Severe Conduct Disorder Conference

# WHĀNAU AS A MODEL FOR EARLY INTERVENTION IN CONDUCT DISORDERS

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## Prevention

*Three Levels of Prevention*

Three levels of prevention can be applied to mental health. Using a public health model, Caplan identified primary, secondary, and tertiary levels of prevention.[1] Importantly distinctions were made between absolute prevention and the prevention of unnecessary deterioration in health. Absolute prevention of an illness or disease occurs when the aetiology is well understood and interventions can be applied before there is any sign of the condition. The more complicated the cause, the less likely is absolute prevention. The three levels of prevention are useful in identifying goals and establishing reasonable service objectives.

Programmes of primary prevention aim to avert the emergence of a disease or disorder. The approach is generally directed at a whole population (e.g. mass vaccination for children to prevent meningitis). In mental health, primary prevention is an ambitious aim, given the interaction of so many risk factors. At a population level total prohibition might be one method of eliminating alcohol related problems, and at an individual level complete abstinence from alcohol and drugs would have a similar effect. But neither strategy would be acceptable in most western societies. On the other hand, national policies in relation to alcohol play an important function in either increasing or decreasing alcohol misuse. Polices and programmes that place limits on alcohol availability have been shown to have the greatest potential to reduce health related consequences of alcohol.[2]

Instead of trying to prevent the emergence of a health problem, secondary prevention aims to reduce the impact of disease by early intervention. The impact of congenital dislocation of the hip for example can be greatly minimised if the problem is detected in infancy and treated promptly. In mental health areas, early treatment of most disorders will reduce their subsequent impact. For alcohol related disorders, however, one school of thought maintains that early intervention will not be effective

as it is necessary to reach 'rock bottom' before recovery can occur. Most modern practitioners do not hold to that view and have argued strongly in favour of intervention at the primary health care level when evidence of alcohol misuse are first manifest . In fact there is evidence that early, brief interventions may have greater effectiveness than the more intensive programmes.[3]

Where a disease or disorder already exists, maximum return to normal functioning is the aim of tertiary prevention. Although a condition may not be preventable then its disabling effects can at least be ameliorated through effective rehabilitation. Insufficient knowledge about causative factors of schizophrenia, for example, means that the disorder cannot be prevented. But socialising programmes can reduce the level of isolation and detachment that might otherwise occur.

Rather than aiming a preventive programme at a whole population, many mental health programmes adopt a targeted approach by identifying the sub-population most at risk (for developing a particular disorder) and then focusing on it. Targeted approaches have elements of both primary and secondary prevention. On the one hand they are attempting to prevent a problem from arising, but on the other they are addressing a group who may already have early signs of a health problem. These two approaches, often used together, have been shown to have some impact on conduct disorders. *Universal interventions* are those that involve total populations (such as all students in a classroom) including those who do not have conduct disorder (a primary prevention method) while *indicated interventions*, are administered to those who show very early signs of conduct disorder (a secondary prevention strategy).[4]

In practice, most New Zealand mental health programmes, broadly defined, in relationship to conduct disorders is focused on tertiary prevention i.e. attempting to reduce the impacts of the disorder made especially obvious by significant harm to others such as assault with a deadly weapon, forced sex, and aggravated robbery. The natural history of the disorder, however, is for an escalating pattern of offending, often with roots in the first five years of life. Because tertiary prevention of conduct disorders is expensive, often ineffective, and too late to prevent irreparable damage to others, including family, there is increasing interest in other types of prevention. Now

there is also evidence that early intervention programmes that target aggressive and non-compliant behaviour in children can reduce delinquency later in life.[5]

**Māori Over-representation**

Western diagnostic systems are dependant on the norms of accepted society. Those norms may not always align with the norms of populations who hold different world views and unless reference is made to those other standards, an inappropriate diagnosis may be made. Misunderstandings and mis-diagnoses are more likely to occur where ethnic minorities have been 'absorbed' into wider society, either through urbanisation or immigration.[6] Conduct disorders for example may be diagnosed in situations where oppositional behaviour is a 'normal' reaction to perceived threats or where it is a learned survival strategy in an environment that is largely seen as hostile.[7] Nor is it necessarily a case of individual over-reaction. The parameters of conduct disorders reflect a two-way interaction between individual behaviours and societal standards and values. People may 'expect' those from other ethnicities or cultures to show anti-social behaviour while members of those ethnicities may simply react to defend their own space or sense of identity – a form of culture shock.[8] Further, the two-way interaction can sometimes be seen in the social breakdown in some African-American neighbourhoods in the USA and the subsequent loss of economic parity, leading to disillusionment and ambivalence about socialising children to conform to a society that rejects them because of race.[9] Aggressive or disobedient behaviour may be covertly encouraged.

Notwithstanding the difficulties of imposing any classification system on cultures where abnormal behaviour is viewed from different perspectives, for whatever reason there is evidence that Māori are over-represented in admissions for conduct disorders and are more likely to enter the youth justice system.[10] Although few estimates of mental disorders at national or local levels have been made, a Christchurch cohort study among eighteen year olds concluded that the prevalence of mental disorders among Māori youth was exceptionally high.

Using the Composite International Diagnostic Interview supplemented by the Self Report Delinquency Instrument, the mental health state of 115 Māori eighteen year olds was assessed. Higher risks of disorder than non-Māori on all measures of disorder were shown. Overall 55 percent of Māori met criteria for at least one disorder in comparison to forty-one percent of non-Māori. Māori males emerged as the group with the highest rate of disorder attributable to the elevated rates of conduct disorder and substance abuse disorders.[11] Moreover, few people with disorders had accessed any formal treatment. The Christchurch study also failed to demonstrate a strong causative link with socio-economic conditions. Instead the strongest predictors of disorder related to the individual's immediate social environment (family, school, peers). As a consequence it was considered that attempts to reduce rates of disorder in Māori adolescents should focus on the development of integrated and multi-compartmental prevention programmes that could address school, family and social factors with culturally appropriate interventions.

**Barriers to Early Intervention**

Although there is now considerable evidence to support secondary prevention of conduct disorders, there are a number of barriers to early intervention. Attitudinal barriers include a mind set that equates oppositional or defiant behaviour with poor moral development; it is dismissed as 'naughty' or 'disrespectful' or a sign of inadequate parenting that ought not to be tolerated. In some populations, behaviours that constitute conduct disorders may be normalised – as a common aspect of culture or a normal part of growing up.[12] Alternately they may be construed as racial vulnerabilities. Studies in New Zealand have shown that the public and the police for example are likely to show increased vigilance towards Māori youth, expecting them to show oppositional or aggressive behaviour, and in the process perpetuating the prejudice.[13]

Information and knowledge barriers also reduce the prospects of early intervention. Parents are often at a loss to understand or respond constructively to oppositional behaviour and may be ashamed to admit feelings of inadequacy. Importantly, if the behaviour has been normalised, it may not occur to seek help and in any case parents may not know which agency could provide appropriate advice. Māori parents are generally reluctant to discuss emotional or behavioural problems with their doctor and

may depend on older relatives who in turn may rely on moral explanations that discourage professional involvement. An inability to distinguish between conduct disorders and other forms of offending or behavioural patterns will also result in a one-size-fits-all approach that fails to recognise the value of a differentiated approach based on developmental needs and opportunities for long term behavioural gains. Front line agencies providing support and advice to families with young children should be especially proficient in recognising abnormal behaviours that are amenable to early interventions.

For very young pre-school children a further obstacle to early intervention is the lack of expertise in local communities. Although schools have access to educational psychologists and special education advisors, there are long wait times and many early childhood facilities have no arrangements in place for expert consultation or even informed opinion. Child and adolescent mental health facilities in New Zealand are stretched and for the most part are necessarily concerned with the most severe problems, referred well after early signs and symptoms have appeared. In contrast the management of conduct disorders receives relatively little attention from psychiatrists.[14] Early intervention has not been a high priority. Resources in New Zealand mental health services are generally skewed towards tertiary prevention, the treatment of illnesses rather than behavioural problems, brief interventions, risk containment rather than promotion of competence and an emphasis on individual 'cure' rather than the promotion of 'coping' competencies.

Apart from resource barriers, a sectoral approach to child and adolescent wellbeing has created silo barriers. Linkages between schools, whānau, health services, the courts, statutory welfare agencies, and community family services are not well established and are often complicated by quite different philosophies and modes of practice. Research in New Zealand and abroad, however, has confirmed the importance of inter-agency and inter-disciplinary collaboration especially for child and adolescent externalising disorders and where early intervention is the goal.[15]

**Models of Early Intervention for Conduct Disorders**

A number of related models for interventions with children and adolescents who show conduct disorders have been promoted. Multisystemic Therapy (MST) for example

has been proposed as an appropriate intervention.[16] It has been promoted in New Zealand as an effective way of managing young people who are still living at home with their families or caregivers and employs cognitive behavioural and family interventions. Based on nine principles, MST addresses the wider social environment of the child or adolescent and has a particular focus on the ecology of interconnected systems. Behavioural changes occur by using existing strengths in each system to facilitate change. Specific well defined problems are targeted and the interfaces between multiple systems provide sites for interventions.[17]

The EARLY ALLIANCE intervention programme is similarly focussed on the social context. It employs four interventions: a classroom programme, peer intervention, Reading mentoring, and family interventions (including parenting and support components).[18] Four conceptual themes run through every intervention: enhancement of coping strategies, recognition of success, positive relationships, positive communication between home and school.

Linking the Interests of Families and Teachers (LIFT) was an intervention designed for elementary school children and their families living in at risk neighbourhoods. It incorporated a school component, a school-parent communication component, and a parent component.[19] The overarching focus of intervention was on the reactions of members within each social domain to children's positive and antisocial behaviours and a combination of support, skill acquisition and problem solving was systematically applied. A five year follow up of children who had been involved in either classroom interventions or school-family interventions showed that both groups sustained greater improvements than controls though the classroom group did slightly better.[20]

Paiheretia is an amalgam of several Māori approaches to counselling. It identifies cultural identity as an important element of mental health and using cultural pathways, suggests interventions that simultaneously facilitate access (to whānau, services, facilities), guide encounters (especially those that are linked to te ao Māori – the Māori world) and promote understanding. Improved relationships and the adoption of integrated and adaptive behaviour are important goals.[21]

While each model has its own characteristics and emphases, they have common themes. In addition to early identification, an ecological approach is a major rational in all four models. Rather than treating a child or adolescent in isolation of a social context, as much attention is given to the caretakers and to the societal institutions that make up much of child's world. Unlike conservative therapeutic models where there is an intensive exploration of individual emotions, thoughts and fantasies, early intervention paradigms are more concerned with actual relationships and the creation of opportunities for gaining greater competence. Typically positive development is encouraged through multiple individual domains such as affect, social engagement, and cognitive competencies and multiple contexts such as families, whānau, schools, peer groups, and community. Cultural relevance becomes an important issue since successful engagement of whānau or individuals in early intervention programmes can depend on cultural congruence with the therapist.[22]

**A Whānau Based Intervention Model**

The use of whānau as a model for intervention with Māori has been applied in several fields including education and the delivery of social services such as health. Te Whānau o Waipereira for example employed a whānau concept to bring together its diverse Māori households and to provide services within the spirit of family mutuality.[23] A whānau model of education and schooling has also been described. It incorporates collective ownership, shared values, recognition of the authority of elders, and the reinforcement of whānau values through the curriculum.[24] The whānau model is widely employed in kura kaupapa Māori (Māori language immersion schools).

The whānau metaphor might similarly be applied to early intervention programmes for Māori with conduct disorders (Table 1). The 'whānau comprises the child (or adolescent), the principal caregivers, other family members, the school or early childhood centre, and peer groups. In addition it includes the primary health care team, education sector specialists (e.g. special education advisors) and whānau therapists.

Whānau therapists might come from a range of disciplines or agencies such as SES, community health centres, Children and Young Persons and their Families Services

(CYFS), or kohanga, kura and other elements of the school system. But whatever background they will have skills and experience in recognising the early signs of conduct disorder (especially in pre-school children), understanding child development from social, psychological, cultural and biological perspectives, interacting with Māori families and with kohanga, kura kaupapa and other school settings, and will have close links with a range of community agencies used by Māori families, such as Māori health providers and CYFS. Whānau therapists will also be able to maximise engagement by drawing on tikanga, Māori communication styles, and culturally compatible interactions.

As with other types of early intervention, the aims of whānau programme are to reduce risk factors (e.g. parental discord, quality of parenting), enhance known protective factors such as family support, positive community experiences and home-school interaction, and assist in the acquisition of cognitive skills relevant to communication, language, problem solving. The therapist will act as an 'agent at the interface', mediating between systems while at the same time encouraging positive relationships based on a value system and broad approach that is shared by the entire 'whānau' as it might apply to the child in question.

However, a central task of the whānau therapist will also be the establishment of a kawa, a set of procedures to guide behaviour based on tikanga and values that are adaptive, positive and mutually reinforcing. Drawing on marae protocols but also the realities of urban living, the therapist will assist parties to agree on codes for living, for relating, and for acquiring skills and knowledge. An ecological approach will underline the importance of an environment that is consistent at least in the application of values and expectations concerning a particular child. Parents will exercise leadership in maintaining the kawa and with the help of the whānau therapist will play pivotal roles in assisting schools and other agencies to agree on the institution of a kawa in the classroom, playground or sports field.

The whānau-based early intervention programme would therefore consist of a range of intervention sites that make up the social environment: home, community, peer groups, schools or kohanga and a range of key tasks including early identification of conduct disorder (under five years, or early in childhood), the promotion of a shared

kawa relating to behaviour, child care and lifestyle, the acquisition of language and communication skills, a consistent approach to problem solving and positive relationship building.

Table 1 Whānau Early Intervention – Sites and Tasks

| *Sites of intervention*<br><br>*Main tasks* | **Home** | **Community** | **Peer groups** | **Kohanga, school** |
|---|---|---|---|---|
| Early identification | | | | |
| Establishment of a kawa | | | | |
| Language & communication skills | | | | |
| Consistent approach to problem solving | | | | |
| Relationship building | | | | |

**Preconditions for Early Intervention**

Early intervention requires different strategies and different skill sets from those associated with conventional individual therapy. First before early intervention can be effectively implemented there must be a capacity for the early identification of children who are at risk for conduct disorder or who are already showing early signs. Often the onset of CD is evident before five years of age and in any event is usually detectable before the onset of puberty. People working with children, including parents, need to know when behavioural patterns suggest CD. In turn, professional family workers in health, education or welfare should be attuned to the early signs of CD and able to alert families to the possibility.

Second early intervention requires a critical mass of trained therapists who can design and implement programmes, act as co-ordinators, and offer skilled advice on aspects of child development including the acquisition of language and communication skills. In order to address the circumstances of Māori children and their families, therapists

should possess the knowledge necessary to develop a kawa based on tikanga and relevant to urban environments. They must also be able to broker relationships between parents, within families, between home and school and with community agencies such as health providers.

**Policy Implications**

In order to effectively promote and implement quality early intervention programmes there will be implications for at least four policy areas (Table 2). First, a shift in priority from tertiary to secondary prevention will be necessary. Currently, mental health funding is heavily weighted towards tertiary prevention whereas early intervention is located at the primary and secondary ends of the prevention spectrum. Nor will early CD intervention programmes result in any less need for services for people with serious mental disabilities, at least not in the short term. It will therefore not be possible to provide for new programmes in primary and secondary prevention by redistributing existing mental health funds. New provisions must be considered.

Second, early intervention anticipates identification of CD before the disorder has reached sufficient severity to warrant specialist attention. In effect there will be a requirement for primary health care to have a more active interest in mental health, especially in the mental health of young children and adolescents. Typically, referral to specialist child and adolescent mental health facilities is late, and in any case facilities are limited. Rather than simply increasing the capacity and number of specialist services, an investment in primary mental health care for children, centred on Primary Health care Organisations would provide greater scope and reach.

Third, there are substantial implications for workforce development that will impact on the health, education and child care sectors. A particular challenge will be to ensure that PHOs, CYFS, and SES have a sufficient range of expertise to enable the early detection of childhood disorders and to initiate some action. Similarly, other community workforces that have dealings with children and families should be sufficiently au fait with the issues to recognise CD before it has become obvious to law enforcement officers. Educational training institutions may also reconsider priorities for training with a greater emphasis on early intervention rather than conventional therapies that are geared towards established patterns of disorder.

Fourth, while the focus on iwi development has been a useful way of generating economic returns for Māori and has played a significant role in Māori development over the past two decades, a specific focus on whānau development will be a more useful way of addressing the needs of Māori children in the future.[25] In this context whānau development will need to include opportunities for growing expertise in whānau relationship building, fostering effective parenting of Māori children, and providing clear pathways for young children who can benefit from preventative programmes. Within this framework, there is a place for increasing the skills of kohanga reo teachers, teachers at primary schools including kura kaupapa Māori and professional and community Māori health workers.

Table 2 Policy Implications

| Policy area | Responsibilities |
|---|---|
| Primary and Secondary Prevention<br>Resources and expertise | Education, Health, Justice, CYFS, Social Development |
| Primary Health Care<br>Inclusion of mental health role | Health, DHBs, PHOs |
| Workforce development<br>Training for early intervention | Education, Health, TEIs |
| Māori development<br>Whānau development<br>Whānau therapists | Te Puni Kokiri, MSD, Families Commission, Education<br>Kohanga Reo<br>Kura kaupapa Māori & schools sector |

**Outcomes**

Early intervention will not be a panacea but evidence suggests that it could play an increasingly important role in reducing the prevalence of serious conduct disorder in 'at risk' children by fostering improved relationships, increasing affective and cognitive competencies, and reducing the number of incidents that create entrenched attitudes, harm to self and others, and progressive loss of hope.

Finally it is possible to construct a Whānau Early Intervention Framework based on an early intervention strategy, interlocking strategies and policies, the national policy environment and best outcomes (Figure 1).

Figure 1 Whānau Early Intervention Framework

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