



Editorial

The application of the promotion, prevention and early intervention framework to severe Conduct Disorder*

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Chad was 12 years old when he was referred to a Child Guidance Clinic for supposedly interfering sexually with his younger sister. While paediatric examination assured the parents she was not damaged physically, Emily was distressed because she had tried to stop her brother's exploration, and he had rather roughly refused. Chad was hard to engage in an assessment. On the one hand obviously scared by being interviewed by police officers and child protection staff, Chad showed little remorse, and seemed unprepared to accept that he had done anything wrong, defiantly stating it was not his problem.

The parents were initially relieved to think they would get some help, but over the next four months found it hard to keep appointments, seemed reticent to accept advice or interventions from the two therapists working with the family, did not follow through with agreed homework, and became more and more abusive about what they saw as lack of progress in their son. The therapist working individually with Chad tried all sorts of ideas and techniques to interest him in changing his behaviour, but felt repeatedly like giving up, and was not-so-secretly pleased when the father terminated contact after one angry outburst.

Chad's problems did not just happen. The oldest of three children, labour was difficult and long, and he spent several days in a humidicrib after being born 'a bit blue'. Mum found it hard to like her new son, especially after he 'refused' to breast-feed. She complained that he cried frequently, did not sleep much, and was different to her friends' babies – he was late to crawl, stand and walk, did not seem to understand things, and could not put more than 2 words together until nearly 3 years old. He had frequent violent outbursts, breaking ornaments, smashing toys and banging his head repeatedly on the floor.

At kindergarten Chad was not much liked by the staff, and even less liked by some children whom he was seen to bully to get toys. The pattern continued at school with frequent complaints from parents of other children. He gained no close friends, was disruptive in class, and 'behind everyone in reading'. From the age of seven he stole objects from school, and ever increasing amounts of money – first from parents, then from others and, finally by the age of ten, from shops. He seemed always to be in trouble, had frequent accidents resulting from taking risks, and lit at least two known small fires in derelict buildings. Explanation, rewards,

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reprimands from teachers and at times the police, loss of privileges, 'time out', all seemed to have little impact. Beatings at home simply alienated him from his father.

Chad's parents sought help from many professionals over the years, but nothing seemed to work. They increasingly felt like failures, and saw Chad's abuse of his sister as just the end of a long string of difficulties they had been unable to manage. When troubles escalated over the next year, in desperation after a physical fight with Chad, the father physically threw him out of the house. Chad lived briefly with a friend's family, but after becoming more and more morose, he stole the father's car and drove it at high speed until a crash led to his death.

This is an extreme story based on true life – hopefully sufficiently disguised. What we can see here is a trajectory toward impending disaster, an accident literally waiting to happen. And much of the at times intensive therapy and other intervention toward the end seems to have made no corrective change. There is a paradox here. Over 60% of referrals to Child and Youth Mental Health Service are to do with behaviour problems ranging from opposition to parental control in small children, through to more serious problems of theft, property damage, violence, and fire setting. However, Mental Health Services are historically not very good at engaging young people like Chad or their families, and have limited skill, knowledge, time and energy to apply to the kinds of problem presented. We are good with depressions, the anxieties and to a certain extent the post traumatic states, but we find it hard to like conduct disordered young people, harder to keep them in any sort of therapeutic alliance, and almost impossible to bend the trajectory back to something more socially acceptable.

So where could intervention have produced consistent change? If we step backward through Chad's life story using our preventative framework, the first question relates to case management – can better and more comprehensive intervention make change? There is now an extensive literature on secondary and tertiary prevention in conduct disorder. Correctional approaches appear to make little

difference (Whitehead & Lab, 1989), and some programs like 'Scared Straight' can even make the situation worse (Petrosino Turpin Petrosino, & Finckenaue, 2000). However, despite the fact that conduct disordered young people frequently drop out of therapy (Bennett & Offord, 2001), intensive family and parenting interventions have a positive impact (Bruce, 2002). More specifically, approaches like multisystemic therapy (Henggeler, Cunningham, Pickrel et al., 1996), while resource intensive and costly, seem to be effective (Woolfenden, Williams, & Peat, 2002).

What stands out from Chad's history, however, is that many opportunities for early intervention were missed. While there might have been the very best of perinatal care, attachment with mother could have been assisted to improve, as could the poor affect regulation seen in the early rage attacks. We know that these two issues underpin the development of empathy (Saltaris, 2002), a central issue in later conduct disorder (Frick, Cornell, Bodin et al., 2003). Development delays are clear indicators of need for intensive intervention, and flag the later learning problems. The social and educational difficulties in kindergarten were noted but no remediation was advised to the parents, nor was a comprehensive assessment suggested when these continued into early school life. Not all children with these difficulties progress, but the pathway from oppositional behaviours through conduct disorder to delinquency is now clear (Loeber, Burke, Lahey et al., 2000), and intervention is indicated. The need for a collaborative approach to prevention does not appear to have been discussed between the school and the parents and other systems of care like the general practitioner or paediatrician. When Chad begins to have frequent accidents, nobody seems to see the complete emerging picture, yet we know that young people with conduct disorder are more impulsive, prone to accidents, and have higher mortality (Werry, 1997). Even when the stealing and other behaviours become publicly obvious, the responses continue to be negative or punitive. A key issue here is whether Chad's life path could have been changed. Recent longitudinal work suggests this is possible (Lacourse, Cote, Nagin et al., 2002).

Chad's story is individual, but many issues presented group him as at heightened risk, and provide a case for selective intervention. He is a boy with birth trauma, early physical difficulties, poor social skills, learning problems and a tendency to impulsive violence. In contrast, there are some protective factors evident. Neither of his parents had a criminal record or a mental illness; neither of them had a history of alcohol or other drug abuse. Despite all of their difficulties, they were still an intact family unit. They cared enough about their son to seek help on many occasions, even if they struggled to follow through. What is evident throughout the story is their ongoing need for education and support with improvement in parenting skill. Parent management training could have made a considerable difference to the outcome (Kazdin, 2002), and there are so many points along the pathway when parents could have been advised to seek out a comprehensive behaviourally based program. One such program, the Triple P - Positive Parenting Program (Sanders, 2002) is examined in some depth in this issue of the Australian e-Journal for the Advancement of Mental Health (AeJAMH).

Werry has suggested (1997) that up to 5% of young people may develop conduct disorder, and the incidence rises steeply with adolescence. With these numbers in our society, and the resulting costs, there is a clear need for universal preventive approaches to the problems. Parenting management support can be seen as selective - that is parents can be referred when they are seen to be struggling. It can also be universal - it can be made widely available for new or young parents or those where intergenerational knowledge of how to provide the best of care for children has been lost in an increasingly fragmented society. One need is for carefully developed, evidence based approaches, easily learned by therapists and capable of being applied in a range of circumstance. It is our hope that this issue of AeJAMH contributes to that evidence by considering one of the many approaches to parenting management. Another need is for professionals to have clear knowledge of risk and protective factors, and the comparative effectiveness and cost-effectiveness of programs, along the trajectory of early life. A final need is for improved communication

between the systems working closely with children and their families, which in turn may contribute to better collaboration. Conduct disorder is complex and expensive to treat, and the more we miss the clues in the early stages, the more entrenched the condition becomes, the less likely it is to be amenable to change. There is now substantial evidence that early recognition and early intervention at key points provide us with the best opportunity for long term success.

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