PROJECT EVIDENCE

PROJECT EVIDENCE for Prevention of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[2] Selective Programs are indicated for situations where subjects are at high risk of developing mental disorders unless there is preventive intervention.

[2 b] Psychological factors

i Children experiencing grief and loss

ii Children with disruptive behaviours

[2 b ii] Children with disruptive behaviours

The great majority of children show socially acceptable behaviour but a minority [1] show significantly disruptive behaviour. In general, children with seriously disruptive behaviour have less satisfactory school progress and social relationships than children with normal behaviour. [2] This tends to persist and result in poor educational outcomes, less stable partnerships, lower socio-economic levels and higher rates of involvement in welfare and justice systems. [3]

There are several degrees of disruptive behaviour disorders recognised by mental health services, with varying degrees of seriousness of outcomes and responsiveness to intervention. [4] The whole life trajectory of the young person is at risk. Research shows that early intervention can have major beneficial effects in improving the outcome as compared to children who are not helped. [5] In general, the earlier the intervention, and the less well-established the behavioural disturbance is at the time of intervention, the better the chance of satisfactory outcome. [6]

MHYFVic advocates early intervention in cases of disruptive behaviour disorders so as to reduce the likelihood of progression to Conduct Disorder and delinquency.

This project is aimed at identifying best practice models, summarising the evidence base for effective interventions and advocating implementation across the whole school system.

Promoting pro-social behaviour

Socially acceptable behaviour comes over a period of time through achievement of developmental tasks of impulse control, frustration tolerance, emotional self-awareness and self-control, understanding and acceptance of rules of conduct, consideration of rights of others, tactfulness and appropriate communication and assertiveness. [7] This is built on a platform of secure attachment to stable parenting figures who serve as appropriate role models and communicate clear standards of expected behaviour, consistent positive reinforcement of desired behaviour and discouragement of unacceptable behaviour. [8] This influence can be extended to other authority figures, such as teachers, with the support of the attachment figures.

The most powerful modifier of behaviour in the securely attached child is the approval or withdrawal of approval by the attachment figures. Weakening of any of these influences on social development can lead to emergence of disruptive behaviours that are naturally reinforced by the child gaining the intended results of the behaviour.

The aim of interventions in disruptive behaviour is to strengthen the positive social/emotional developmental processes, whereby it becomes more positively reinforcing to be approved of by others than by 'getting away with' the disruptive behaviour.

In relatively securely attached children this improved social development can be achieved by an enjoyable social learning experience accompanied by a child behaviour management program based upon 'behaviour modification' principles. [9] Consistency of management across school and home settings requires shared participation by teachers and parenting figures. These healthy, non-stigmatising approaches can be appropriately applied within a universal service system such as a regular school without the need for identification or formal referral to mental health agencies.

Research indicates that a high proportion of children who participate in an appropriate program show significant improvement in their social/emotional development and adaptive behaviour.[10] Hopefully, this behavioural improvement foreshadows an improvement in the life trajectory but this will require decades of longitudinal research to confirm. Children who are unable to respond, such as those who may have a damaged capacity for attachment, may need referral to specialist mental health professionals for assessment and therapy.

A pilot program for children with disruptive behaviour has been trialled in some Victorian state primary schools with significant success. [See 'casea description 2011' pdf] The program CASEA (CAMHS and schools early action) has been implemented in schools serviced by four metropolitan (Austin Health, Southern Health, Royal Children's Hospital, and Eastern Health) and four rural (Gippsland health, Bendigo Health, Ballarat Health, and North Eastern Health) mental health regions. The program involves a series of small group 'play sessions' in which the rules of social behaviour are explored and reinforced. The principles communicated in the sessions are carried over to the daily classroom activities. Concurrently, parent groups explore the principles of behaviour modification.

The research literature and results are published by the Mental Health Branch of the Victorian Health Department.[11]

Notes

1. Statistics

   Antisocial behaviours in primary aged children are fairly common and often are developmentally normal. However, when antisocial behaviours significantly interfere with a child's academic, social and/or emotional development the child may be at risk of developing conduct disorder.

   In 2000, a national survey examined child and adolescent mental health (Sawyer et al, 2000) and found that 14% or 500,000 children and adolescents in Australia have significant mental health problems, with rates in children the same or higher than rates in adolescents. More specifically it identified that delinquent behaviour (7%), attention problems (6.1%) and aggression (5.2%) are major mental health problems of Australian children (Sawyer, M.G. 2000).

   Information collected by the former Mental Health Branch (now the Mental Health, Drugs and Regions Division) in 2001 indicated that 17% of clients attending child and adolescent specialist mental health services (CAMHS) had conduct disorder with approximately half of these also having co-morbid emotional disturbance.

2. Evidence of poor progress

   To be further researched

3. Evidence of poor outcomes

   To be further researched

4. Diagnostic information

   Diagnostic statement of spectrum to be added.

   Three percent of children meet diagnostic criteria for conduct disorder — the most severe behavioural disorder in childhood and adolescence. "The essential feature of conduct disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated" (DSM IV 1994).

   There are four main groupings of these behaviours:

   • Conduct that is aggressive and threatens or causes harm to others, people or animals

• Conduct that is not aggressive and causes damage or loss to property
• Deceitfulness or theft
• Serious violations of rules.

Sanders, M.R. (2000) characterises conduct disorder by at least three of the following: pervasive and extreme anger, physical aggression, blaming others, destruction of property, lying, stealing, defiance, running away, cruelty to animals and other antisocial acts.

Conduct disorder is a disorder of social and psychological development, caused by interactions between biological, psychological and social factors. These may include socio-economic disadvantage, difficult temperament, early aggression, inconsistent and coercive parenting, attention and learning difficulties and poor problem-solving skills (Sanders, M.R. 2000; Hill, J 2002).

Conduct disorder is a serious problem in young people. It causes significant stress, not only to the young person who is a sufferer, but also to the family/carers, school and peers, and can eventually take its toll on the community. It is a disorder that is often not diagnosed until later childhood/early adolescence but signs of emerging conduct disorder can be identified at an early age. Unfortunately, children at risk of developing conduct disorder are often seen as wayward and naughty rather than as struggling with a disorder that needs identification and intervention.

5. Early intervention outcome study

Early intervention appears to be an important characteristic of programs known to be most effective in treating conduct disorders (Durlack JA, 1998 pp512-520). Data from well-controlled studies indicate that the optimal management of conduct problems in children needs to be based on an early intervention strategy, which emphasises the role of parent-child interaction factors in the development of conduct disorders. There is growing evidence that suggests added benefits when child-focussed and school-focussed interventions are included (Sanders, M.R. 2000).

Kenneth Dodge, in 2002, delivered a paper entitled 'Preventing Chronic Violence in Schools to a United States White House conference. In it, he raised concern about chronically violent and delinquent adolescents and their cost to society, estimated at US $1 .3million per criminal. Longitudinal studies indicate that high-risk children can be identified by the time they complete kindergarten and that chronic violence develops over a lifetime, depending on life experiences. Contributing factors may include harsh parenting styles, a lack of parental supervision, a history of abuse, and social and learning difficulties. Dodge piloted an early intervention program that produced positive results; the implementation of a universal program 'Fast Track` that delivered group training for children, parents and teachers with coaching, remedial education and home visits to support the changes. Dodge argued that if such a program cost US$40,000/child to deliver then there would be significant economic benefit if just 3 % of the children were saved from careers of crime.

Zubrick et al (2005) evaluated the effectiveness of a universal group behavioural intervention program (Triple P) in preventing behaviour problems in children. The intervention program was associated with significant reductions in parent-reported levels of dysfunctional parenting and parent-reported levels of child behaviour problems. Positive and significant effects were also observed in parent mental health, marital adjustment, and levels of child rearing conflict.

6. Factors influencing outcomes

To be further researched

7. Basis of social/emotional development

Additional reference notes to be added.

8. Basis of behaviour modification

A number of psychosocial strategies have been adopted in treating children with conduct disorders. AusEinet (Sanders, MR 2000) reviewed the literature to determine the most successful of these interventions. Only selecting

treatments on the strength of the available evidence from empirical research examining their efficacy, three main intervention modalities were highlighted:

a. Child-focussed interventions — interventions designed to improve children's capacity to regulate their behaviour. Several randomised controlled trials of the cognitive-behavioural models of intervention have been conducted which support the dominance of Cognitive Behaviour Therapy (CBT) approaches in producing therapeutic change. Evidence indicates that these approaches reduce behaviour problems, notably aggressive behaviour and increase pro-social behaviour (Sanders, NIR 2000).

It is worth noting that while there is increasing evidence to support the use of stimulant medication for children with ADHD who have co-morbid conduct problem behaviour, "...there is no direct controlled evidence that psycho-stimulants confer a therapeutic benefit for children selected with a primary diagnosis of conduct disorder" (Sanders, MR. 2000 p65).

b. Family/carers and/or Parenting interventions — interventions designed to improve parenting skills and relationships. A number of well-controlled trials have been conducted, evaluating the effectiveness of family/carers interventions for pre-school and primary aged children who are viewed to be at risk for developing later conduct and emotional problems. Many of these interventions focus on improving parenting and enhancing the child's social and cognitive development. According to the AusEinet findings, in the most successful early intervention programs for conduct problems, parent training forms a central focus for the intervention (Sanders, MR 2000).

c. School-based interventions — interventions designed to improve classroom and playground behaviour at school. School based interventions have been identified as a key component in the effective treatment of conduct disorders for school-aged children. These include teacher skill development, class wide interventions, curriculum-based interventions, individually tailored interventions, child focussed interventions, environmental interventions and multi-component interventions (see Sander, M.R. 2000 for further details of each component). There is growing evidence attesting to the effectiveness of a broad range of school-based interventions for improving the behaviour and academic achievements of children with conduct disorders. There is also good evidence for the effectiveness of child-focussed interventions (out of class, group-based) that provide social problem solving skills training to high-risk children.

Thus, the treatment of conduct disorder ideally includes interventions delivered at multiple levels, that is, interventions for the student, parents and school community. When this is delivered in an early intervention model it is best located in the early years of school, as this ensures increased accessibility and hopefully, if the program is accepted and normalized within the school curriculum, it will reduce the stigma of severe behavioural problems. The CAMHS & Schools Early Action Program (CASEA) adopts this multi-level intervention model and encourages services to form clear protocols for referral, service delivery and consultation.

9. Evidence of usefulness of BM in daily life

   Additional reference notes to be added.

10. Result of CASEA study

    A range of services are already in place to assist in the early identification of conduct disorders. Young children with challenging behaviours can be identified early on by a range of primary care and early years services including general practitioners, maternal and child health nurses and suitably trained child care and pre-school staff. If they have not been detected earlier, problems usually occur upon school entry.

    Primary schools are well placed as sites for early identification and intervention. Currently there are approximately 1250 government primary schools in Victoria. These schools are organised regionally into school networks that also incorporate a number of secondary and special schools. When children present with co-morbidity of behavioural and emotional symptoms, often within a complex family system, they may be referred to general practitioners, paediatricians or specialist Child and Adolescent Mental Health Services (CAMHS) if a more comprehensive assessment is required. An individual management and treatment plan would then be developed to provide the child and their parents with timely and appropriate intervention.

11. Research and results

Outcome findings to be summarised

Conclusion

MHYFVic advocates that proven initiatives of preventive mental health should immediately be made available in **all** primary schools and that research be undertaken for possible implementation in pre-schools. The future costs to the community of a behaviourally-impaired life trajectory can be immense, and the savings by a favourable improvement far outweigh the costs of the program. This is an extremely important health initiative not only because it can improve the life of individuals but also the lives of current and future families and friends.

References

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. (DSM IV) Washington DC, American Psychiatric Association, 1994

2. Commonwealth of Australia (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.*

3. Commonwealth of Australia *Fourth National Mental Health Plan* 2009-2014 (2009). Department of Health and Aging. Available online at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09

4. Commonwealth of Australia *National Mental Health Plan* 1992. Mental Health Branch, Department of Health and Family Services.

5. Dodge, K (2002) Preventing chronic violence in schools. United States White House Conference Paper.

6. Durlack, J.A. (1998) Primary prevention programs for children and adolescents are effective, *Journal of Mental Health*, 7, 5: pp463-469.

7. Hill, J. (2002) Biological, Psychological and Social Processes in the Conduct Disorders, *Journal of Child Psychology and Psychiatry* 43: pp. 133-164

8. Sanders, M.R. et al (2000), Early intervention in conduct problems in children in Kosky, R. et al (Eds) *Clinical Approaches To Early Intervention In Child And Adolescent Mental Health*, Australian Early Intervention Network for Mental Health in Young People, Vol 3, Adelaide.

9. Sawyer, M.G., Arney, F., Baghurst, P.A., Clark, J.J., Graetz, B.W., Kosky, R.J., Nurcombe, B., Patton, G.C., Prior, M.R., Raphael, B., Rey, J.M., Whaites, L.C. & Zubrick, S.R. (2001). The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. *Australian and New Zealand Journal of Psychiatry*, 35, 806-814.

10. The Victorian Department of Education & Training Program for Students with Disabilities Handbook 2006 (also available online at www.sofweb.vic.edu.au/wellbeing/disabil/index.htm)

11. Victorian Government Department of Education & Training. *Framework for Student Support Services in Victorian Government Schools* (1998) (also available online at www.sofweb.vic.edu.au/wellbeing/index.htm)

12. Victorian Government Department of Human Services *New Directions for Victoria's Mental Health Services: The Next Five Years* (2002) also available online at www.health.vic.gov.au

13. Victorian Government Department of Human Services, Mental Health Branch (2002). *CAMHS & Schools Report* (2004) (also available online at www.health.vic.gov.au)

14. Victorian Department of Premier and Cabinet (2001) *Growing Victoria Together*

15. Zubrick, S.R, et al (2005) Prevention of Child Behaviour Problems Through universal Implementation of a Group Behavioural Family Intervention. *Prevention Science*.

See also PE 1 c Education to Potential summary of Lyndale Project, or read the full account in downloadable pdf [Link] in /resources/Lyndale-Project-1.pdf

[Go to Best Practice Model BP2b ii]

[Go to Policy POL2b ii]

[Back to Index]

Last updated 24/12/2018