures such as Parenting Orders and the Super Nanny scheme. There are also a growing number of information services, supports and training programmes available to parents to assist them in meeting their parenting responsibilities. In Ireland, such supports continue to remain limited. *A Vision for Change* and *Child Mental and Emotional Health* both emphasise the key role of parents in supporting children with behavioural problems and the general lack of supports and services for both parents and children in dealing with behavioural problems. Despite compelling evidence, that early identification and response to a child's behavioural problems promotes better outcomes for children and reduces the

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<sup>1</sup> <http://www.barnardos.ie/news62.htm>

burden of suffering for families and the community, services and supports for families in Ireland are still in their infancy and remain insufficient to truly tackle the prevalence and diversity of behavioural problems. Recent media reports highlighted the extensive waiting period children must endure for an assessment. How long a child is forced to wait depends on where he or she lives. In Dublin, they may wait for up to two years, in Carlow/Kilkenny it can take nearly four years and in Kerry a child who goes on a waiting list on his fifth birthday may not get a diagnosis until he is nine and a half<sup>2</sup>. Given the extensive waiting periods to access secondary and tertiary services in Ireland, and indeed internationally (e.g. Australia, US), the emphasis on the importance and pivotal role primary services within the community can play has increased in recent years.

### **1.1 Paper Outline**

This background paper aims to provide an overview of the type, extent and prevalence of behavioural problems of children and young people in Ireland. The paper will review risk factors which may contribute to and/or accelerate the development of such problems, and protective factors and support programmes/services which may respond to behavioural problems or reduce their likelihood of occurrence in the first instance. It pays particular attention to the support needs of parents, and the key role supports can and do play in preventing the development of behavioural problems, and in resolving/responding to such problems where existent. It concludes with a summary of key findings from the literature review to guide Barnados in the identification and design of possible supports/strategies to support parents of children with behavioural problem in the Carlow region.

The paper was commissioned by Barnados, Carlow and aims to provide an introductory context to the organisation of key considerations and potential approaches which may inform discussion regarding the organisation's response to supporting parents whose children experience behavioural problems locally. The paper will also assist the organisation in designing their research instruments for primary research to assess the scale and extent of child and youth behavioural problems in the area and the support needs of parents in coping/responding to these.

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<sup>2</sup> <http://www.rte.ie/news/2006/1205/health.html>

## SECTION TWO:

### SETTING THE CONTEXT: OVERVIEW OF BEHAVIOURAL PROBLEMS

#### 2.0 Defining Behavioural Problems:

Hall & Elliman (2003) define psychological, emotional and behavioural problems as

*'behaviours or distressed emotions, which are common or normal in children at some stage of development, but become abnormal by virtue of their frequency or severity, or their inappropriateness for a particular child's age compared to the majority of ordinary children'.*

The most prevalent types of disorders disclosed in children are:

- emotional disorders, e.g. depression, anxiety states, phobias and psychosomatic disorders
- oppositional defiant disorders and conduct disorders (ODD and CD), e.g. non compliance, defiance, stealing, truancy, aggression and more persistent delinquency.
- attention deficit disorder, with or without hyperactivity (ADHD and ADD)
- major psychiatric disorders e.g. psychosis, which increasingly occur from puberty onwards
- developmental delay and autism
- eating disorders, e.g. anorexia nervosa
- anti-social behaviour e.g. drug and alcohol abuse

(Cummins, McMaster; 2006)

The spectrum of behaviours can therefore vary from very mild to clinically problematic, and their definition and nature often expands beyond the term 'behavioural problems' itself to incorporate mental and emotional health problems. Often the behavioural problem is a manifestation of a deeper emotional/mental health problem. This paper will focus on the most commonly experienced and reported problems amongst children and adolescents. Emotional disorders (such as depression, anxiety and obsessions), hyperactivity (involving inattention and over-activity) and conduct disorders (involving awkward, troublesome, aggressive and antisocial behaviour) are the three most common groups of childhood mental health problems<sup>3</sup>.

#### 2.1 Prevalence and Occurrence of Behavioural Problems

Table One presents estimated prevalence rates of behavioural problems amongst zero to eighteen year olds in Ireland. It is estimated that a fifth of the child and adolescent population may suffer from psychological problems at any given time (Cummins and McMaster, 2006), a statistic which is not out of line with other internationally developed countries such as the US<sup>4</sup>, and Canada<sup>5</sup>.

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<sup>3</sup> <http://www.counselling-directory.org.uk/childrenstats.html>

<sup>4</sup> The US Surgeon General's 2000 *Report on Children's Mental Health* estimates that one in five children and adolescents will experience a significant mental health problem during their school years.

<sup>5</sup> A Canadian study estimated that approximately 26% of school - age children experience mental health problems (Offord, Boyle, & Szatmari, 1987).

**Table 1: Prevalence of child emotional and mental health problems (0 – 18)**

Disorder	Percentage	Ratio
Psychological Problems	20%	1 in 5
Mental Illness with some impairment	10%	1 in 10
Major Psychiatric Disorder	5%	1 in 20
Mental Illness requiring in patient admission	.5%	1 in 200
ADHD	3 – 5%	1 in 20 to 30
Autism and related conditions	.5 – 1%	1 in 100-200
Mental health problems among children in care	60 – 70%	> 1 in 2
Mental health problems among children in residential homes	90%	< 1 in 1

Source: Irish College of Psychiatrists (2006) in Cummins, McMaster, 2006

Current data from epidemiological studies of psychological disorders in children in Ireland are limited. In 2004, a HSE commissioned epidemiological study of behavioural problems in children screened 3,274 children in Clonmel (representing 74% of all people under eighteen in the area) for mental health difficulties using the Child Behaviour Checklist and related instruments<sup>6</sup>.

The study found an estimated prevalence rate of 18.71% for at least one psychological disorder in the preceding year. The study found 17% of two to five year olds, 10% of six to twelve year olds and 26% of 13 – 18 year olds screened positive for a mental health problem. Almost half of these (43%) had an anxiety disorder, a quarter had ODD and just over a fifth had ADHD. Slightly more than a tenth had a conduct disorder problem, and one in ten had a mood disorder, alcohol abuse or intellectual disability (Martin & Carr, 2005).

## 2.2 Trends in Child/Adolescent Behaviour Problems

Research generally suggests two key entry points in the development of behavioural problems – early childhood and early adolescence with potentially different risk factors associated with each (Lahey, B, Waldman, I, McBurnett, K, 1999) (risk factors are discussed in greater detail in Section 2). The most significant age difference is that ADHD is more common amongst children, while conduct disorder is more common amongst adolescents (Martin & Carr, 2005). Several international longitudinal studies have provided a picture of the changing forms of behavioural problems from early childhood through to adolescence. Richman and colleagues found that 67% of children who displayed externalising behavioural problems (e.g. non compliance, oppositional behaviours and overt physical and verbal aggression) at age 3 were still aggressive at age 8 (Richman, Stevenson, & Graham, 1982). Similarly, a UK study found that 60% of three year olds with conduct disorders still exhibit problems at the age of eight if left untreated and predict that many problems will persist into adolescence and adulthood (National Institute for Health and Clinical Excellence, 2006). A number of studies have documented that boys who reach the criteria for ADHD in childhood are at increased risk for conduct disorder and anti-social behaviour in adolescence and early adulthood (Hann, D., Borek, N., 2001).

The Australian Temperament Project (ATP), a large scale, longitudinal study, which followed approximately 1600 Victorian children from infancy through to 18 years of age, recently released data supporting two different pathways associated with the development of anti social behaviour in adolescents. The study identified three groups were identified on the basis of self-reported involvement in antisocial behaviour during adolescence. Groups were designated low/non antisocial and persistent and experimental antisocial. Those in the persistent group began to exhibit significantly higher rates of

<sup>6</sup> Note that the Behaviour Checklist screens for a wide range of behavioural problems and is used to identify problems such as aggression, hyperactivity, bullying, conduct problems, defiance and violence. The first section of the questionnaire consists of 20 competence items and the second section consists of 120 items on behaviour or emotional problems.

antisocial behaviour from the age of 5/6, increasing until age 11/12 when they began to plateau. Those in the experimental group did not begin to exhibit anti social behaviour at a significantly higher rate than the low/non anti-social group until 12/13, with these differences increasing until the age of 15/6, when there was a slight downward trend (Ralph & Sanders, 2003).

### *Key Entry Points to Development of Behavioural Problems*

#### *2.2.1 Early Childhood*

Early behavioural problems has been cited as one of the strongest predictors of later problems, including psychological difficulties, involvement in crime and antisocial behaviour (Kolvin, Miller, Scott, Gatzanie, Fleeting, 1990). Children who exhibit particularly high levels of externalising behaviour problems early in their lives are at high risk for intensifying to lying, bullying and fighting in middle childhood, and more serious behaviours such as cruelty to animals, vandalism and aggressive criminal behaviours in adolescence (Hann, D., Borek, N., 2001). Children with conduct disorders at a young age are more likely to have higher rates of juvenile offending, substance use and mental health problems in later adolescence (Fergusson & Lynskey, 1998). Current thinking therefore emphasises a focus on the early primary school years to prevent the development of persistent anti social behaviour. However, thinking also concludes that interventions targeting experimental antisocial behaviour should focus on the early secondary school years (Ralph, Sanders, 2003).

#### *2.2.2 Early Adolescence*

Adolescence is a key stage of life development when children require an understanding of the life challenges they face and need to develop basic skills to cope with difficult emotions. It is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders, and substance misuse becoming more prevalent, as well as an increasing risk of deliberate self harm and suicidal behaviour (Department of Health & Children, 2006).

Some young people begin to exhibit problem behaviours during early adolescence. In such cases, entry into conduct problems generally occurs through associations with peers. Externalising behaviour problems can intensify during this period when peer influences can lead to rule breaking behaviour such as delinquent and anti-social behaviours, substance use, and in some cases, gang involvement and drug dealing (Hann & Borek, 2001).

The ATP found that the late onset group who began to engage in anti social behaviour for the first time in late adolescence did not appear to be associated with a more difficult transition to adult life, but changing behaviour coincided with new friendships with other anti social young people, psychosocial adjustment problems, substance use and difficulties in relationships with parents and friends (Smart, Richardson, Sanson, Dussuyer, Marshall, (2005). Initial data on these 'late starters' suggests that much of their anti-social behaviour tended to be non aggressive and that they are more likely to desist in problem behaviours as they become older. However, other research suggests that some late starters might be involved in highly aggressive and problematic behaviours (Hann & Borek, 2001).

UK surveys have shown that up to 90% of parents believe young people's drug use derives from the need to conform with their peer group. However, placing too much emphasis on peer pressure, may lead parents to underestimate their own influence on children, which, though it varies at different ages, has been shown to affect young people's long term behaviour (Oyguard et al., 1999). Targeted supports which highlight the role and influence of parents as well as the risk factors of an adolescent's association with peer groups are therefore essential.

## SECTION THREE:

### RISK AND PROTECTIVE FACTORS

#### 3.0 Introduction

Risk factors can be defined as those factors associated with a higher likelihood of negative outcomes and have mainly been studied in relationship to the development of problem behaviour (Deković, 1999). In order to accurately identify support strategies for parents whose children exhibit behavioural problems, it is essential to have an understanding of the factors that place children at risk of, or contribute to the development of such behaviour in the first place.

Research suggests, that, in isolation, risk factors may make relatively little contribution to the development of behavioural problems, whereas such factors in combination may be powerful determinants of negative outcomes (Klein & Forehand, 2000; Kolvin et al 1990). Problems result from interactions between characteristics of the child and situations within the family, peer group, school and community. Therefore, it can be expected that families with multiple risk factors experience more problems and thus also a greater need for support. Cummins and McMaster's study (2006) found that children who screened positive for mental health difficulties were more socially disadvantaged, had more behavioural difficulties and adaptive behaviour problems, more physical health problems, more family problems, more life stress and poorer coping skills.

An understanding of the key risk factors associated with the onset and development of child and adolescent behavioural problems, and in turn, an identification of high risk groups of children is important in the effective identification and design of supports for parents and children. Key risk factors are briefly summarised in Section 2.1.

#### 3.1 Parent/Child Biological Factors

##### *Maternal Factors*

##### *3.1.1 Age*

Although it is not clear how maternal age is related to child behaviour problems, at least two kinds of variables can be hypothesised as mediators. First having a child earlier in life often restricts maternal educational and occupational attainment and related life circumstances, such as neighbourhood of residence, that are associated with youth conduct problems and crime (Hann, Borek, 2001). Bradley and Hayes's 2006 study in a disadvantaged area of Dublin found half of all mothers in the area who resided in local authority housing had their first child before the age of 20<sup>7</sup>. Almost three quarters (73%) of these mothers had left full time education by the age of sixteen. A quarter reported difficulty in coping with their child 'sometimes' and a further 14% reported difficulty in coping with their child 'all the time'.

Research also suggests that less mature women may be more likely to raise their children in ways that foster conduct problems, such as use of harsh and inconsistent discipline (Hann, Borek, 2001). The impact of parental discipline on children's behaviour is discussed in more detail later in this section.

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<sup>7</sup> Total population of mothers in survey sample = 74.

### *Maternal Smoking/Alcohol Consumption*

Research has consistently associated factors such as low birth weight and maternal smoking or alcohol consumption during pregnancy with later health, education and behaviour problems (Sutton, Utting, Farrington, 2004).

#### *3.1.1 Child Gender*

Fitzgerald and Jeffers (1994) categorised almost a fifth of the Irish children they studied as behaviourally disordered with twice as many boys as girls classified in this way. Boys are vulnerable in terms of developing conduct and behavioural difficulties and for offending (Kolvin et al., 1990). Anxiety disorders are more common amongst girls and disruptive conduct behaviour amongst boys (Martin & Carr, 2005).

### **3.2 Family Factors and Processes**

A number of aspects of family interaction can increase the risk of developing behavioural problems from early childhood through to adolescence. Specifically, lower levels of engagement, greater use of invalidation, and harsh and inconsistent discipline have all been identified as causal risk factors for the development of behavioural problems (Hann, Borek, 2001). Links drawn between low educational achievement, unemployment, involvement in crime, poor health, teenage pregnancy, and family factors have further underlined the importance of promoting and supporting positive family experiences (Riordan, 2001).

#### *3.2.1 Parent's Relationship Status*

Research in relation to the impact of parent's relationship status on child well-being and behaviour is mixed. McKeown, Pratschke and Haase (2003) found practically no statistically significant variation in the well being of children in four family types<sup>8</sup>, indicating parent's marital status and presence of one or two parents in household do not, of themselves, affect the child's wellbeing. Existing evidence in relation to the effects of differing family types on children suggests that the nature of the household is not the most significant factor, but rather the quality of the relationships and the economic resources available to the family (Hobcraft & Kiernan, 2001). Other studies have shown that a higher proportion of children in lone-parent households have scholastic or emotional problems, compared to those living with both parents, but report this to be more likely due to economic circumstances than to parental marital status (McMunn, Nazroo, Marmot, Boreham & Goodman, 2001; Flanagan, 2001).

#### *3.2.2 Parenting Approach*

Ongoing parental conflict, particularly where it directly involves children increases the risk of poor outcomes for children. McKeown et al., (2003) found the first and most important process to affect child wellbeing, as reported by the child, was that of unresolved problems between the child and its parents, including conflicts relating to behaviour (e.g. homework, school progress, drinking/smoking), family issues (e.g. doing things as a family, communication) and personal autonomy (e.g. how much pocket money is spent, boyfriend/girlfriend)<sup>9</sup>. Similarly, an Australian study of parent's experiences of their teenager's behaviour revealed that issues around family conflict and management of emotions featured strongly and were identified as areas where parents wanted assistance (Ralph, Sanders, 2003). Conflict with parents has been found to be strongly associated with contact with anti-social peers and substance use. High levels of positive family relations, parental monitoring, rule setting, and positive reinforcement for appropriate behaviour are associated with less contact with disruptive peers, less engagement in antisocial behaviour and less substance use. A range of parenting skills and attributes are important. A close parent child bond may discourage drug use directly, and choice of non drug using friends (Crundall, 1993), while low family cohesion may predispose children towards deviant behaviours which parents then lack the influence to control.

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<sup>8</sup> Four family types included in study were two parent married families, two parent co-habiting families, one parent single families and one parent separated families.

<sup>9</sup> This refers to behaviours that aid in exploring a given problem and generate potential solutions. For young children, this also includes parental exploration of problems, helping to give structure to the situation and encourage prosocial means of understanding the situation.

Research shows that preschool children who develop attention/hyperactive difficulties experience coercive family interactions and their parents often report disciplinary concerns (Bor, Sanders, Markie-Dadds, 2002). Research also suggests that parents of children with conduct disorder frequently lack several important parenting skills. Predictive longitudinal studies indicate that harsh and inconsistent parenting predicts later youth conduct problems (Patterson, Chamberlain, Reid, 1982).

#### *Firm Discipline V Hard Discipline<sup>10</sup>*

Parents who provide firm discipline and monitoring of their adolescents tend to have children who become involved with peers of similar parenting discipline styles. Being involved in networks of this type protect against delinquency because parental monitoring protects against association with disruptive peers (Hann, Borek, 2001).

Parental discipline and conflict management have been primary targets for many intervention programmes and trials have consistently documented that improvements in these areas leads to improvements in child/adolescent behaviour. Beginning in toddlerhood through middle childhood and adolescence, interventions that include improvement in parental discipline, in addition to monitoring and validation, show reductions in youth conduct and anti-social behaviour (Patterson et al, 1982).

#### *3.2.3 Family Income*

Economic disadvantage is linked with relatively high rates of marital unhappiness, general dissatisfaction, vulnerability to depression and restricted access to employment opportunities, childcare and social participation (Riordan, 2002). Compared to their economically advantaged peers, children in economically disadvantaged households are exposed to more family turmoil, violence, separation from their families and instability (Evans, 2004).

Studies also show that low income children are read to relatively infrequently, watch more TV and have less access to books and computers. Their homes are more crowded, noisier and of lower quality (Ibid., 2004). For example, while 55%<sup>11</sup> of parents of four year old children in Hayes and Bradley's aforementioned study played 'letter/number games' with their children on a daily basis, the remaining 45% did so 'less often'. Furthermore, almost half of all parents (49%) stated their children watched at least three hours of TV/DVD per day (Bradley, Hayes, 2006).

There is evidence of a close response relationship between child behaviour and poverty: the longer a child is in poverty, the more at risk they are of behavioural problems when compared to children from families in short term poverty or affluence (Duncan, Brooks-Gunn, Klebanov, 2004). The prevalence of significant emotional and behavioural problems were found to be 6% higher for children from lower socio-economic groups than the average 10% for children at primary school level in a recent study in the South East of Ireland. For children in secondary school, the prevalence rate was 10% higher for those from lower socio-economic classes than the average 26% (Martin & Carr, 2005).

#### *Parental structuring of the learning environment*

Research to date conducted with school aged children and adolescents suggests that families that encourage involvement with school and maintain contact with the school have children who show fewer problematic behaviours than do families who are less involved (Hann, Borek, 2001).

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<sup>10</sup> Firm discipline refers to parental strategies for managing and controlling child behaviour that consistently use rules, set limits, provide reasons for the rules, and offer non punitive consequences for breaking the rules. Hard discipline refers to non abusive strategies, controlling child behaviour that may involve inappropriate or inconsistent use of rules, little reasoning, and punitive or excessively negative reactions to rule breaking (Hann, Borek, 2001).

<sup>11</sup> Total survey population: 95

### *Family history of problem behaviour*

A sizeable body of literature has examined whether the presence of anti-social behaviour, delinquency or criminal behaviour in other family members places children at increased risks for similar behaviours. Much of this work has found increased risk when mothers, fathers, or siblings were rated as more antisocial or had a history of delinquency or criminal behaviour (Farrington, Hawkins, 1991). One UK study found that 63% of boys with convicted fathers were subsequently convicted themselves. Having a convicted parent at age 10 was the best single predictor of an anti-social personality at age 32 (Farrington, Coid, 2003).

## **3.3 The Community**

### *3.3.1 The Neighbourhood*

Social factors play an important role in parenting and may place certain families at risk of suboptimal parenting, leading to an increased risk of emotional and behavioural problems in children. The neighbourhood one lives in can provide protection, or increase risk. In Kolvin et al's (1990) study, the surrounding environment was almost as important in predicting delinquency as was family deprivation. In Bradley and Hayes's Ballymun study, 60% of surveyed eleven year olds reported a problem with crime in their neighbourhood and 68% wished they lived in a different neighbourhood.

Other neighbourhood factors cited in research which influence child behaviour include community disorganisation and neglect, availability of drugs, general disadvantage in the neighbourhood, high turnover and lack of neighbourhood attachment.

### *3.3.2 Peer Influences*

Particularly as children mature into adolescents, peers play a large role in shaping both appropriate and inappropriate behaviours.

### *3.3.3 School*

The way that young people engage with or disengage from formal education and training is crucial to their later experiences and behaviours. Ensuring that children and adolescents remain engaged in the educational system is a crucial first step that can be taken to break the cycle of social exclusion. School may act as an important risk or protective feature in the child's life (Hayes & Kernan, 2001). School offers the possibility of academic and social success and factors that will influence outcome include socio-economic and family background, IQ, the ability to learn and the school environment (Brazelton, T., 1992).

## **2.4 Protective Factors**

For every risk factor, an increased exposure to risk is found to relate significantly to an increased likelihood of reported involvement in problem behaviour. Conversely, the more young people are exposed to protective factors, the less likely they are to report taking part in antisocial activities (Beinart, Anderson, Lee, Utting, 2002).

While there has been an abundance of research on risk factors, there has been much less research on the protective factors that enable a child to 'bounce back' or show resilience in the face of challenges and threats (Cummins, McMaster, 2006). Protective factors can operate in a variety of ways. They can:

- Directly reduce a risk
- Buffer an individual against the effects of a risk
- Disrupt the mediating factors associated with the risk
- Prevent the initial occurrence of the risk factor

Place, Reynolds, Cousins and O'Neil (2002) have described protective factors under three main headings:

- Individual factors: good problem solving, good social skills, self reliance, positive outlook on life, high cognitive ability, emotional resilience
- Family factors: quality of attachment, socio-economic status
- Community factors: parental satisfaction with social support.

Protective factors are linked to positive outcomes even when children are growing up in adverse circumstances and heavily exposed to risk. They may also include positive events or turning points in people's lives such as educational success (Garmezy 1987). In addition to the above, protective factors encourage health standards set by parents/teachers/community; opportunities for involvement in family school and community; social and learning skills that enable participation and recognition and praise for positive behaviour (Beinart et al., 2002). Overall, then, any strategy or support which fosters and enhances exposure to protective factors for parents and their children are likely to impact positively on children's behaviour.

Resilience is also an important feature when considering/promoting protective factors to address behavioural problems. Resilience refers to the strengths and protective factors which cushion a vulnerable child/young person from the worst effects of adversity in whatever form it takes and help a child/young person to cope, survive and even thrive in the face of hurt and disadvantage (Gilligan, 1997). Rutter (1979) estimated that even with the most severe stresses and adversities, it is unusual for more than half of all affected children to succumb to a maladaptive outcome. Gilligan (2000) notes, that although child qualities are important in understanding resilience, the experiences the child encounters and how she/he processes these are also important, since it is this part of resilience which is susceptible to influence. He argues that reducing, even by one the number of problem area in a child's life may have a disproportionate and decisive impact as adversity seems most debilitating when it comes in multiple forms. Swedish researchers also report that reducing the accumulation of problem areas seems to reduce the risk of later problems (Statton and Magnusson, 1996).

The strength and protective factors associated with (the development of) resilience have been explored (Masten & Garmezy, 1985; Werner and Smith, 1992) under three sets of characteristics:

- Attributes of children/young people themselves (e.g. self-esteem, positive values and social competencies);
- Characteristics of their families (e.g. quality of parent child relationship, family environment where there are clear expectations and opportunities for child/young person's participation);
- Characteristics of their wider social environment (includes nature of friendships, education, community).

A resilience led approach focuses on developing strengths and protective factors that help children adapt to difficulties and do better than might be expected. They attempt to shift the balance from vulnerability to resilience by increasing the number of available protective factors in children's lives (Werner, 1990). This means identifying, and increasing strengths (protective factors) in children's lives wherever possible.

## SECTION FOUR:

### ADDRESSING BEHAVIOURAL PROBLEMS: ASSESSMENT AND INTERVENTION

#### 4.0 Introduction

In Ireland, childhood emotional, developmental disorders, behavioural problems and mental illness are under recognised, often remain untreated and are subject to delays in diagnosis and receipt of treatment. This can adversely affect the child's behaviour, emotional well being and educational attainments, as well as affecting family, friends and society at large (Cummins, McMaster, 2006). Research on changing lifestyles and parenting styles, as well as those focused on risk and protective factors suggest the need to plan early intervention or prevention programmes and are based on the assumption that if children are reached early enough, their life course can be significantly changed for the better (Barlow & Parsons, 2003). *A Vision for Change* (2005) recommended programmes addressing risk and protective factors early in life be targeted at child populations at risk and cited the *Community Mothers Programme*<sup>12</sup> and *Lifestart*<sup>13</sup> as examples of best practice in this regard.

#### 4.1 Current Assessment and Intervention Services for Children with Behavioural Problems

##### 4.1.1 Secondary and Tertiary Services

Currently, secondary and tertiary<sup>14</sup> services for children are inequitably distributed across the country, not all teams are fully resourced and many have unfulfilled posts. Some geographical areas lack provision altogether and waiting lists are often long (Cummins, McMaster, 2006):

*It seems unlikely that child and adolescent mental health services will ever be extensive enough in any country to treat all children with mental health problems. It is therefore necessary to identify disorders at a primary care level and to intervene early to prevent progression to disorders of marked severity or chronicity.*

Resource shortages and promotion of intervention at primary level are emphasised in several other developed countries. For example, *Mental Health of Young People in Australia* (2000) highlights the disparity between the number of young people with mental health problems and the limited number of clinicians available to help them which makes it *unlikely that specialised programmes based in secondary and tertiary settings will ever be able to provide direct care for all those with problems in Australia* (Sawyer, M., Arney, F., Baghurst, P., Clark, J., Graetz, B., 2000). There is therefore a need to focus on supports to respond to behavioural problems and to provide assistance and support as early as possible.

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<sup>12</sup> The Community Mothers Programme is a Parent Support Programme in which friendly local women known as Community Mothers carry out monthly visits to first and second-time parents in their own homes. These visits are made by appointment and they focus on health care, nutrition and the baby's overall development. The Community Mothers are volunteers and are guided and supported by Family Development Nurses. Objectives of the Programme are detailed in Appendix A.

<sup>13</sup> *Lifestart* is a home-based, educational and family support programme for parents of children aged birth to five years. The aim of the programme is to empower parents to enable their children to reach their full potential. Monthly, age-appropriate, child developmental material is delivered in the home by trained family visitors to parents throughout the first five years of the child's life. The material used is taken from the *Growing Child* and covers the physical, intellectual, emotional and social dimensions of children in this age group.

<sup>14</sup> Includes child and adolescent mental health services and departments of psychiatry in hospital. Services are usually delivered by multidisciplinary and early intervention teams from a variety of disciplines, including community based clinical psychologists, social workers, PHNs, speech and language therapists, physiotherapists and occupational therapists, as well as paediatricians and child and family support workers

#### 4.1.2 Primary Care Services

It is recommended that young people and their families, identified through screening, should be offered prompt intervention, within the context of a stepped care model. There are a wide range of community care services that deliver mental health care at primary care level in the community, particularly for children. Less intensive interventions should be offered within a primary care context initially and only if children do not respond to these, should more intensive interventions be offered, or referral made to secondary or tertiary services (Martin, Carr, 2005).

The children's centre programme in the UK is based on the concept that providing integrated education, care, family support and health services are key factors in determining good outcomes for children and their parents. It has been proposed that Child and Family Centres in Ireland are developed in a similar fashion and facilitated by cooperation of the HSE, Community Development Programmes, Family Resource Centres and others to provide:

- early education and day care, including early identification of an provision for children with special educational needs and disabilities,
- family and parent outreach support, including support for parents of children with special needs,
- health services,
- service hub within the community for parents and providers of childcare services,
- effective links with local employment services, local training providers and further and higher education institutions,
- effective links with children's information services, out of school and after school clubs,
- management and workforce training.

(Cummins, Mc Master, 2006).

#### 4.2 Supporting Parents as an Intervention Mechanism

A particularly effective means of supporting families is to focus on parenting behaviour. Mental health problems can have a significant and adverse impact on children, adolescents, parents and families. It is therefore important that interventions provide broadly based help for the parents and families of young people with problems as well as the young people themselves (Sawyer et al., 2000). Interventions that have addressed parental engagement (as well as discipline and problem solving) have been successful in decreasing later childhood behaviour problems (Hann, Borek, 2001). The development of effective parenting skills has been considered as the primary mechanism for change in child conduct disorder, through the reduction in the severity, duration and manifestation of the disorder<sup>15</sup>. Since behavioural problems have not been found to be attributable to a single source or situation, interventions for changing these behaviours need to focus on multiple risk factors across multiple settings. Similarly, the relative contribution of individual risk factors may change with development suggesting different targets for interventions at different ages (See Section 4.1 for further discussion). Behaviours targeted for intervention, as well as the immediate expected outcome from such interventions will therefore differ depending on the age of the child (Hann, Borek, 2001). Sample interventions and support programmes for parents of children with behavioural problems are discussed in detail in Section 4.

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<sup>15</sup> <http://www.adhd.com.au/conduct.html>

## SECTION FIVE:

### SUPPORTING PARENTS IN ADDRESSING AND RESPONDING TO CHILD AND ADOLESCENT BEHAVIOURAL PROBLEMS

#### 5.0 Introduction

Parenting is a life-long process and parent's need for support varies depending on family circumstances, the stage of development of the child, the number of children, the child's behaviour etc. A child's family system plays an important role in the prevention and treatment of behavioural problems. The child rearing practices of parents are an important part of this dynamic. It has been well established that children's early experiences are important and that intervention and support for parents in the early years can stimulate children's intellectual, social and physical development (Riordan, 2001). Parent behaviour can set the stage for children to develop and use coping skills that make them more resilient, or conversely place them at risk for problems. Preventative work with families has been identified by numerous sources as the most effective means of avoiding severe long term problems (Pugh, De'Ath, Smith, 1994; Kamerman & Kahn, 1993).

In designing support services for parents, it is pivotal to remember that parents are not a homogenous group. Their backgrounds and experiences vary, their needs are dynamic and change with circumstances and supports must reflect and respond to the diverse lifestyles, experiences and needs of parents and their children. For example, increasing numbers of dual income households, ethnic families and young parents who (due to reasons such as house prices and employment options) are living further distances from the family home all highlight the need for new and varied supports to assist parents in raising their children. In certain instances, especially for those affected by disadvantage, a wide support from a myriad agencies may be required to help parents in their role, again highlighting the multi-dimensional risk factors and associated behavioural problems children may experience.

#### 5.1 Stages of Intervention to Support Parents & Children

The age of the child will very often affect the type of support required, however it is never too early to make support available nor is it ever too late. Assertive strategies should be used to engage young people with behavioural problems and their families in treatment. With young children, engagement should target parents. With adolescents, services may directly target teenagers, as well as their parents (Martin, Carr, 2005). Family disorganisation and lack of knowledge or motivation may prevent young people and their families from proactively engaging with health and/or other support services. Community based, attractive, accessible, evidence-based training programmes may be used as a vehicle for identifying children at risk, and engaging with families of children with problems. A variety of professionals, including family doctors, PHNs, pre school and school staff may all play a role in helping parents engage with such programmes (Ibid., 2005). The key intervention stages to prevent, reduce, control or respond to behavioural problems are briefly discussed in this section. The remainder of the section pays particular emphasis to the support needs of parents and reviews potential strategies in this regard.

##### *5.1.1 Prevention During Pregnancy*

Good anti natal preparation is a way of giving parents and children a good start in life and is often delivered through Home Visiting Programmes (HVPs). Programmes focus on the importance of the early years and the pivotal role parents play in shaping children's lives, and operate on the premise that one of the best ways to reach families with young children is by bringing services to them, rather than expecting them to seek assistance in their communities. Programmes in the US now number in the thousands and are supported through a variety of public and private funds. Many programmes begin during pregnancy to support parents and focus on better outcomes for parent and child from the onset.

Examples include the Nurse Family Partnership Programme (NFPP)<sup>16</sup>, Hawaii's Healthy Start<sup>17</sup>, Parents as Teachers (PAT)<sup>18</sup> and the Comprehensive Child Development Programme (CCDP)<sup>19</sup>. Irish examples include the aforementioned Lifestart and Community Mothers Programme.

Given the strong link, between mothers' stress and anxiety during pregnancy and children's behavioural problems (O'Connor, Heron, Glover, 2002), this is one area where a well-designed and professionally-delivered home visiting programme, such as the Nurse-Family Partnership, appears especially promising. This programme was found to have long-term effects on children's behaviour, including fewer arrests and convictions by the age of 15 (Olds, Henderson, Cole, Eckenrode, Kitzman, & Luckey, 1998).

#### *5.1.2 Birth to Two Years*

Research literature in child and adolescent behavioural and emotional problems strongly supports refocusing a significant proportion of resources towards an early intervention/prevention model that provides parents with appropriate support and assistance during children's early years (Sanders, 1999). As science becomes more systematic and skilled at diagnosing maladaptive behaviour in children under 3 and in identifying some of the early warning signs in infants as young as six months, intervention supports for parents of young children are gaining increasing recognition (Sutton, Utting, Farrington, 2006).

Parents may be more willing to hold the door open to friendly, non-stigmatising support and advice when they have young children than at any other time as the Sure Start programme has demonstrated (Sutton et al., 2004). Supports for children in this age range also usually take place through HVPs and evaluations of such programmes demonstrate long as well as short-term benefits (Also discussed Section 4.2.1). Programmes send individuals into the home and seek to improve the lives of the children by encouraging changes in attitude, knowledge, and/or behaviour of the parents. The valuable role that trained nurses/health visitors can play is reinforced by evidence that they can successfully deliver programmes as varied as screening and support for mothers with postnatal depression (Cooper et al, 2003) and parenting courses for the parents of children with attention deficit (ADHD) disorders (Sutton et al., 2004).

#### *5.1.3 Three to Eight Years*

In objective terms, severe conduct problems are relatively stable and easier to identify by age three. There is also a rich seam of research concerning effective preventive interventions for this age group.

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<sup>16</sup> The Nurse-Family Partnership consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child to improve parent and child outcomes. Home visiting also promotes the cognitive and social-emotional development of the children, and provides general support and parenting skills to the parent. The program is designed to serve low-income, at-risk pregnant women bearing their first child. Nurse home visitors work with families in their homes during pregnancy and the first two years of the child's life.. Typically, a nurse visitor is assigned to a family and works with that family through the duration of the program. A fifteen year follow up study of programme outcomes included 79% fewer verified reports of child abuse or neglect, 44% fewer maternal behavioural problems due to alcohol and drug abuse, 56% fewer arrests on the part of the 15-year-old children and 56% fewer days of alcohol consumption on the part of the 15-year-old children .

<sup>17</sup> Hawaii's Healthy Start, a home visiting programme that serves families identified through screening at birth as highly stressed and/or at risk of child abuse.

<sup>18</sup> PAT, a program that began in Missouri and now operates at more than 2,000 sites across the US to promote the development of children from birth to age three.

<sup>19</sup> CCDP, a five year federal demonstration program that worked with poor families to promote children's development, parents' ability to parent, and family self sufficiently.

The Incredible Years Programme in the US is amongst the best known of all group-based parenting programmes and amongst the more extensively and rigorously evaluated (Sutton et al., 2004). Improvements in parental style, relationships and parent-child behaviour have been recorded from trials in clinical and community settings (Webster-Stratton, 2001), positive findings which have been replicated in both types of setting in the UK, Canada and Norway (Morph, Clifford, Larsson, Rypdal, Tjeflatt, Lurie, 2004). The Positive Parenting Programme ('Triple P') devised and positively evaluated in Australia (Sanders et al., 2002) has also gained a foothold in the UK.

High quality preschool programmes for young children have also been shown to contribute to cognitive, emotional and social development in childhood and later school success, economic performance and reduced levels of crime in adulthood. The short and long term benefits of pre-school, are now, universally recognised and accepted as evidenced through the increasing trend for between one and two years free pre-school education in several European countries (Schweinhart, 2000, NWCI, 2006, OECD 2004).

For an older age group, the Promoting Alternative Thinking Strategies ('PATHS') programme (Kushce, Greenberg, 1998) is an example of a strongly evaluated curriculum being used in UK primary schools to promote social competence, self-control and problem-solving.

#### *5.1.4 Nine to Thirteen Years*

As children reach the 'cusp' between the end of primary school and their first years of secondary education, the influences on their behaviour grow increasingly complex. Their relationships with parents are still hugely important, but so increasingly are friendships and the example set by teachers and other significant adults in their lives. They are more aware of the neighbourhoods where they live and of messages delivered through television and other media (Sutton et al., 2004). This is also an age group where some children will become involved in 'early onset' offending and in under-age smoking, drinking and other substance misuse. In terms of prevention, there is a continuing need for universal services – this is, for example, the age group most likely to benefit from drug and alcohol education, including strategies for resisting negative peer pressure (Ibid., 2004). 'Whole class' and 'whole school' approaches have also proved effective in reducing the risks associated with anti-social behaviour, for example the Bullying Prevention Project (Smith & Sharp, 1994).

Some interventions for this age group originally evaluated in the US, have been introduced into the UK in recent years. Some have worked through schools or youth organisations to reduce conduct problems, and delay the onset of substance use and/or offending. For example, mentoring programmes have sought with varying degrees of success to tackle anti-social behaviour through regular contact with an adult/older peer who befriends a young person and offers them a positive role model. The Big Brothers & Sisters programme, working with children and young people from one parent families, has yielded some of the most positive evaluation results to date, in terms of preventing anti-social behaviour (Sutton et al., 2004). Other interventions make families the main focus for intervention, albeit in a more intensive and age-specific format. Some Youth Offending Teams in England have, for example, made use of the Functional Family Therapy model (Barton, Alexander, Waldron, Turner, Warburton, 1985) when designing programmes for use with the Parenting Order introduced by the Crime and Disorder Act, 1998.

Various evaluations of Multi-systemic Therapy (MST) (Henggeler, 1999) are an even stronger indication of the range and depth of service delivery that may be needed to achieve positive results with children from the most dysfunctional and disadvantaged families. Practitioners in London and Cambridge have begun using this approach, which, in the US, is presented as a cost-effective alternative to youth custody (Utting et al., 2004). However, prevention at this level requires the intensive services of a multi-disciplinary team, on-call for much of the day, providing a combination of behavioural therapy with tailored support services for the whole family (Henggeler et al, 1998).

## 5.2 Sample Programmes

Parents of children with behavioural difficulties bear a heavy burden and stress and depression as well as familial and marital discord often develop. Great emphasis has been placed on programmes which address parents' situations and needs and treatments must take account of the fact that parents and family members suffer considerable stresses even while when the child is of pre-school or primary school age. A central issue relating to treatment is how it affects the family as a unit, and what kinds of benefit are obtained (Morch et al., 2004).

A number of parent training programs focus on increasing parents' skills in managing their child's behaviour and facilitating social skills development. Research indicates such programs have been positive, resulting in significant changes in parents' and children's behaviour. For example, research suggests that parents who have participated in parent training programs are successful in reducing their child's level of aggression by 20 - 60%<sup>20</sup>. The skills focused on, include parents learning to assist in administration of appropriate reinforcement and disciplinary techniques, effective communication with the child and problem solving and negotiation strategies. A further component of training incorporates behavioural management and involves providing families with simple and effective strategies including behavioural contracting, contingency management, and the ability to facilitate generalisation and maintenance of their new skills, thus encouraging parents' positive interaction with their child<sup>21</sup>. There are other types of programmes which help parents understand their and their child's emotions and behaviour and improve communications.

Research has found that parent training programmes result in significant decreases in overall internalising and externalising behaviour problems. They also decrease family conflict and stress, the number one identified cause of reduced child well-being in McKeown et al.'s 2003 study.

Parenting programmes usually last one to two hours a week for between 8 and 22 weeks and are usually held in groups of between six and ten participants. This may vary somewhat depending on the nature of the problem and the extent/severity of parental need. Training is sometimes delivered on a one to one basis where a parent's needs are too complex for group work. In the UK, parenting programmes are increasingly attached to schools and/or children's centres. This usually facilitates greater engagement and uptake amongst parents. Social or children's services also provide and also contract voluntary or private organisations to deliver courses for them. Youth offending teams also provide parenting courses or make them available through voluntary organisations, particularly where children are involved or at risk of involvement in crime and/or anti social behaviour<sup>22</sup>.

A list of sample programmes with the strongest evidence of improving the quality of parenting are summarised in Table 2 and an outline description of programmes are provided thereafter.

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<sup>20</sup> <http://www.adhd.com.au/conduct.html>

<sup>21</sup> <http://www.adhd.com.au/conduct.html>

<sup>22</sup>

[http://www.respect.gov.uk/uploadedFiles/Members\\_site/Articles/Resources/Respect\\_academies/Supporting\\_parents.pdf](http://www.respect.gov.uk/uploadedFiles/Members_site/Articles/Resources/Respect_academies/Supporting_parents.pdf)

**Table 2: Sample Programmes to Support Parents of Children with Behavioural Problems**

<b>Programme Name</b>	<b>Target Group</b>	<b>Detail</b>	<b>Evidence</b>
Webster Stratton Incredible Years	2 – 12 Years	Treats aggression and conduct problems, helps parents support their child's education, and deal with bad behaviour.	<ul style="list-style-type: none"> <li>• US research found that the benefits of every \$1 spent is \$4.25 from reductions in the cost of crime alone</li> <li>• UK control trial found that children showed a large reduction in anti social behaviour while those in the waiting list (control group) did not.</li> </ul>
Positive Parenting Programme (Triple P).	Middle Childhood (A Teen Triple P has also been developed specifically for adolescent problems – Section N)	Provides Guidance for Parents on Parenting Skills to Promote Good Behavioural and Emotional Adjustment. Uses a tiered system of increasing intervention according to parental need	<ul style="list-style-type: none"> <li>• 66% of children diagnosed with ODD/Conduct Disorder whose parents received the parenting programme were in the normal range of behaviours (at both 1 and 3 year follow ups).</li> </ul>
Mellow Parenting	Family must include child <5, aimed at parents whose relationships with children are under severe stress.	Focus on mother-child relationship	<ul style="list-style-type: none"> <li>• Successful in engaging hard to reach families, often with severe, multi-generational parenting problems. Change has been demonstrated in maternal well-being, child behaviour, child development and mother child interaction.</li> <li>• Pilot study in US found reduction in risk of abuse.</li> </ul>
Strengthening Families Programme	3 – 17 Years	14 session family skills programme designed to reduce risk factors for substance abuse, aggression, depression and delinquency	<ul style="list-style-type: none"> <li>• Improving parenting behaviour and child outcomes: substance use, problem conduct, school related problem behaviours, affiliation with anti social peers and peer resistance.</li> </ul>
Multi Systematic Therapy		Clinically significant anti social behaviour Intensive parenting intervention involving therapists, (available to families 24 hours a day) who help parents to set rules aimed to improve different aspects of child's behaviour.	<ul style="list-style-type: none"> <li>• Decreasing behaviour problems, improving family relations, reducing recidivism</li> <li>• Reducing re-arrest rates, reducing time spent by juvenile offenders in institutions</li> </ul>

Source: Gombay, Culross, Behrman, 1999

### 5.2.1 Webster Stratton Incredible Years

The Incredible Years is a programme designed for children aged 4 to 8 with behavioural problems and is widely regarded as one of the best documented and successful intervention approaches (Sutton et al., 2004). In addition to treatment based on parent groups, known as the Basic Programme, there is an Advanced Programme with a number of sessions for parents and a focus on parent's relationship and functioning. Two versions of the treatment programme have been designed for groups of children, one clinic based and the other adapted for use in preschool. A class room management programme has also been developed to assist teachers and pre-school staff. Not least because of the stringent designs, Webster-Stratton's methods have been regarded as fulfilling the strictest criteria of evidence-based treatments. The basic programme has produced impressive and consistent results - evaluations have shown parents respond very well to the programme and nearly 70% of children whose parents participate in the programme show a significant improvement by leaving the clinical group (Morch et al., 1999). An 18 month post treatment follow up study with parents, found that most parents had been satisfied with the programme and reported:

- improved self-esteem and self-confidence
- reduced feelings of guilt and isolation.
- learning of new parenting skills which enabled them to relate to the child in a more positive way.

(Ibid., 1999)

A Norwegian evaluation found that while some parents reported quite dramatic changes in children's behaviour, others reported little or no improvement, despite having gained self-esteem and new skills. Parents generally felt that the *group* aspect of the programme was most valuable for most; meeting parents in a similar situation was very important for their morale and self esteem and it helped reduce feelings of stigmatisation, guilt and isolation. Parents also found it encouraging to meet other parents who understood the problems they faced with their child. It was a great benefit to be able to talk honestly and openly about the difficulties they had to deal with, in a supportive group environment. Parents were generally *very satisfied with group leaders* and were most impressed with what they perceived as the leaders' positive personal qualities including warmth, optimism, enthusiasm, supportiveness, attentiveness and humour, however, they spoke more positively about their interaction with other parents than with group leaders (Ibid., 1999).

In terms of programme content, role play was enjoyed by most mothers who found it a good way to break the ice and reduce tension. Others (mainly fathers) found it intimidating, artificial and largely a waste of time. Likewise, some found the video clips were a useful way of presenting group session objectives, while others found them old fashioned, unrealistic and too American<sup>23</sup>. Home assignments were seen by some as useful while others found it difficult to devote time and energy to them with other work and family commitments (Morch et al., 1999).

Parent's views of their situation eighteen months post programme completion varied. Many felt the programme was too short and wanted follow up or 'booster' sessions, and continuing contact with other group members, and with child psychiatry. Parents who had seen improvements felt they had acquired tools they could use to meet future problems and were confident of their ability to cope with difficulties that might arise (Ibid., 1999).

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<sup>23</sup> Data on 18 month follow up with parents based on data collected from participants in the Incredible Years Programme in Norway.

### 5.2.2 Positive Parenting Programme (Triple P)

Triple P, is an Australian developed system<sup>24</sup> which aims to provide guidance for parents on parenting skills in order to promote good behavioural and emotional adjustment. It is a multi-level parenting and family support strategy<sup>25</sup> that aims to prevent severe behavioural, emotional and developmental problems in children from birth to age 12 by enhancing parents' knowledge, skills and confidence. The enhanced intervention targets parenting skills together with other family adversity factors such as marital discord, depression and high levels of parenting stress. The aim is to provide highly accessible resources for parents, including newsletters, leaflets, loans of videotapes, and 'seminars' for parents to provide consistent, high-quality advice on parenting (Ralph, Sanders, 2003).

The project also provides training and accreditation to enable staff who come into regular contact with parents to provide clear advice and help to those who have difficulty with aspects of their child's behaviour. Referral routes have been specified to ensure that families with greater difficulties are seen by appropriately trained professionals. Triple P promotes positive, caring relationships between parents and their children and helps parents develop effective management strategies for dealing with a variety of childhood behavioural/developmental problems<sup>26</sup>. Programme principles include ensuring a safe, interesting environment; creating a positive learning environment; using appropriate discipline strategies; having realistic expectations, and taking care of oneself as a parent. The system is empirically proven to be helpful to families and is currently employed by health professionals internationally (Burley, Hayes, Martin, 2005). Implementation takes the form of provision of information and advice at a number of levels.

- Schools will distribute newsletters with parenting tips and information on help available to all parents
- Leaflets will be available in schools, and community centres (eg libraries)
- Videotapes will be available for parents to borrow from schools
- Short Triple P 'seminars' on parenting will be presented in schools by trained professionals, to provide advice on common behaviour problems
- Individual consultations will be available through Triple P trained professionals for parents requiring specific advice on a specific problem<sup>27</sup>

#### 5.2.2.1 Teen Triple P

Teen Triple P aims to specifically prepare parents for their child's transition to the teenage years by focusing on the common difficulties for children (and parents) of making a successful transition to secondary school. Schools provide a potentially convenient and appropriate community based contact point where parenting issues can be legitimately discussed (Ralph, Sanders, 2003).

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<sup>24</sup> The programme was developed by Professor Matt Sanders and colleagues from the Parenting and Family Support Centre of the School of Psychology at the University of Queensland, Australia.

<sup>25</sup> Level 1, Universal Triple P targets an entire population with the aim of preventing the development of adverse outcomes. Level 2, Selected Triple P targets specific sub groups of the general population who are believed to be at greater risk than others for developing a problem through primary care or community services. Level 3, Primary Care Triple P, is a more intensive, selection, preventative strategy targeting parents who have mild and relatively discreet concerns about their child's behaviour or development. Level 4, Standard/Group/Self Directed Triple P targets high risk individuals who are identified as having problems, but who do not yet meet the diagnostic criteria for a behavioural disorder. Level 5, Enhanced Triple P is designed for families who are experiencing ongoing child behaviour difficulties after completing a less intensive Triple P level, or who may have additional family adversity factors such as parental adjustment difficulties and partner support difficulties.

<sup>26</sup> <http://www.psych-sci.manchester.ac.uk/research/projects/ppp>

<sup>27</sup> <http://www.psych-sci.manchester.ac.uk/research/projects/teenppp>

Teen Triple P can be delivered universally; as an indicated prevention program for teenagers; and also as an early intervention program for those who meet diagnostic criteria with the aim of preventing progression of problem behaviour. This level of intervention can target parents of individual teenagers thought to be at risk or an entire population as a preventative approach to risk reduction (Ibid., 2003).

Group Teen Triple P is an 8 session program, optimally conducted in groups of 10 – 12 parents. It employs an active skills training process to help parents acquire new knowledge and skills. The Programme consists of four two hour group sessions that provide opportunities for parents to learn through observation, discussion, practice and feedback. Parents receive constructive feedback about their use of skills in an emotionally supportive context. Following the group sessions, four 15 – 30 minute follow up telephone sessions provide additional follow up support to parents. The benefits of the group rather than individual sessions include support, friendship, constructive feedback from other parents as well as opportunities for parents to discuss and learn through peer interactions (Ibid, 2003).

An evaluative post course completion follow up study found<sup>28</sup>:

- Parent teenager conflict as reported by parents was reduced significantly post treatment.
- Parental laxness and over reactivity improved significantly post treatment.
- Parents reported significant improvements following group treatment on measures of self efficacy, self sufficiency, and self management, but not on personal agency.
- Parents reported a significant reduction on disagreements over their parenting strategies post treatment.

(Ibid., 2003)

The evaluation also found group facilitators reporting anecdotal evidence that most parents enjoyed participating in the group program and parents also reported good consumer satisfaction indicating that the program was appropriate for them helped them to achieve their goals.

### *5.2.3 Mellow Parenting*

Mellow Parenting<sup>29</sup> is a 14 week one day a week group designed to support families with relationship problems with their infants and young children. It combines personal support for parents with video and direct work with parents and children on their own parenting strategies, and has proved effective in recruiting and engaging hard-to-reach families with a variety of problems<sup>30</sup>. The programme aims to empower parents, to find better ways of relating to their children and focuses on families with children under 5 who are experiencing relationship problems with their children<sup>31</sup>.

The programme combines personal group therapy with parenting support using behaviour modification principles. By agreement, videotapes record parent/child interactions in the home, which are then used as an aid to group discussions. The programme has shown lasting

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<sup>28</sup> Findings are based on 25 parent who had participated in the Triple P programme. Parents were contacted through their child's high school in QLD (located in a socio-economically disadvantaged region) and had participated in the parent programme.

<sup>29</sup> The Mellow Parenting organisation does not directly run groups itself but trains professionals to run the group according to the model. It was developed by a group of professionals with psychology and social work expertise: Christine Puckering, Maggie Mills, Tony Cox and John Rogers. It is administered through the Association for Child Psychology and Psychiatry.

<sup>30</sup> <http://www.mellowparenting.org/>

<sup>31</sup> <http://www.northamptonshire.gov.uk/child/family/ParProg.htm>

gains in maternal well being, parent-child interaction, child behaviour, development and mother's effectiveness and confidence in parenting. Changes were sustained over an 18 month period. In the UK, the programme improved parenting on several dimensions. Negative interaction as evaluated on videotapes dropped threefold and 80% of the parents involved were able to come off the local Child Protection Register (Scott, 1998).

#### *5.2.4 Strengthening Families Programme (SFP)<sup>32</sup>*

The Strengthening Families Programme targets parents and children aged 10 – 14. It is a universal, family-based intervention programme which enhances parents' general child management skills, parent-child affective relationships, and family communication. Based on a developmental model, it assumes that increasing the family's protective processes while decreasing its potential risk factors can alter a child's future, so that problem behaviours can be reduced or avoided. The program also seeks to delay the onset of adolescent alcohol and substance use by improving family practices.

In the seven-week intervention programme, parents and children learn individual skills and are then brought together to improve family communication and practices.

- During the parent training sessions, held in groups with an average of eight families, parents are taught to clarify expectations of children's behaviour, especially substance use; utilize appropriate and consistent discipline techniques; manage strong emotions concerning their children; and use effective communication.
- In the child sessions, adolescents learn similar skills, as well as peer resistance and refusal techniques; personal and social interaction skills; and stress and emotion management.
- In the combined parent and children classes, families practice conflict resolution and communication skills, and engage in activities designed to increase family cohesiveness<sup>33</sup>.

Both post-test evaluations of family processes and follow-up studies of individual substance use have demonstrated positive effects for families and adolescents, compared to control groups. In addition, post-test participants showed:

- Improved child management practices, including monitoring, discipline and setting of standards;
- Increased parent-child communication;
- Increased child involvement in family activities and decisions; and
- Strengthened family affective quality.

One- and two-year follow-up studies revealed that participating adolescents had:

- Lower rates of alcohol initiation at both follow ups; and
- 30-60% relative reductions in alcohol use, using without parents' permission, and being drunk<sup>34</sup>.

In 1993, Project Family in the US conducted an experimental test of the IFSP with 442 families in areas with a high percentage of economically disadvantaged families. All families were video taped during structured family interactions in their home and completed extensive survey forms before and after the programme. Data revealed significant gains in targeted behaviour. For example, youth whose families took part in the programme were more likely

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<sup>32</sup> Formerly, the Iowa Strengthening Families Program (ISFP)

<sup>33</sup> <http://www.colorado.edu/cspv/blueprints/promising/programs/BPP18.html>

<sup>34</sup> <http://www.colorado.edu/cspv/blueprints/promising/programs/BPP18.html>

to associate with appropriate peers than those from non participating families. Positive gains were sustained during one and two year follow ups.

#### 5.2.5 *MultiSystematic Therapy (MST)*

MST is an intensive support programme for young people aged 10 to 17 and their families targeting the multiple risk factors for delinquency and behavioural problems. Evaluation and replication in clinical and community settings in the US suggest that it is a particularly effective intervention for adolescents with behavioural problems, including anti-social behaviour, violent and chronic young offenders and is now being introduced in the UK<sup>35</sup>.

MST targets multiple factors and promotes approaches such as: encouraging young people not to spend time with peers who are a bad influence; building stronger bonds with family, school and other conventional groups; enhancing parenting skills such as monitoring and discipline; and developing greater social and academic competence in the young person. The approach views individuals as part of a complex network of interconnected systems that encompass individual, family and extra familial factors (school, peers and neighbourhood). Intervention may be necessary in any one or a combination of these areas<sup>36</sup>.

Individualised treatment plans are designed in collaboration with family members, and include addressing identified barriers to effective parenting such as parental mental health problems or drug abuse. MST also helps family members build social support networks and uses the strengths of these to bring about changes in behaviour. The programme is usually provided in the home, school and other community locations over a period of about four months<sup>37</sup>.

Evaluations of MST have demonstrated the following results for serious juvenile offenders:

- reductions of 25 – 75% in long term rates of re-arrest
- reductions of 47 – 64% in out of home placement
- extensive improvements in family functioning
- decreased mental health problems for serious juvenile offenders<sup>38</sup>

#### *Community Programs*

Community based interventions have also addressed both treatment and prevention. A number of programs have been developed, and focus on involving the youths in activity programs and providing training for those activities. The children are rewarded for attendance and participation in the programs. Examples include

### **5.3 Effective Targeting**

Parents may be anxious for help but unaware of how to find it and those who most need help are very often those who are unlikely to seek help voluntarily, however, this does not, nor should it, rule out intervention. For example, one of the major problems parenting support programs face is that they do not reach all the families that need support (Barton, Roman, Fitzgerald, & McKinney, 2002). This is a common phenomenon in early intervention programs: especially as parents with children at greater risk are less likely to participate in such programs (Prinz, 1994). So far, most support has been given to those families who happen to know about the available services or to families that belong to particular target groups with special needs (e.g., Llewellyn, McConnell, & Bye, 1998). Although several of the aforementioned projects did operate in socially deprived areas, there is an awareness that in many instances projects/programmes are unable to engage the least educated and more marginalised parents, who traditionally did not attend school events (Ralph, Sanders, 2003).

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<sup>35</sup> <http://www.literacytrust.org.uk/socialinclusion/children/support.html>

<sup>36</sup> <http://www.promoteprevent.org/documents/EBI/Multisystemic%20Therapy.pdf>

<sup>37</sup> <http://www.literacytrust.org.uk/socialinclusion/children/support.html>

<sup>38</sup> <http://www.promoteprevent.org/documents/EBI/Multisystemic%20Therapy.pdf>

The very first step in supporting parents whose children experience behavioural problems is through the provision of advice and information which will help them cope with the problem, access the supports they need and respond to the problem. Gaps in information provision impact upon parents' ability to use existing resources and services and to build social support networks (Riordan, 2001). Studies have shown that the principal sources of advice and information for parents are family and friends, followed by health professionals, teachers, and social services (Grimshaw & McGuire, 1998). Health and behavioural problems were the most frequently cited reasons by parents for seeking information from sources outside the circle of family and friends and in most cases parents turned to professionals, notably GPs, for advice in relation to medical and 'non-medical' concerns. In her evaluation of the Triple P Programme, Sanders (2003) found schools and community networks key in recruiting parents. Key contact points, in terms of the provision of advice regarding community supports for children who experience behavioural problems include local GPs, pre-school, primary and post primary schools and other contact points with which parents have regular contact. The Triple P project in Zurich included several strategies to maximize participation including subsidisation of childcare costs, the promotion of the programme to parents that may not have been successfully approached by other means of communication, personal contact with parents from minority groups to discuss the programme and implementation of the programme during the first year of primary school when parent interest in promoting and supporting their children was expected to be particularly high<sup>39</sup>. A similar strategy could be applied where implementation of parent supports parallels with the onset of secondary school commencement.

There is a clear challenge to be more successful with regard to recruitment and engagement of parents. In response to low recruitment rates, an assertive approach has been developed in the US, including home visits, meetings at the family's convenience, written contacts, and concrete problem solving as well as incentives such as free transport, crèche facilities, meals and prize draws (Kosterman, Hawkins, Spoth, Haggarty, Zhu, 1995). It is essential, when designing supports, to bear in mind how diverse a group parents are, and the subsequent mechanisms for recruitment and engagement must vary according to need, location, programme type etc.

Research has found parents involvement in projects is assisted by:

- active networks with schools, local agencies, and community groups;
- project workers skills, personality, persistence and empathy;
- the use of familiar environments for sessions;
- invitations addressed to the whole family;
- courses with a wider than the problem area (e.g. not specifically drugs, anti social behaviour);
- continued worker parent contact;
- flexibility to fit with parents' commitments; and
- the judicious use of news media.

(Vellerman, Mistral, Sanderling, 2000).

For example, the use of local newspapers, radio and television were believed to have been too brief prior to Triple P placement offers for parents in one region and it was felt that a more coordinated and sustained media promotion program would probably have helped to 'seed the ground' more effectively in terms of generating greater parental awareness and interest which could perhaps be translated into greater participation (Ralph, Sanders, 2003)<sup>40</sup>.

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<sup>39</sup> <http://www.z-proso.unizh.ch/Projekt/project.en.html>

<sup>40</sup> The author also highlights the urgent need for research to test this hypothesis as improved strategies for the engagement of parents clearly need to be part of any community-based intervention in the future.

Parents involvement in projects has been hindered by:

- social difficulties (including the extra financial and organisational difficulties of single parents);
- the location of the event and personal safety;
- lack of engagement with the school or community;
- lack of self-confidence;
- fear of being stigmatised as a parent of a drug user/violent child etc;
- lack of perceived need; and
- lack of project resources.

(Velleman et al., 2000).

#### **5.4 Strategic Issues for Consideration in Designing Support Services for Parents**

A key consideration in designing support services for parents of children with behavioural problems centres around tailoring services to reflect the needs of parents and children in that area. It is recommended that supports for parents include:

- assistance to communicate adequately with their children about what is happening and why (good communication between parents and children)
- provision of help for their own distress (supportive and appropriate parenting)
- support for and information about parenting (reduction/minimising parental distress)
- information about and opportunities for developing skills for containing and managing conflict (minimal conflict and no involvement of children in parental disputes)
- encouragement to foster regular contact for children with extended families on both sides, and with children's friends (optimal living and visiting arrangements for children)
- help to make arrangement for the future, including encouragement to foster involvement of parents in their children's lives (successful fostering of children's relationship with other parent and wider kin).

(Hawthorn, Jessop, Pryor, Richards, 2003).

It should also be noted that the group aspect of programmes, which provided parents with an opportunity to liaise with parents experiencing similar difficulties was consistently praised by programme participants and often listed as one of the key and most beneficial aspects of the programmes.

*What to bear in mind when considering approaches to supporting parents.*

By asking fundamental questions at the beginning of a service, and involving those who are likely to benefit, a different and more effective approach to delivering services may emerge. Fundamental questions include:

- Who are we aiming to reach?
- How do parents/ children gain access to the programme?
- Questions of privacy and confidentiality also arise as there may be some stigma attached to children's attendance at programme.
- What are the aims of the programme and are they specified to users?
- Does the choice of programme match what we are trying to achieve?

- Does the programme content reflect its aims?
- Are the aims of the programme based in research?
- Are trained personnel involved?
- Is the programme age appropriate?
- Is the programme culturally and religiously appropriate?

### **5.5 Focus on Child Also**

Services which directly address the needs of the child are also pivotal, if child behavioural problems are to be effectively addressed, treated, and resolved. For example, a 2000 – 2001 UK study on services and interventions for children of parents who have/are separating found that in line with the predominant ‘caretaker’ view of childhood, many of the traditional support systems operated via parents and other adults on the assumption that their benefits will flow through children. The impact on children of programmes designed for parents is therefore indirect and mediated by parents. While research suggests that children may benefit from interventions that help to improve adult relations, children still have separate needs for support (Hawthorn et al., 2003). Gomby and colleagues (1999) reported that most home visiting programmes try to benefit children indirectly through changes in parents’ behaviour, rather than directly through interventions with the children and argue that it is not surprising, then, that the outcomes of home visiting programmes for children’s general health and development are not as positive as the outcomes for parents (Gomby et al., 1999). International research on models of best practice in reducing and effectively responding to the behavioural problems of children within families incorporated, at least, a two pronged response of support for parents and the children (some cases also included wider reaching community supports).

Tony Bates, CEO of Headstrong<sup>41</sup> recently outlined a 5 step plan for Irish society to adopt in improving youth mental health. The plan proposed (1) involving young people, (2) supporting families, (3) working together, (4) acting early and (5) investing in change<sup>42</sup>.

For adolescents, community based, attractive, accessible drop in centres may be used as a vehicle for engaging with adolescents at risk or in the early stages of developing mental health difficulties. Adolescents want accessible, user friendly services, specific to their needs. Young people say they are least likely to approach adults/professionals when they have problems and are more likely to depend on peers. Family doctors, school staff, JLOs may all play a role in helping adolescents engage with programmes, especially where they use evidence based approaches for working with families to engage young people in treatment, such as those which have been shown to work in cases of adolescent substance abuse (Dept. of Health & Children, 2006).

It is therefore essential to recognise that in addressing the support needs of parents of children with behavioural problems, a simultaneous/parallel response to the needs of children who exhibit behavioural problems is essential. Such a strategy has resonances of a children’s rights approach to service planning, a primary commitment from the National Children’s Strategy.

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<sup>41</sup> Headstrong is a new initiative to ensure that young people in Ireland aged twelve to twenty five are better supported to achieve mental health and well being. Headstrong works with others to improve services for young people and to reduce the stigma about mental health issues. Headstrong’s goal is that the normal experience of a young person encountering problems with their mental health is that they will be able to speak openly about how they feel and to get the support they need when they need it.

<sup>42</sup> [www.headstrong.ie](http://www.headstrong.ie)

## SECTION SIX:

### SUMMARY OF KEY FINDINGS & RECOMMENDATIONS

#### Overview:

- The spectrum of child behavioural problems varies from very mild to clinically problematic, and their definition and nature expand beyond the term 'behavioural problems' to incorporate mental/psychological and emotional health problems. Often the behavioural problem is a manifestation of a deeper emotional/mental health problem. The most prevalent types of disorders disclosed in children in Ireland are, emotional disorders, oppositional, defiant and conduct disorders, attention deficit disorder, with or without hyperactivity, major psychiatric disorders, developmental delay and autism, eating disorders and anti-social behaviour e.g. drug and alcohol abuse.
- It is estimated that a fifth of the child and adolescent population may suffer from psychological problems at any given time. A 2004 Irish study found 17% of two to five year olds, 10% of six to twelve year olds and 26% of 13 – 18 year olds screened positive for a mental health problem (Cummins, McMaster, 2006). Almost half of these (43%) had an anxiety disorder, a quarter had oppositional defiant disorder and just over a fifth had ADHD.
- Research suggests two key entry points in the development of behavioural problems – early childhood and early adolescence with potentially different risk factors associated with each (Bartusich, Lynam, Moffitt and Silva, 1997). The most significant age difference is that ADHD is more common amongst children, while conduct disorder is more common amongst adolescents (Martin & Carr, 2006).
- Early behavioural disturbance has been cited as one of the strongest predictors of later problems, including psychological difficulties, involvement in crime and antisocial behaviour (Rutter, 1989; Kolvin et al. 1990). Children who exhibit particularly high levels of externalising behaviour problems early in their lives are at high risk for intensifying to lying, bullying and fighting in middle childhood, and more serious behaviours such as cruelty to animals, vandalism and aggressive criminal behaviours in adolescence (Hann, D., Borek, N., 2001).
- Adolescence is a key stage of life development when children require an understanding of life challenges they face and need to develop basic skills to cope with difficult emotions. It is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders, and substance misuse becoming more prevalent, as well as an increasing risk of deliberate self harm and suicidal behaviour (Department of Health & Children, 2006).
- Some young people begin to exhibit problem behaviours during early adolescence. In such cases, entry into conduct problems generally occurs through associations with peers. However, placing too much emphasis on peer pressure, may lead parents to underestimate their own influence on children, which, though it varies at different ages, has been shown to affect young people's long term behaviour (Oyguard et al., 1999).
- Risk factors for behavioural problems include maternal factors (age of mother, smoking/alcohol consumption during pregnancy, maternal stress), family factors and processes (parent's relationship status, parenting approach, family income, family

history of problem behaviour) and the community (neighbourhood, peer influences and school).

- For every risk factor, an increased exposure to risk is found to relate significantly to an increased likelihood of reported involvement in problem behaviour. Conversely, the more young people are exposed to protective factors, the less likely they are to report taking part in antisocial activities (Beinart, S., Anderson, B., Lee, S., Utting, D., 2002). Protective factors directly reduce a risk, buffer an individual against the effects of a risk, disrupt the mediating factors associated with the risk and prevent the initial occurrence of the risk factor (Cummins, McMaster, 2006).

### **Assessment and Intervention**

- Early identification of behavioural difficulties and early implementation of family support programmes promote better mental health outcomes for children at risk of behavioural, emotional and mental health problems. In Ireland, childhood emotional, developmental disorders, behavioural problems and mental illness are under recognised and often remain untreated. This under recognition may adversely affect the child's behaviour, emotional well being and educational attainments, as well as affecting family, friends and society at large (Cummins, McMaster, 2006).
- Currently, secondary and tertiary services are inequitably distributed across the country, not all teams are fully resourced and some geographical areas lack provision altogether. Waiting lists are often long, a situation which is not unique, even in developed countries. There is consequentially a need to develop alternative approaches to reduce the prevalence of child and adolescent mental health problems and to provide assistance and support as early as possible where problems arise. The earlier support is accessed the better.
- There are a wide range of community care services that deliver care at primary level in the community. Less intensive interventions are usually offered within a primary care context initially and only if youngsters do not respond to these, should more intensive interventions be offered, or referral made to secondary or tertiary services (Martin, Carr, 2005).
- A particularly successful means of supporting families is to focus on parenting behaviour. Mental health problems can have a significant and adverse impact on children, adolescents, parents and families. It is therefore important that interventions provide broadly based help for the parents and families of young people with problems as well as the young people themselves (Sawyer et al., 2000).
- Parent behaviour can set the stage for children to develop and use coping skills that make them more resilient, or conversely can place children at risk for problems (Blout, 1989). Preventative work with families has been identified by numerous sources as the most effective means of avoiding severe long term problems (Pugh et al., 1994; Kamerman & Kahn, 1993). The development of effective parenting skills has been considered as the primary mechanism for change in child conduct disorder, through the reduction in the severity, duration and manifestation of the disorder<sup>43</sup>.

### **Recommendations for Supporting Parents**

- Parents of children with behavioural difficulties bear a heavy burden and stress and depression as well as familial and marital discord often develop. Great emphasis has

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<sup>43</sup> <http://www.adhd.com.au/conduct.html>

been placed on programmes which address parents' situation and needs. Treatments must take account of the fact that parents and family members suffer considerable burdens and stresses even while the behaviourally disturbed child is of pre-school or primary school age. A central issue relating to treatment is how it affects the family as a unit, and what kinds of benefit are obtained (Morch et al., 2004).

- Family disorganisation and lack of knowledge or motivation may prevent young people with psychological problems and their families from proactively engaging with health and/or other support services. Community based, attractive, accessible, evidence-based training programmes may be used as a vehicle for identifying children at risk, and engaging with families of children with mental health problems. With young children, engagement should target parents. With adolescents, services may directly target teenagers, as well as their parents. A variety of professionals, including family doctors, PHNs, pre school and school staff may all play a role in helping parents engage with such programmes.
- The age of the child will very often affect the type of support required by parents of children with behavioural problems.
- Research indicates that parenting programs have been positive, with significant changes in parents' and children's behaviour and parental perception of child adjustment. Research suggests that parents who have participated in parent training programs are successful in reducing their child's level of aggression by 20 - 60 %<sup>44</sup>.
- Model programmes with proven results include the Webster Stratton Incredible Years Programme, Positive Parenting Programme, Mellow Parenting, Strengthening Families Programme and Multi Systematic Therapy.
- Evaluations of these and other programmes have highlighted several factors which parents reported as beneficial in supporting them in coping with their child(ren)'s behaviour. These include:
  - The group dynamic of several parenting programmes: parents found it very encouraging to meet other parents who understood the problems they faced with their child. It was a great benefit to be able to talk honestly and openly about the difficulties they had to deal with, in a supportive group environment.
  - The qualities of group leaders: parents were generally *very satisfied with group leaders* and were most impressed with what they perceived as the leaders' positive personal qualities including warmth, optimism, enthusiasm, supportiveness, attentiveness and humour.
  - Programme content: assistance to communicate adequately with their children about what is happening and why, provision of help for their own distress, support for and information about parenting, opportunities for developing skills for containing and managing conflict, encouragement to foster regular contact for children with extended families on both sides, and with children's friends and help to make arrangement for the future, including encouragement to foster involvement of parents in their children's lives (Morch et al., 1999).
- Follow up studies also highlighted the following factors which parents believed would be of benefit in future programmes:

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<sup>44</sup> <http://www.adhd.com.au/conduct.html>

- Maintenance of small group sizes: in designing programmes, small courses of no more than ten parents were thought to be most effective. This is because they encouraged more open communication and involvement.
- Follow up booster sessions: where these excited parents specifically noted their benefit and where they did not, many expressed a desire for follow up or ‘booster’ sessions (Morch et al., 1999).
- One of the major problems that parenting support programs face is that they do not reach all the families that need support. There is a clear challenge to be more successful with regard to recruitment and engagement of parents. A key point of contact, therefore, in terms of the provision of advice regarding community supports for children who experience behavioural problems is through local GPs, pre-school, primary and post primary schools and other contact points with which parents have regular contact. In response to low recruitment rates, an assertive approach has been developed in the US, including home visits, meetings at the family’s convenience, written contracts, and concrete problem solving as well as incentives such as free transport, crèche facilities, meals and prize draws (Kosterman, Hawkins, Spoth, Haggarty, Zhu, 1995).
- It is recommended that supports for parents include:
  - assistance to communicate adequately with their children about what is happening and why (good communication between parents and children)
  - provision of help for their own distress (supportive and appropriate parenting)
  - support for and information about parenting (reduction/minimising parental distress)
  - information about and opportunities for developing skills for containing and managing conflict (minimal conflict and no involvement of children in parental disputes)
  - encouragement to foster regular contact for children with extended families on both sides, and with children’s friends (optimal living and visiting arrangements for children)
  - help to make arrangement for the future, including encouragement to foster involvement of parents in their children’s lives (successful fostering of children’s relationship with other parent and wider kin).  
(Hawthorn, Jessop, Pryor, Richards, 2003)
- Services which directly address the needs of the child are also pivotal, if child behavioural problems are to be effectively addressed. The impact on children of programmes designed for parents is necessarily indirect and mediated by parents. It is therefore essential to recognise that in addressing the support needs of parents of children with behavioural problems, a simultaneous/parallel response to the needs of children who exhibit behavioural problems is essential.

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