INTER-AGENCY PLAN FOR

Conduct Disorder/ Severe Antisocial Behaviour

2007-2012

Acknowledgements

This plan has been developed by an Inter-agency Working Group with representatives of the Ministries of Education, Health, Justice, Social Development (including Child, Youth and Family) and the High and Complex Needs Unit. The Working Group would like to acknowledge the help of the following individuals in producing this plan:

Dr John Church, School of Education, University of Canterbury

Professor David Fergusson, Christchurch School of Medicine, University of Otago

Dr John Langley, Dean of Education, University of Auckland

Dr Kathleen Liberty, School of Education, University of Canterbury

Professor Richie Poulton, Dunedin Multidisciplinary Health and Development Research Unit, University of Otago

Professor Kevin Ronan, Department of Behavioural and Social Sciences, Central Queensland University (formerly at Massey University)

Dr John Scott Werry, Emeritus Professor of Psychiatry, University of Auckland, Consultant Child and Adolescent Psychiatrist, Bay of Plenty and Tairawhiti District Health Boards and Ngati Porou Haurora

---

Published September 2007
by the Ministry of Social Development
Bowen State Building
PO Box 1556, Wellington 6140
New Zealand

Telephone: +64 916 3300
Facsimile: +64 4 918 0099
Website: www.msd.govt.nz

ISBN 978-0-478-29300-5 (Print)
ISBN 978-0-478-29303-6 (Online)

MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga

MINISTRY OF HEALTH
MANATŪ HAUORA

MINISTRY OF SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora

INTER-AGENCY PLAN FOR

Conduct Disorder/ Severe Antisocial Behaviour

2007-2012

Table of Contents

Ministerial Foreword 1

Executive Summary 2

Introduction 4

Section 1: Background Information on Conduct Disorder/Severe Antisocial Behaviour 8

What is conduct disorder/severe antisocial behaviour? 8

Risk and resilience factors 10

Impact on long-term outcomes 11

Effective treatment approaches 12

Section 2: Overview and Evaluation of Specialist Services for Children and Young People with Conduct Disorder/Severe Antisocial Behaviour 16

Overview of specialist services 16

Evaluation of specialist services 21

Section 3: Strategic Framework 26

Outcomes framework 26

Key principles 26

Section 4: Key Actions 2007–2012 30

Introduction 30

Action Area One: Leadership, co-ordination, monitoring and evaluation 31

Action Area Two: Transition existing service provision to evidence-based, best-practice interventions 33

Action Area Three: Establish an intensive, comprehensive behavioural service for 3–7 year-olds 36

Action Area Four: Build a shared infrastructure for the delivery of specialist behavioural services 40

Appendix 1: Existing Services 42

Appendix 2: Proposed Service 50

Appendix 3: International Examples 52

Appendix 4: Reviews of Current Practice 54

Bibliography 56

Ministerial Foreword

The Inter-agency Plan for Conduct Disorder/Severe Antisocial Behaviour 2007 – 2012 is about addressing severe behavioural difficulties in early childhood so affected children and families can look forward to a brighter future.

Conduct problems are the single most important predictor of later chronic antisocial behaviour problems including poor mental health, academic underachievement, early school leaving, teenage parenthood, delinquency, unemployment and substance abuse. The pathway for many affected young people typically leads on to youth offending, family violence and, ultimately, through to serious adult crime. The inter-agency plan aims to counter this trend.

This plan has four action areas:

- leadership, co-ordination, monitoring and evaluation
- transition existing service provision to evidence-based, best-practice interventions
- establish an intensive, comprehensive behavioural service for 3–7 year-olds
- build a shared infrastructure for the delivery of specialist behavioural services.

The inter-agency plan supports Government's priority theme of Families – Young and Old, and in particular, the priority of giving our children the best start in life. It builds on the Intersectoral Strategy for Children and Young People with High and Complex Needs and the Severe Behaviour Initiative in schools. The plan also builds on the early intervention focus of the Youth Offending Strategy.

Poor outcomes for children with severe behavioural problems are not inevitable. We want all children to have the opportunity to reach their potential. As a Government, we are committed to doing as much as we can at a national level to achieve better outcomes for all New Zealanders, particularly young children.

The critical time for addressing severe behavioural difficulties is in early childhood. Effective responses require a co-ordinated and mutually reinforcing approach from parents, teachers, health professionals and other key adults in a child's life. Treatment programmes also need to be delivered by highly skilled and well-trained professionals.

The inter-agency plan focuses our efforts on those areas where we know a real, positive difference can be made to the lives of these children, their families and their communities.

Hon Steve Maharey
Minister of Education

Hon Pete Hodgson
Minister of Health

Hon Ruth Dyson
Associate Minister for Social Development and Employment (CYF)

Executive Summary

This six-year inter-agency plan (2007–2012) represents the first step towards a more comprehensive and effective cross-government approach to conduct disorder/severe antisocial behaviour.

Conduct disorder/severe antisocial behaviour refers to behaviours which are severe, persistent across contexts and over time, and which involve repeated violations of societal and age-appropriate norms.

Children and young people with conduct disorder/severe antisocial behaviour do a significant amount of harm to themselves and others. Behavioural disorders, particularly those that begin in early childhood, are also one of the strongest predictors of adverse outcomes into adulthood. It is estimated that up to 5% of primary and intermediate school-age children have conduct disorder/severe antisocial behaviour. The prevalence of conduct disorder/severe antisocial behaviour appears to increase during adolescence.

The pro-social development of children needs to be fostered across a wide range of domains, including maternal ante-natal and infant healthcare services, childcare and early childhood education, school-wide behaviour management strategies, and well-considered urban planning. Children and young people who have been identified as being on an antisocial developmental pathway need more intensive, specialist and individualised services.

Government already commits significant resources towards specialist services for the management and treatment of conduct disorder/severe antisocial behaviour. A number of different government agencies either fund or provide these specialist services, including the Ministry of Education and, to a lesser extent, the Ministry of Social Development, the Ministry of Health and district health boards. The services a child or young person with conduct disorder/severe antisocial behaviour receives will vary depending on which agency is providing the services, the child's age and the severity of their behaviours, whether they are in statutory care, and, to some extent, their geographic location. It is estimated as many as 1% of 0–17 year-olds receive a specialist behavioural service each year.

It is difficult to assess the effectiveness of these services because very little data is collected across agencies on the impact of behavioural interventions on problem behaviours in the short and longer terms. However, some key challenges associated with the adequacy and efficacy of these services have been identified, including:

- inadequate and inconsistent mechanisms for identifying and determining eligibility for services for young people who are on an antisocial developmental pathway

- gaps in the availability of specialist services, particularly for younger children and teenagers
- some programmes are not well aligned with the evidence base around the effective treatment of conduct disorder/severe antisocial behaviour eg: interventions are not usually co-ordinated across all of the key settings in which a child or young person operates, interventions do not necessarily address other needs in a child's or young person's life, and interventions are often lacking in sufficient intensity and duration
- difficulties in engaging and retaining highly vulnerable families in interventions
- insufficient strategic overview of conduct disorder/severe antisocial behaviour across government.

The plan sets out four action areas for a more comprehensive and effective cross-government approach to behavioural disorders. It includes a framework for the expansion and re-design of some existing services, as well as measures to support better co-ordinated services and evidence-based decision-making across government into the longer term.

The key proposals are:

- Leadership, co-ordination, monitoring and evaluation, including establishing an Experts' Group.
- Building on the specialist behaviour services already provided by the Ministry of Education to ensure that by 2012, children requiring a comprehensive behavioural intervention (up to 5% of children) receive this level of intervention before they are eight years old.
- Progressively transitioning current service provision to evidence-based, best-practice interventions.
- Developing a shared infrastructure across agencies for the delivery of specialist behavioural services. This will include the development of common screening and eligibility processes to identify and assess the needs of children and young people on an antisocial pathway, and joint workforce development and training.

The Ministry of Social Development will assume ongoing leadership of the inter-agency plan, and an Inter-agency Governance Group, comprising officials from the Ministries of Social Development (lead), Education, Health and Justice, will be established to oversee the implementation of the plan. The Ministry of Social Development will develop a set of indicators to monitor the overall effectiveness of the inter-agency plan.

Introduction

This six-year inter-agency plan builds on recent initiatives that have been designed to improve the interventions provided to children and young people with conduct disorder/severe antisocial behaviour, including the *Intersectoral Strategy for Children and Young People with High and Complex Needs*, and the *Severe Behaviour Initiative* in schools. The plan aims to bring some coherence to these existing programmes by aligning eligibility, screening and assessment processes, and improving the co-ordination between these programmes.

All children and young people need support and guidance from their families, their teachers and other key figures in their lives to develop into socially and emotionally competent adults. Government provides or funds a range of universal services to support pro-social development, including maternal ante-natal and infant healthcare services, childcare and early childhood education, and primary and secondary schooling. A small percentage of children and young people have behavioural difficulties that require more intensive and specialist support than can be provided by parents or teachers alone. Government's aim in providing this specialist support is both to minimise the harm children and young people with behavioural difficulties can do to themselves and to others, and to improve the long-term outcomes for these children and young people. This plan represents the first step towards a more comprehensive approach to the management and treatment of these behavioural difficulties.

Who is this plan designed for?

In the context of this plan, children and young people with conduct disorder/severe antisocial behaviour refers to 0–17 year-olds who have a range of behaviours that are:

- severe, ie at an intensity and rate that is outside the levels of behavioural difficulties normally found in children of the same age
- persistent across contexts (at home, at school and in other social situations) and over time
- antisocial, involving repeated violations of societal and age-appropriate norms and that result in a negative impact on family, early childhood centres, school, peers, self etc.

A range of different expressions are used to describe this group of behaviours. The terms conduct disorder and oppositional defiant disorder are used in medical and psychiatric research and practice. The term conduct disorder is not common in the developmental and educational fields (in part reflecting concerns at the potentially stigmatising effect of the word disorder) and, instead, severe behavioural difficulties, emotional and behavioural difficulties, and antisocial behaviour are often used. This plan refers to these behaviours as conduct disorder/severe antisocial behaviour.

Many of the children and young people who are eligible for specialist behavioural services will also have other conditions and co-morbid disorders, including physical and intellectual disabilities, learning difficulties, autistic spectrum disorder (ASD), attention deficit/hyperactivity disorder (ADHD), childhood phobias, anxiety, and depression. There are also relatively high rates of alcohol and substance abuse among young people with conduct disorder.

Why do we need an inter-agency plan for conduct disorder/severe antisocial behaviour?

Children and young people with conduct disorder/severe antisocial behaviour do significant harm to themselves and others. Their behaviour frequently disrupts family functioning, their peers will often suffer emotional and physical harm as a consequence of their violent and aggressive behaviours, and their presence in the classroom can be highly disruptive and damaging for teachers and other students. Those who are in care will often be shifted, or will abscond, from one placement to another as carers struggle to manage their very difficult behaviours. Children and young people with conduct disorder/severe antisocial behaviour will often also suffer psychosocial harm as a consequence of their behaviours, including rejection by their peers, high rates of anxiety, depression and suicide and early and serious substance abuse.[1]

Conduct disorder/severe antisocial behaviour, particularly in younger children, is also one of the strongest predictors of poor long-term outcomes into adulthood, including criminal offending, substance abuse, and mental health problems.[2] Many serious and violent adult and youth offenders show a pattern of antisocial behaviours dating back to early childhood, suggesting that effective interventions for conduct disorder/severe antisocial behaviour are critical to reducing long-term rates of offending. Adults with a history of conduct disorder/severe antisocial behaviour will tend to transmit the same behaviours to their children through genetic predispositions, permissive or harsh parenting, negative modelling, or other processes of inter-generational transmission.

---

[1] Vermeiren (2003) cited in Frick (2006).

[2] Fergusson et al (2005).

The long-term costs associated with severe antisocial behaviour are significant. A New Zealand study estimated that the lifetime cost to society of a chronic adolescent antisocial male is $3 million.[3] A review of (the limited number) of rigorous British and American studies in this area concluded that substantial economic benefits, including increased educational achievement, higher earnings, and savings to the criminal justice system, are produced from the early prevention of antisocial behaviour.[4]

Behavioural difficulties are of increasing concern in a number of jurisdictions. While there is some variation in the concept of antisocial behaviour used in different countries[5], there is a shared focus on assessing the costs and benefits of intervention at different stages in the developmental cycle, and the need to develop cross-disciplinary and cross-government research language and agendas, and implementation plans.[6]

The Government already commits significant resources to the management of conduct disorder/severe antisocial behaviour and the people working in this difficult area bring a high level of expertise and commitment to their work. However, these services have evolved in a somewhat ad hoc and isolated manner within agencies, and there is widespread support for Government to review the overall effectiveness and adequacy of the services currently provided across agencies, and in particular to:

- review the overall level of services provided and the targeting of those services to different age groups
- improve the alignment of existing services with evidence of best practice
- clarify the respective roles and responsibilities of key agencies in the management of conduct disorder/severe antisocial behaviour
- identify how the wide range of services currently provided can be better integrated for individual clients.

---

3 Scott (2003). The study identified “chronic adolescent antisocial males” as those male offenders who had their first adult court conviction before 17 years and at least one offence after 45 years.

4 Welsh (2006) in Farrington and Coid (2006).

5 For example, the British Government’s Respect Action Plan, which is a major cross-Government policy initiative to tackle antisocial behaviour, defines antisocial behaviour as “acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the defendant” which could include, for example, an isolated incident of littering or graffiti. In contrast, the emphasis in the United States, like that in New Zealand, has traditionally been on children and young people who exhibit an ongoing pattern of severe and persistent antisocial behaviours (see Rubin et al 2006).

6 See for example Lochman (2006).

What services are included in the plan?

Children's pro-social development needs to be fostered across a wide range of domains. Universal schemes, such as good maternal ante-natal and infant healthcare services, high-quality childcare and early childhood education, school-wide behaviour management strategies, and well-considered urban planning contribute to pro-social behaviours within families, the classroom and beyond. Universal services are of concern to the extent that there is appropriate co-ordination, collaboration and support available to enable children and young people with conduct disorder/severe antisocial behaviour to remain in these services.

For the minority of children and young people who have been identified as being on an antisocial developmental pathway, universal programmes alone are not sufficient to tackle behavioural difficulties and these need to be complemented by more intensive and individualised services. It is these services that are the primary focus of this plan.

Section 1: Background Information on Conduct Disorder/Severe Antisocial Behaviour

What is conduct disorder/severe antisocial behaviour?

Challenging behaviours are the norm among most children at various points during their development. Researchers and practitioners from across the fields of education, mental health and criminology have, however, identified a pattern or clustering of behavioural difficulties that is dissimilar to age-appropriate norms. These behaviours include hostility to others, aggression and rule infractions, defiance of adult authority and violations of social and cultural norms. Many different terms are used to describe this set of behaviours, including conduct disorder, oppositional defiant disorder, severe behavioural difficulties, emotional and behavioural disorder, and antisocial behaviour.

At the extreme ends of the behavioural continuum it is relatively easy to distinguish between "normal" and "abnormal" patterns of behaviour. It is difficult, however, to identify an exact point at which patterns of behaviour can no longer be described as "normal".[7] A number of criteria have been developed to distinguish between normal and abnormal development and, while there is still much debate around which are the best criteria to use, the criteria identify three key elements to severe behavioural disorders:

- severe, ie at an intensity and rate that is outside the levels of behavioural difficulties normally found in children of the same age
- persistent across contexts (at home, at school and in other social situations) and over time
- antisocial, involving repeated violations of societal and age-appropriate norms and that result in a negative impact on family, early childhood centres, school, peers, self etc.

The severity criterion used to identify conduct disorder/severe antisocial behaviour is an age-related criterion, ie the behaviours are severe relative to the normal behavioural patterns of a child of the same age. Hence, while conduct disorders/severe antisocial behaviours in small children may be perceived by teachers and parents as only mild or moderate behavioural difficulties because they are typically easier to manage than similar behaviours in older and larger children, they may be no less severe relative to age-appropriate norms.

---

[7] Frick (1998).

Prevalence

The prevalence of conduct disorder/severe antisocial behaviour is important information to have when planning the necessary level of treatment services. Broadly, mild to moderate behavioural difficulties are relatively common, and the prevalence of conduct disorder/severe antisocial behaviour decreases sharply as the severity increases. However, there is a relatively wide range of estimates of the prevalence of conduct disorder/severe antisocial behaviour among children and young people. This, in large part, reflects the different methods researchers have used to identify abnormal behaviours and behavioural patterns.

Based on the Dunedin and Christchurch longitudinal studies, approximately 4.5% of the primary and intermediate school population demonstrate conduct disorder/severe antisocial behaviour.[8] Surveys of primary and intermediate school children in Canterbury and Otago showed little change in the prevalence of severe behavioural problems between Year 4 and Year 7.[9] By far the greatest numbers of young children identified as having severe behavioural problems in these studies were boys. For example, 83% of 7–13 year-olds who had severe conduct problems in the Christchurch Health and Development Study were male.

While there is some debate about how the prevalence of conduct disorder/severe antisocial behaviour shifts with age, it appears that during adolescence the rate of behavioural disorders tends to increase. Certainly, serious aggressive behaviours such as rape and serious violent offending increase with age. The Christchurch longitudinal study found no significant difference between the rate of conduct disorder in girls and boys at age 15 years.

There is some anecdotal evidence that conduct disorder/severe antisocial behaviour, particularly in young women, has increased over time. It is difficult to confirm this with available data, however, and overall youth offending rates have not increased over the past decade. There has, however, been an increase in violent offending among 14–20 year-olds over the past five years.[10]

---

8 The results from these studies are based on data collected over 20 years ago. There is no more recent data available to establish whether the prevalence of conduct problems has changed over that period.

9 Church (1996).

10 Based on police apprehensions data sourced by the Ministry of Justice from Statistics New Zealand.

The prevalence of conduct disorder/severe antisocial behaviour is much higher in children from lower socio-economic groups. In one New Zealand study, the percentage of antisocial children enrolled in Decile 1 and 2 schools was six times greater than the percentage to be found in Decile 9 and 10 schools. New Zealand research suggests that Māori and Pacific males are more likely to have behavioural difficulties than non-Māori, though to a large extent this is likely to be a function of economic disadvantage.[11]

Risk and resilience factors

There is considerable debate about the relative roles of factors such as genetic influences, social learning, parenting practice and social conditions as determinants of conduct disorder/severe antisocial behaviour. Most of the research concerned with addressing conduct disorder/severe antisocial behaviour focuses on the risk factors associated with its development, rather than seeking single causative relationships, and there is considerable agreement on the nature of those factors. Among them are:

- parental antisocial behaviour
- parental substance abuse
- parental mental illness
- limited or lax parental supervision
- harsh and coercive discipline and abuse
- neurological deficits
- genetic factors
- child temperament type
- lower verbal IQ
- low socioeconomic status
- younger maternal age (at first birth)
- maternal smoking during pregnancy
- antisocial peer influences.

While no one risk factor has been shown to be sufficient or necessary for the development of persistent behavioural problems some, such as a combination of negative parenting with high levels in two other risk factors, seem predictive of ongoing difficulty. In general the more risk factors that are present the more likely conduct disorder/severe antisocial behaviour becomes.

---

[11] Fergusson et al (2004).

Nevertheless, children show considerable resilience. In the Christchurch Health and Development Study, for example, 13% of children raised in the highest 5% of high-risk family situations reached adolescence with no obvious disorders of behaviour, learning or psyche. There has been less research attention to these "resilience factors" but those identified include:

- a secure attachment relationship with a parent, and in particular firm and responsive parenting
- a secure attachment relationship with a significant adult outside the immediate family
- higher intelligence
- an agreeable temperament/personality.

Impact on long-term outcomes

Children and young people with severe behavioural difficulties are at a significantly higher risk of adverse long-term outcomes through to adulthood than children with few or only moderate behavioural difficulties. Box One below compares outcomes for the 50% of children with the least behavioural difficulties and the 5% of children with the most severe behavioural difficulties, using data from the Christchurch Health and Development Study.

Box One: Associations between childhood conduct problems (7–9 years) and outcomes into adulthood[12]

	The 50% of children with the least behavioural difficulties	The 5% of children with the most severe behavioural difficulties
Violent offending (21–25 years)	3%	35%
Arrested/convicted (for non-traffic offences) (21–25 years)	3%	33%
Suicide attempt (ever)	4%	18%
Inter-partner violence (past 12 months)	5%	24%

[12] Fergusson et al (2005) p 842.

Children in the study with mild to moderate behavioural difficulties were also at a higher risk of adverse long-term outcomes, but to a lesser degree than for children with severe behavioural difficulties. For example, 12% of children with what might be described as moderate to severe behavioural difficulties[13] had engaged in violent offending in early adulthood compared with 35% of children with the most severe behavioural difficulties. Fifteen percent had been arrested or convicted for non-traffic offences compared with 33% of children with the most severe behavioural difficulties.

Children and young people who exhibit severe behavioural difficulties in childhood are likely to account for a significant proportion of adult criminal offending. For example, 6% of the eight year-old boys in the Cambridge Study in Delinquent Development accounted for half of all convictions in the study up to age 32 years.[14]

The research suggests that, particularly for boys, behavioural difficulties that emerge during early childhood are significantly more likely to lead to poor long-term outcomes into adulthood than behavioural difficulties that emerge during adolescence. Recent research suggests, however, that girls whose behavioural difficulties become apparent during adolescence may be more similar to the early-onset group of boys in terms of the impact of conduct disorder/ severe antisocial behaviour on adverse long-term outcomes.[15]

Effective treatment approaches

A range of interventions have been shown to be effective in the treatment of conduct disorder/severe antisocial behaviour. There are many dimensions to what makes an intervention work, including the skills and training of the staff delivering the intervention, the design of the intervention itself and the fidelity shown to the original programme design. While it is not possible in the context of this plan to conduct an exhaustive review of the role these factors have in making an intervention “work”, Table One below outlines some broad treatment approaches that have been shown to have a beneficial effect on problem behaviours.[16]

---

13 This group represents children who were ranked in the 81st to 95th percentiles for behavioural difficulties.

14 Farrington and West (1993).

15 Silverthorn, Frick and Reynolds (2001).

16 This table is based on evidence reported in Fonagy et al (2002), Church (2003) and McLaren (2000).

Table One: Effective intervention approaches to the treatment of conduct disorder/severe antisocial behaviour

Type of intervention	0–2 years	3–7 years	8–12 years	13–17 years
Parent training programmes[17]				
What is provided? Parents are shown how to focus on rewarding positive behaviours and how to avoid inadvertently reinforcing negative behaviours. Consequences for inappropriate behaviour are applied consistently, contingently and immediately. Training is often incorporated into home-visiting programmes targeted at at-risk families with young infants. Alternatively, it may be provided in the clinical setting, using "bug in the ear" instruction to the parents with the child, or using video vignettes of parent/child interactions. **Rationale** Behavioural disorders are likely to result, at least in part, from parental difficulties in reinforcing pro-social behaviours and the maintenance of antisocial behaviours through coercive interactions.	Evidence of good effectiveness. About two in three children under 10 years whose parents participate in parent training show behavioural improvements.		Effectiveness tends to reduce with age, though a small number of programmes have shown some success with older children. Programme effectiveness improved if provided with training to address child's/adolescent's cognitive deficits, eg problem-solving skills.	
	Within the target group, the young people who are likely to benefit the most are those with the most severe presentations. However, programmes are more likely to reduce antisocial behaviour and prevent offending altogether where the child is younger, there is less co-morbidity (intellectual impairments, hyperactivity etc), there is less socioeconomic disadvantage in the family, there is less parental discord, social support is high and there is no parental history of antisocial behaviour.			
Child/adolescent training programmes				
What is provided? Can involve psychodynamic therapy, training in social skills or moral reasoning, problem-solving skills, anger management. **Rationale** Children and young people with conduct disorder/severe antisocial behaviour often have difficulty in developing solutions to inter-personal problems, tend to misread the motivations of others and cannot see the consequences of their behaviour.	n/a	Evidence of some effectiveness when developmentally appropriate to the age of the child. Social skills training and anger management have some beneficial effect for children with mild conduct problems, but appear to be less effective for chronic or severe cases. Problem-solving skills effective when combined with parent training. Programmes of negligible use for children and young people with intellectual impairments.		Evidence of effectiveness is weak, or not yet demonstrated. Group-based approaches risk worsening the problem behaviours.

[17] Details of two prominent examples (Incredible Years and Triple-P) are provided in Appendix 3.

Table One: Effective intervention approaches to the treatment of conduct disorder/severe antisocial behaviour

<table>
<tr><th>Type of intervention</th><th>0–2 years</th><th>3–7 years</th><th>8–12 years</th><th>13–17 years</th></tr>
<tr><td colspan="5">School-based programmes</td></tr>
<tr><td rowspan="2">What is provided?
Examples include modifying teacher behaviour, school-wide non-violence programmes, and contingency management in the classroom, where pupils earn rewards, receive frequent praise and have time-out if needed.
Rationale
Children spend a high proportion of their time in school, there are unaccounted for differences in the prevalence of conduct disorder/ severe antisocial behaviour between schools, and the behaviour of children who move schools often worsens or improves depending on the culture within the school.</td><td rowspan="2">n/a</td><td>Programmes need to be offered in combination with child and parent components to be effective.
Evidence of some effectiveness for contingency management for behaviour within the classroom, but improvements not shown to extend to other settings.</td><td colspan="2">Effectiveness not demonstrated.</td></tr>
<tr><td colspan="3">School-wide non-violence programmes insufficient alone, but basic requirement for all schools.</td></tr>
<tr><td colspan="5">Home and school</td></tr>
<tr><td>What is provided?
Programmes provide individualised interventions which include behaviour management training for parents (often home-based) and teachers, and sometimes also social skills training for the child/adolescent themselves.
Rationale
Interventions that target both the home and school environment may be more effective than single-site interventions.</td><td>Evidence of good effectiveness.</td><td>Evidence of good effectiveness.</td><td colspan="2">Some evidence of effectiveness, but not as effective as for younger children.</td></tr>
</table>

Table One: Effective intervention approaches to the treatment of conduct disorder/severe antisocial behaviour

Type of intervention	0–2 years	3–7 years	8–12 years	13–17 years
Multimodal interventions for adolescents [18]				
What is provided? Programmes offer intensive, individualised interventions that target a range of identified risk factors and which work with the adolescent, their family, the school (where applicable) and sometimes also their neighbourhood and broader peer group. Case management, with the therapist brokering access to other services, can also be incorporated in the programme. Can entail placement with specially-trained foster parents for an extended period of time. **Rationale** As children get older, their behavioural difficulties can become more embedded, and are reinforced across a wider range of settings beyond the home and classroom. This may require more intensive and wide-ranging interventions.	n/a	n/a	Evidence of effectiveness, particularly for structured and focused programmes that use multiple treatment components (ie they use a number of techniques) and that are behavioural and skills-focused. Interventions in the residential setting are generally less effective than non-residential treatments.	
Medication				
What is provided? Medication **Rationale** Behavioural disorders have high rates of co-morbidity with mental health disorders, particularly attention deficit/hyperactivity disorder (ADHD). Treatment for any co-morbid mental health problems is an essential component of intervention for conduct disorder/severe antisocial behaviour. Stimulant medication to manage the impulsivity associated with ADHD may have positive flow-on effects on conduct disorder/severe antisocial behaviour.	n/a	Not the first line of treatment for conduct disorder/severe antisocial behaviour, but appropriate where primary or co-morbid psychiatric disorders exist.		

[18] Details of three prominent examples (Multi-systemic therapy, Multi-dimensional treatment foster care and Functional family therapy) are provided in Appendix 3.

Section 2: Overview and Evaluation of Specialist Services for Children and Young People with Conduct Disorder/Severe Antisocial Behaviour

Overview of specialist services

Government funds a range of specialist services designed to help modify the behaviours of children and young people exhibiting more severe behavioural difficulties. The main providers/funders of these specialist services are the Ministry of Education, the Ministry of Social Development (Child, Youth and Family), the Ministry of Health and district health boards. How do children and young people, their parents, and other people involved in their care access these types of services?

There are four main routes by which these types of specialist services can be accessed:

- Children under five years who are not in any form of early childhood education and who are showing early signs of behavioural difficulties can be referred, with parental permission, by health providers and other professionals working with young children to the early intervention services provided by the Ministry of Education.
- Children and young people who are in early childhood education or Years 1–10[19] of the primary and secondary schooling system and who are identified by teachers and other education specialists as meeting antisocial behaviour-related criteria can be referred, with parental permission, to the Ministry of Education's early intervention services, Group Special Education or residential schools programme.
- Children and young people who are involved with Child, Youth and Family either because of their criminal offending or care and protection needs, and who have been identified as having some form of behavioural difficulties, can be referred to a range of specialist services either funded or provided by Child, Youth and Family.
- Children and young people with behavioural difficulties can be referred to a range of health care providers, including paediatricians, and Child and Adolescent Mental Health Services (CAMHS). They will only be eligible for services from CAMHS providers, however, if those behavioural difficulties are co-morbid with one or more mental health conditions that are included in the Nationwide Mental Health Services Framework, such as attention deficit/hyperactivity disorder and depression.

[19] Young people above Year 10 (around 14 years-old) may also gain access to the specialist education services for severe behaviour difficulties if they qualify for the Ongoing and Reviewable Resourcing Schemes (ORRS).

Vulnerable families with young children can also access early intervention programmes, such as Family Start. Some of these programmes help parents to manage difficult behaviours in their children through, for example, the provision of parenting programmes.

The High and Complex Needs Unit also provides funding for specialist treatment services for children and young people who have needs so high, complex and multi-faceted that it is unreasonable to expect single sector interventions will work. Some of these children will have conduct disorder/severe antisocial behaviour.

What types of services are provided and by whom?

The services provided to a child or young person and their family will vary according to which agency is providing the services, the child or young person's age and the severity of their behaviours, whether a child or young person is in the care of family members or statutory care and, to some extent, the geographic location of the child or young person.

The Ministry of Education provides a range of programmes to manage children and young people with severe behavioural difficulties, including:

- advice and specialist support for students with severe behaviour difficulties, their schools and their families, which may involve setting some clear behavioural goals with established positive and negative consequences, and ensuring that parents, educators and other key adults are aware of, and able to reinforce, the behaviour-change process
- provision of parenting programmes which teach parents how to monitor behaviour, give clear instructions, teach compliance, and refocus attention from antisocial to pro-social behaviour
- provision of funding or support workers to help the school and family to implement a programme of support
- Centres for Extra Support that provide day provision of withdrawal settings
- residential programmes for 8–13 year-olds who are unable or unwilling to remain in day-schooling.

Children and young people and their families who are clients of Child, Youth and Family may be provided with parenting programmes, one-to-one therapy with mental health providers, community-based therapeutic programmes (including iwi-based provision), intensive residential treatment programmes, and multi-component programmes that incorporate child, family and peer dimensions. A small number of children and young people who are in the care of Child, Youth and Family are also accommodated within specialist foster care or group homes where the carers are trained in the management of severe behavioural difficulties.

Many of the services delivered by health providers are based in the family setting and cover behaviour management techniques. Some provide access to parenting programmes. Children and young people with conduct disorder/severe antisocial behaviour who also have a diagnosis of ADHD may be prescribed stimulant medication to manage ADHD. While the medication is not directly targeted at managing conduct disorder/severe antisocial behaviour, it may be an important component of treatment for these children because the impulsivity of ADHD directly contributes to aggressive behaviours associated with conduct disorder/severe antisocial behaviour.[20]

There are also a few key non-governmental organisations working in this area using recommended evidence-based programmes, such as the Youth Horizons Trust.

Services are provided by a range of different professionals including educational and clinical psychologists, child and adolescent psychiatrists, drug and alcohol abuse specialists, social workers, counsellors and paediatricians.

[20] Frick (1998) p 111.

Case Study

Peter is a nine-year-old boy who is attending a residential school after not having attended any school for 12 months.

Peter and his younger brother have been in the care of adoptive parents from infancy. Peter's adoptive parents reported at an early stage that he didn't listen to instructions, acted out, had violent temper outbursts and had not developed the social skills expected from his age group. Attempts to attend early childhood education ended in disaster. The adoptive parents sought help from a number of agencies and a diagnosis of possible attention deficit/ hyperactivity disorder (ADHD), with features of oppositional defiant disorder (ODD) was made. Medication was recommended but the adoptive parents chose not to follow these recommendations, preferring to home-school Peter.

Peter's behaviour continued to deteriorate and when he turned seven, his adoptive mother had a complete breakdown resulting in his being placed in the temporary care of Child, Youth and Family. He was placed with caregivers who were unable to manage his behaviour at all. He started attending school but was stood down after a couple of weeks for continued non-compliance and severely threatening the safety of other students. A referral to the Ministry of Education, Group Special Education (GSE) was made. Peter was assessed by a GSE psychologist who identified insecure attachment, poor self regulation and impulse control, high anxiety and lack of social skills, and a behaviour management plan was put in place. A parental training course was recommended for both the adoptive parents and caregivers, and a referral to a paediatrician to re-assess the previous diagnosis of ADHD was made.

During this time, Peter's violent outbursts escalated further and the school excluded him. The police began to investigate allegations against Peter's caregivers and he was moved to new caregivers. Peter's adopted parents indicated they could not have him back at home.

Several Strengthening Families meetings were held where Ministry of Education Student Support Services became involved to assist Child, Youth and Family and his new caregivers to find a school placement. The police investigation continued. He was diagnosed again as having ADHD with co-morbid features of ODD. He also started seeing a counsellor for high anxiety, family and attachment issues. His care placement changed twice in this year. A trial of medication was ineffective.

After a year, a mainstream school agreed to enrol Peter. During the first two weeks his non-compliance, hyper-alertness and poor social skills led to several incidents of hitting peers, adults and his caregivers. At a Strengthening Families meeting it was decided his social worker would apply for the joint interagency one-to-one flexible service to support his learning and school placement, while a referral to a residential school was made.

His caregivers at that time attended a parent programme run by the residential school. GSE and the school supported his transition back to a mainstream school. During this transition his care placement changed again. Peter's behaviour started to escalate but due to effective monitoring this was quickly noticed and at the Strengthening Families meeting it was decided that the social worker would again apply for the joint agency funding of the flexible one-to-one care to support Peter at school during this period of change. Peter would also start exploring his cultural identity by joining the school's kapa haka group. His counselling continued with a focus on identity formation. Contact with his brother was formalised and monitored by his social worker. His care placement was maintained and became long term. After three terms he was able to manage without additional support. The agencies stayed vigilant and know that transition to college is another high-risk period that needs planning and management.

More detail is provided in Appendix 1 on the services provided by the different government agencies.

How many children receive specialist behavioural services each year?

It is hard to quantify the number of children and young people accessing specialist services for the management of conduct disorder/severe antisocial behaviour each year because of the difficulties in extracting data on the level of services provided by district health boards and regional Child, Youth and Family offices. However, it is estimated that at least 7,000 and possibly as many as 10,000 children and young people receive some form of specialist government service for conduct disorder/severe antisocial behaviour each year. This represents between 0.7 and 1% of the 0–17 year-old population and comprises the following:

- Approximately 6,500 children and young people receive specialist services from the Ministry of Education each year. The Ministry's main focus is on children and young people below Year 11 and 95% of the children and young people receiving specialist services are under 15 years old.
- Approximately 600 children and young people in the care of Child, Youth and Family receive specialist behavioural management services each year. Almost all of these 600 children are in the 12–16 age-group. Local site managers also have discretionary funding to purchase therapeutic interventions to help resolve care and protection concerns where the issue is outside the responsibilities of primary agencies to resolve (eg health, education). In some instances, this might include a behavioural intervention.
- Many children and young people receive some form of behaviour management intervention through health services as part of their treatment for other problems, but separate data is not available for this group.

Approximately 4.5% of New Zealand families can access Family Start, an intensive home-visiting service for vulnerable families with young infants. The service includes a parenting programme which may help parents manage their young child's difficult behaviours.

Evaluation of specialist services

There is little data collected on the impact of existing interventions on problem behaviours in the short and longer term. However, the ongoing exclusion of young people with problem behaviours from mainstream settings, particularly school, the increase in violent offending by 14–20 year-olds over the past five years and the concerns expressed by teachers and foster carers about the increasing frequency and severity of problem behaviours raise some concerns about the overall effectiveness of the current set of interventions. Some of the key challenges are outlined below.

Inadequate mechanisms for identifying and determining eligibility for services for children and young people with conduct disorder/severe antisocial behaviour

There are inconsistent approaches both across and within agencies to identifying children and young people with severe behavioural difficulties, and in deciding what level of intervention those children and young people should receive.

The Ministry of Education has developed its own national criteria for accessing Group Special Education services[21], but these criteria are relatively broad, and it is likely they are interpreted differently across the regions. These criteria are also only for school-age children, and eligibility for services for children under five years is set locally and varies across the country. The Ministry is now developing a screening and eligibility tool to systematise the process by which children and young people gain access to severe behaviour services (see Section 4 for further discussion).

Child, Youth and Family does not have national criteria to guide which children warrant what level of behavioural intervention. Some of the providers contracted to Child, Youth and Family use the guidelines set out in DSM IV[22] for diagnosing conduct disorder as the basis for determining access to services.

---

[21] The operational criteria for services are that behaviour: jeopardises the physical safety of the student or others; threatens to cause, or causes, significant property damage; severely limits the student's access to ordinary settings and interferes with social acceptance, their sense of personal wellbeing and educational performance.

[22] The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is a handbook used to guide the diagnosis of mental disorders.

Other providers use administrative data on the degree of involvement in youth justice processes to determine eligibility for services – for example if a young person has been the subject of a certain number of family group conferences they are eligible for a particular service.

The terms and diagnostic criteria set out in DSM IV are used by health professionals working with children and young people.

The mechanisms in place for identifying and referring very young children who are on an antisocial developmental pathway are particularly inadequate. While some young children with difficult behaviours are identified by early childhood educators and primary teachers, and then referred to the Ministry of Education's behaviour management services, this process is in no way systematic:

- For young children in early childhood education or in the early years of primary schooling, teachers are often able to manage problem behaviours without recourse to outside support. Children will often not be referred to specialist services until they are older when (often because of their physical size) their behaviours become too difficult to contain. By this stage it is both more difficult and more costly to effect a change in those problem behaviours.
- For children under five years not in any form of education, health workers, social workers and Child, Youth and Family carers may not be trained to identify problem behaviours in young children. Again, the impact of these behaviours in younger children can often be contained without outside support. Many of these professionals are unaware they can refer these children to the early intervention behavioural services provided by the Ministry of Education.

Gaps in the availability of specialist behaviour services, particularly for younger children and teenagers

It is estimated as many as 1% of children and young people receive some specialist intervention for conduct disorder/severe antisocial behaviour each year. It is difficult to assess to what extent this represents an overall shortfall in specialist services, however, as it is not clear what level of services is needed each year for the approximately 5% of children and young people with conduct disorder/severe antisocial behaviour. Specifically, many of these children and young people will not need a specialist intervention each year, but rather will require an initial intensive intervention followed up by specialist support at specific transition points or developmental stages in subsequent years.

The evidence for gaps in the supply of specialist services is strongest for the 0–7 year-old and 13–17 year-old age groups:

- 0–7 year-olds: the Ministry of Education is the main provider of specialist behavioural services for this age group, through its Early Intervention and Group Special Education services. As outlined above, however, teachers often find difficult behaviours easier to contain in younger children than in their older counterparts and, consequently, the Ministry disproportionately targets its behavioural services to the 8–14 years age group. It is estimated that approximately 0.5% of 0–7 year-olds receive these services compared with approximately 1% of 8–12 year-olds.
- 13–17 year-olds: the Ministry of Education provides intensive behavioural services to approximately 0.5% of this age group. This reflects that the Ministry of Education's severe behaviour initiative is limited to children Year 10 and below and who are enrolled in school.[23] Children who are not enrolled in school or who are in school but beyond Year 10 are unable to access any specialist services unless they are clients of Child, Youth and Family or they are eligible for health services that provide behaviour management interventions as part of broader treatment services.

Interventions are not co-ordinated across all of the key settings in which a child or young person operates

Conduct disorder/severe antisocial behaviour is a function of the conditions that occur across all the settings in which a child or young person operates, including the home, the school and the peer environment (particularly as they get older). In order to foster pro-social development in children and young people with conduct disorder/severe antisocial behaviour, interventions need to be supported by teachers, family/whānau members, parents/caregivers, and other people closely involved in the child's life, such as health professionals and social workers. Specifically, interventions will only succeed if all of these adults adopt the same approach to discipline and supporting a child's pro-social development. Interventions become more complex as the child grows older and moves out into the wider community.

No service is mandated or funded to work across all of the settings in which a child or young person operates. For example, the main motivation for the Ministry of Education to provide behavioural interventions is to improve student learning outcomes by improving behaviour.

---

[23] A very small number of 15–21 year-olds receive specialist education services for severe behaviour difficulties because they qualify for the Ongoing and Reviewable Resourcing Schemes (ORRS).

A behaviour-change programme may be implemented in the classroom but this is not always integrated with an effective parenting programme or co-ordinated with other service providers, and parents may not be informed that their child is receiving (or needs) a behavioural intervention.

There are a number of local initiatives where front-line agencies are working together to try and provide this kind of comprehensive service.

Parenting issues are both central and common to a number of agencies. In Tauranga a number of agencies purchased their own resources to enable them to deliver The Incredible Years Basic Parent Programme. In 2002 an inter-agency group, known as the Guardian Group (GG), was set up to "guard" a new, community-owned, resource being used by these agencies to deliver a range of Incredible Years programmes.

The GG held regular monthly meetings at which agencies could share information about community needs, plan parenting programmes so facilitators from different agencies could co-facilitate, and discuss fidelity and practical issues around programme delivery. Membership of the GG expanded to include family therapists, social workers, psychologists (education and health based), PAFT parent educators, the Strengthening Families co-ordinator and a retired primary school principal.

Discussion at the GG meetings often highlighted the barriers to participating in the parenting programme for some families so the GG was formalised for fundraising purposes. Funds were used to help families access the programmes (eg petrol vouchers, taxi chits), to purchase resources that could be borrowed by facilitators (eg video/DVD player) and to provide facilitators with the consumable resources required for courses (eg books, stickers).

The experiences of two members of the GG who had received facilitator training overseas encouraged the GG to explore ways to make quality training available to facilitators in New Zealand. A trainer was organised to come to NZ in mid 2004, though it was not possible to source government funding for the training. The GG approached the newly established Werry Centre and discovered that the Centre was committed to bringing The Incredible Years training to New Zealand. At that point a new relationship was formed between the GG and the Werry Centre to train a group of mentors to enable New Zealand to become self-sustaining for facilitator training within five years.

Relationships between Ministries of Education and Health were formalised and the result has been the provision of facilitator training in both 2004 and 2005 and the Werry Centre taking a lead role in establishing the supports necessary (eg three-day workshop and regular teleconferences) for nine experienced facilitators from around New Zealand participating in the certification process with the US-based training providers (Webster – Stratton).

Interventions do not typically address other needs in a child's or young person's and their family's life

Many of the children and young people with conduct disorder/severe antisocial behaviour and their families have complex needs which can involve the provision of housing and income support, drug and alcohol counselling, or services for parents/caregivers with mental health issues. For these families to be able to respond to a behaviour intervention, there needs to be an element of co-ordination of care to meet these complex needs. In most instances, services are not resourced and staff are not trained to provide this kind of wrap-around dimension to behavioural services.

Interventions are not necessarily of sufficient intensity or duration

Behaviour interventions and programmes for this group of children and young people need to be of sufficient duration and intensity to promote significant behavioural change in all settings. For many children, support will need to be ongoing and available at key transition points.

Difficulties in engaging and retaining highly vulnerable families in specialist behavioural services

Many of the families of the children and young people most affected by conduct disorder/severe antisocial behaviour are those least likely to participate and remain in these programmes. Parents may feel stigmatised or blamed for their child's or young person's behaviours, may feel alienated by the language used in the programme, may have behavioural or learning difficulties themselves, or may not be able to attend at the scheduled time and venue.

In the United Kingdom, attendance at programmes can be mandated. The effectiveness of this approach has, however, not yet been demonstrated. Also, existing parent order provisions in New Zealand have not been widely used by the Court. Foster parents can be paid to attend programmes in New Zealand.

Insufficient strategic overview across government

There is insufficient strategic oversight at a national level in the area of government interventions for conduct disorder/severe antisocial behaviour. While there are some co-ordination mechanisms already in place that overlap with this work, particularly the Severe Behaviour Initiative within the Ministry of Education, the Youth Offending Strategy, and the Intersectoral Strategy for Children and Young People with High and Complex Needs, these tend to be either sector specific, or to apply to only a subset of the population of children and young people on an antisocial developmental pathway. As a result, initiatives are developed in each sector with no overall coherence, with gaps and with potential overlaps. To date, there has been little planning across government in how services should be targeted across age groups.

Section 3: Strategic Framework

It is proposed that agencies adopt a common strategic framework for the ongoing development of services for children and young people with conduct disorder/ severe antisocial behaviour. The framework comprises a joint set of desired outcomes for children and young people engaged in behavioural management programmes, and a set of key principles to guide the targeting, design and delivery of these programmes.

Outcomes framework

Ultimate outcome

This plan will contribute to the ultimate outcome that all children and young people participate, succeed and make contributions that benefit themselves and others, now and in the future.

Intermediate outcomes

The plan will help to achieve the ultimate outcome by:

- reducing antisocial development and accelerating pro-social development
- increasing the proportion of young adults who leave school with self-regulation, self esteem, self efficacy and personal responsibility
- increasing the capacity of families/whānau, schools, peer groups, communities and iwi to actively participate in positive behaviour development and reduce exclusion
- reducing the number of young people who progress to chronic offending and reducing the incidence of all types of violent offending
- improving educational outcomes by reducing the number of young people who have to leave school prematurely because of their antisocial behaviour at school.

Key principles

The following set of principles has been used to guide the development of the inter-agency response to conduct disorder/severe antisocial behaviour in children and young people.

Interventions should be provided as early as possible

Targeting services to younger children is the most cost-effective approach to the long-term reduction of conduct disorder/severe antisocial behaviour in childhood, adolescence and adulthood:

- The onset of conduct disorder/severe antisocial behaviour in early childhood is one of the strongest predictors of juvenile delinquency and behavioural difficulties into adulthood.

- Interventions are significantly more effective for younger children than their older counterparts. Prior to school entry, it is estimated that there is a 75–80% chance of halting existing severe antisocial behaviour in young children and increasing pro-social behaviour.[24] Programme effectiveness drops sharply with age.
- Interventions for younger children are significantly less costly because, as the child ages, interventions become more complex and are required in more domains.

While there are some well-established methods for assessing the likelihood that a young child is on an antisocial developmental pathway, it is inevitable that in the process of determining eligibility for early intervention programmes, a number of false positive (ie children who are incorrectly identified as having conduct disorder/severe antisocial behaviour) will be generated. However, many of these children will have some degree of behavioural difficulties and programmes for this larger group of children are still likely to be cost-effective.

Effective early intervention programmes need to be complemented by programmes for older children as (i) some children will need ongoing behaviour support from childhood through to adolescence, particularly at key transition points (eg from intermediate to secondary schooling) and during any high-risk life events (eg death of a parent, placement in foster-care), and (ii) conduct disorder/severe antisocial behaviour will not be apparent in some children, and particularly girls, until adolescence.

Services must be provided by a highly skilled and well-trained workforce

Successful interventions require well-trained, skilled workers who have an understanding of developmental psychology, psychopathology and the antisocial developmental pathway; a detailed knowledge of effective comprehensive interventions; well-developed engagement skills; and the capability to work effectively across agencies and disciplines. There are currently a limited number of professionals in New Zealand who have the necessary skills and training to deliver these types of programmes.

Services must be consistent with evidence of best-practice

There is a strong and growing evidence base on what are effective practices in the treatment of conduct disorder/severe antisocial behaviour. Agencies must commit to ensuring the programmes they deliver are consistent with this evidence base, and in particular that:

---

[24] Church (2003).

- programmes are provided on the basis of an individual assessment carried out by competent professionals and founded on known critical factors
- programmes are individually tailored and based on what is known to be effective for the child or young person's age, developmental stage and gender
- services involve multiple components and consistent approaches across settings
- there are high levels of fidelity to the original programme design and the programmes are manualised so they can be implemented consistently and correctly.

Services must be effective for different ethnic and cultural groups

There is good international evidence on which programmes are likely to be effective in the management of conduct disorder/severe antisocial behaviour. Some of these programmes have been successfully replicated for different ethnicities and in a number of different countries. Most of these programmes, however, have not yet been tested for their effectiveness in the New Zealand context. Any programmes selected for use in New Zealand must be shown to be effective for different cultural and ethnic groups, and agencies need to consider whether and how programmes can be supplemented to improve their effectiveness.

There must be clear agency accountability for engaging children, young people and their families and for producing, monitoring and reporting on clinically significant outcomes

Government and non-government agencies, professionals working with children and young people, and children and young people and their families themselves must have a clear understanding of which agencies are accountable for providing conduct disorder/severe antisocial behaviour services to which sub-groups of children and young people. There must be clear and pre-established measures of the effectiveness of interventions and these must be regularly monitored and reported on.

Effective inter-agency processes, at both a national and local level, are critical to success

All children need to receive core education and health services, and children with conduct disorder/severe antisocial behaviour should not be excluded from these services. Effective processes are required to co-ordinate broader services to meet all the needs of the individual child and their family. Joint training, interdisciplinary debate and relationship building are necessary for cross-agency work. Agreed screening and assessment tools, intervention strategies and programmes are needed to foster a consistent approach and to avoid multiple assessments of the child or young person and their family.

Achieving sustainable reductions in the prevalence of conduct disorder/ severe antisocial behaviour requires a long-term approach

There are significant challenges to achieving lasting reductions in the prevalence of conduct disorder/severe antisocial behaviour. In particular, it will take some time to build a well-trained and skilled workforce. Programme effectiveness also requires careful implementation and high levels of fidelity to the original design, and there must be sufficient time allocated to establishing how programmes shown to be effective overseas can also be effective in New Zealand.

Section 4: Key Actions 2007–2012

Introduction

This section sets out a six-year approach (2007–2012) to improve government's response to the management and treatment of children and young people with conduct disorder/severe antisocial behaviour.

The inter-agency plan represents the first step towards a more comprehensive cross-government approach to severe behavioural disorders. It includes a framework for the expansion and re-design of some existing specialist behavioural services, as well as measures to support better co-ordinated services and evidence-based decision-making across government into the longer term. Existing initiatives will be incorporated within these broader mechanisms.

The long-term approach set out in this plan reflects a number of environmental constraints. Firstly, any expansion to existing services in the short to medium-term must take account of the limited number of appropriately skilled and trained professionals working in this area. Secondly, the treatment of conduct disorder/severe antisocial behaviour is a complex area and we are still building our knowledge about what are effective approaches in this field. The main challenges in the area of best practice are in relation to services for older children who tend to require more complex and intensive interventions than younger children.

The plan sets out four broad action areas for ongoing work through to 2012:

- leadership, co-ordination, monitoring and evaluation
- transition existing service provision to evidence-based, best-practice interventions
- establish an intensive, comprehensive behavioural service for 3–7 year-olds
- build a shared infrastructure for the delivery of specialist behavioural services.

Action Area One: Leadership, co-ordination, monitoring and evaluation

Objective

Action Area One aims to ensure there is ongoing leadership, co-ordination, monitoring and evaluation of behavioural services across government throughout the implementation of this inter-agency plan.

Rationale

Action Areas Two, Three and Four set out a number of initiatives for the medium to long-term re-design of existing services and for the immediate development of new behavioural services. Action Area One will ensure there is good information sharing and co-ordinated decision-making across agencies as these initiatives progress.

Summary of key tasks

The Ministry of Social Development will assume responsibility for the ongoing leadership, co-ordination, monitoring and evaluation of this inter-agency plan. An inter-agency working group, with representation from the Ministries of Health, Education and Justice will contribute to this work. The Ministry will develop a detailed implementation and reporting plan through to 2012 that will include a series of regular reports to joint Ministers[25]. The Ministry will also develop a set of indicators to monitor the overall effectiveness of the inter-agency plan.

A national-level, inter-agency governance group comprising officials from the Ministries of Social Development, Health, Education and Justice will be established to oversee the implementation of the plan.

These officials will be supported by the establishment of an Experts' Group who will help guide the ongoing implementation of the plan and the development of specialist behavioural services. The Experts' Group will comprise leading researchers and practitioners in the area of conduct disorder/severe antisocial behaviour, and will include people with backgrounds in mental health, education, developmental psychology, and criminal justice. The Experts' Group will have four key tasks:

- report on the best-practice evidence base around the treatment of conduct disorder/severe antisocial behaviour and provide ongoing advice to agencies on how to better align their services with this research base (Action Area Two)

---

[25] This group will comprise the Minister for Social Development and Employment, the Ministers of Education, Health, Justice and the Associate Minister for Social Development and Employment (CYF).

- advise on the design and evaluation of a Centre of Excellence for behavioural services for 3–7 year-olds (Action Area Three)
- develop a common language and framework across agencies for the treatment and management of conduct disorder/severe antisocial behaviour (see Action Area Four)
- advise on the design of a shared, cross-agency screening and assessment tool (Action Area Four).

Box Two below sets out the key stages for the implementation of Action Area One.

Box Two: Action Area One Implementation Timeframe

Phase One 2007–2008
• The Ministry of Social Development (MSD) to develop a detailed implementation and reporting plan through to 2012. • MSD, with advice from the Inter-agency Governance Group, to appoint an Experts' Group and to manage the relationship between agencies and the Experts' Group.
Phase Two 2009–2012
• Ongoing monitoring of inter-agency plan.

Action Area Two: Transition existing service provision to evidence-based, best-practice interventions

Objective

Action Area Two

- builds on initiatives already under way within agencies to develop a comprehensive, cross-government, knowledge base of what are effective interventions in the management and treatment of conduct disorder/severe antisocial behaviour
- establishes a process for agencies to identify a series of measures to transition their existing services to better align with this research base by 2012.

Rationale

There is a good understanding across agencies about some of the key issues surrounding current practice and there are a number of initiatives already underway to pilot new treatment approaches and to review the effectiveness of existing specialist behavioural services. However, the treatment of conduct disorder/severe antisocial behaviour is a highly complex and specialist area, and no one agency has sufficient expertise to undertake a comprehensive and wide-ranging review of their services in isolation. This Action Area will establish a systematic process for the review and transition of existing behavioural services and will enable agencies to draw on the expertise located outside of government and in other government agencies throughout this process.

Summary of key tasks

The first step under Action Area Two is to develop a comprehensive body of knowledge on the effective management and treatment of conduct disorder/severe antisocial behaviour. This work will be done by the Experts' Group (see Action Area One).

The Ministries of Education, Health, Social Development and Justice and the Department of Corrections will use the best-practice report as the basis upon which to conduct their service reviews. The report will ensure agencies take a systematic and comprehensive approach to the review exercise, and will identify the issues that need to be covered in the reviews, including:

- eligibility criteria: are agencies using appropriate eligibility criteria to determine access to services?
- overall level and targeting of services: to what extent do agencies have an unmet demand among their clients for behaviour management services and are services being appropriately targeted (eg by age, by severity of behaviours, by geographic location)?

- range and mix of services provided: what is the evidence base for the effectiveness of the interventions currently being provided and are there any other promising interventions that should be investigated?
- programme implementation: what makes an intervention work, including the skills and training of the staff delivering the intervention and the fidelity shown to the original programme design?
- workforce capacity: does the existing workforce have the necessary skills, training and capacity to deliver effective behaviour management programmes?
- reporting and monitoring: to what extent do existing reporting and monitoring practices enable agencies to assess the impact of their services on short and longer-term outcomes, and for key population sub-groups?

Each of the agencies will draft a report for the Inter-agency Governance Group that identifies issues around current practice and proposes a series of measures to transition current practice to better align with the evidence base by 2012. The Inter-agency Governance Group will consider the comprehensiveness and alignment of these proposals across government and will ask the Experts' Group for comment and advice on the direction set out in these reports.

The Ministry of Social Development will then draft an inter-agency summary report that sets out the next phase of work in improving government's response to the management and treatment of children and young people with conduct disorder/severe antisocial behaviour.

There are already a number of initiatives under way to review current practice and some specific areas have already been identified by agencies that will be included in the agency reviews. These are discussed in more detail in Appendix 4.

Box Three: Action Area Two Implementation Timeframe

Phase One 2007–2009
• Experts' Group established and completes report on best-practice evidence base. • Agencies provided with a reporting template identifying areas to be covered in agency reviews. • Agencies report to Inter-agency Governance Group with findings on current practice and with proposals to transition services to better align with evidence base. • Experts' Group reviews proposals and reports findings to Inter-agency Governance Group. • Inter-agency Governance Group agrees a cross-government work programme through to 2012 and Ministry of Social Development drafts inter-agency summary report that sets out key milestones in the transitioning of government services.
Phase Two 2010–2012
• Implementation of cross-government work programme.

Action Area Three: Establish an intensive, comprehensive behavioural service for 3–7 year-olds

Objective

By 2012, build on the specialist behaviour services already provided by the Ministry of Education to ensure that children requiring a comprehensive behavioural intervention (up to 5% of children) receive this level of intervention before they are eight years old.

Rationale

Comprehensive behaviour interventions would benefit children and young people of all ages with conduct disorder/severe antisocial behaviour. Limited workforce and organisational capacity mean, however, it is not feasible to roll out comprehensive services to all age-groups in the short- to medium-term. Consequently, the priority will initially be given to establishing an effective behavioural service for 3–7 year-olds. There are a number of reasons underpinning this approach:

- it is possible to identify with a relatively high degree of accuracy which children in this age-group are on an antisocial developmental pathway
- services for this age group have a markedly higher success rate and are significantly less costly than services for older children[26]
- children who develop conduct disorder/severe antisocial behaviour in their early years are at a higher risk of poor long-term outcomes into adulthood than children who develop problem behaviours during adolescence
- there is currently an undersupply of services to this age group.

The service has a lower-age limit of three years. There is already a significant number of early intervention services that provide parenting programmes to vulnerable families, and parenting programmes are a core component of any behavioural change programme for very young children. For example, Family Start, an intensive home-visiting service that includes a parenting programme, is currently provided to 4.5% of New Zealand families and this figure is set to expand over the coming years. Additionally, as part of the work arising from Te Tahuhu, the Second New Zealand Mental Health and Addiction Plan, the Ministry of Health will update the framework for child and youth mental health services to address maternal and infant mental health. Children under three years will also be included in the Ministry of Health's review of Well Child/Tamariki Ora services that will consider post-natal depression and infant mental health.

---

[26] Church (2003).

Summary of key tasks

The behavioural service will include:

- systematic screening and eligibility processes across all early childhood centres and primary schools
- routine screening of 4 year-old children as part of the Well Child programme
- a comprehensive behavioural intervention for up to 5% of children with the most severe behavioural difficulties that comprises:
    - comprehensive assessment
    - individualised intervention planning and implementation
    - group-based parenting courses, that are evidence-based, to develop the skills of parents in supporting pro-social development
    - teacher skill development to help in the management of behaviours of particular children
    - child development programmes (for 5–7 year-olds only).
- case management, monitoring and referrals to other agencies as required.

More detail on these components is provided in Appendix 2.

The Ministry of Education is already piloting effective parenting and teacher programmes and will continue to build the service from 2007 onwards. It will take some time for the comprehensive service to be fully operational, and the initial phase will entail expanding the services already provided by Group Special Education, investing in workforce capacity, and testing and refining the new service before its full implementation.

The Ministry of Education will start increasing the proportion of 3–7 year-olds who currently receive specialist behaviour interventions and whose parents and teachers are provided with an evidence-based skill development programme. The Ministry of Education will adopt an evidence-based programme and implement supervision practices to ensure programme fidelity. The Ministry of Education will work with the Werry Centre[27] to build its capacity to deliver evidence-based parenting programmes, with the aim of being able to cater for all of its own training needs in the medium-term. Until then, the Ministry of Education will rely on specialist trainers from the United States and the United Kingdom.

To support this development, the Ministry of Education will establish a Centre of Excellence where the effectiveness of the comprehensive service can be demonstrated and evaluated. The purpose of the Centre will be to:

---

[27] The University of Auckland's Werry Centre provides workforce development, teaching and research in the field of child and adolescent mental health. It has a primary contract with the Ministry of Health to provide workforce development services.

- Create a benchmark for the level of change to be expected from future programmes. The evaluation of the demonstration programme will look at the impact of the programme on the prevalence of conduct disorder/severe antisocial behaviour, engagement in early childhood education or school, and other key outcome measures. This will include testing the effectiveness of the programme for different ethnic groups, and identifying any modifications that need to be made to the programme as a consequence.
- Identify any additional elements or refinements that need to be made to the comprehensive behavioural service. One of the key issues already identified by agencies is that a significant proportion of children engaged with the behavioural service will exhibit signs of other co-morbid mental health conditions that require specialist child mental health assessment and treatment. The Centre of Excellence will assess whether CAMHS services are able to respond to the increasing demand the behavioural service will create for specialist child mental health services and, if not, what further level of investment in these services would be required to meet this demand.
- Evaluate the fidelity measures required to ensure this ongoing level of effectiveness.
- Help identify implementation challenges.

The Experts' Group will be asked to advise on the design and evaluation of the Centre of Excellence.

The key stages in developing this behavioural service are set out in Box Four.

Box Four: Action Area Three Implementation Timeframe

Phase One 2007–2008

- Systematic screening and eligibility processes for the education sector developed, piloted and published.
- Gradually increase the proportion of Ministry of Education behaviour clients in the 3–7 age group receiving evidence-based parenting, child and teacher programmes.
- Begin investment in size, skills and training of Ministry of Education specialist workforce, including development of a group of experienced practitioners accredited in mentor and trainer roles.
- Complete design work on Centre of Excellence, with advice from Experts' Group, and begin implementation.

Phase Two 2009–2010

- Ongoing expansion of parent, teacher and child components of Ministry of Education services.
- Complete establishment of Centre of Excellence to test and refine the comprehensive behaviour intervention.
- Implement systematic screening and assessment processes for all 3–7 year-olds within the education sector.
- Continue to develop mentor and trainer role.

Phase Three 2011–2012

- Ministry of Education behaviour clients aged 3–7 years begin a comprehensive programme within 12 months of becoming eligible.
- Expand provision to ensure that children requiring a comprehensive behavioural intervention (up to 5 percent of children) receive this level of intervention before they are eight years old.
- Review the comprehensive intervention offered by the Ministry of Education and consider whether further refinement or additional components are required.
- Mentor and trainer group accredited.

Action Area Four: Build a shared infrastructure for the delivery of specialist behavioural services

Objective

Action Area Four aims to support agencies in the ongoing delivery of behavioural services by developing shared planning and delivery tools.

Rationale

There is currently a duplication of effort, and some inconsistencies, across agencies in the design, planning and delivery of specialist behavioural services.

Summary of key tasks

There are three main elements to this action area:

- The development of a common, inter-disciplinary and New Zealand-wide language and framework for understanding conduct disorder/severe antisocial behaviour. While there is a relatively high level of consensus across the disciplines of education, medicine, criminal justice and psychiatry on what are effective treatments for conduct disorder/severe antisocial behaviour, there are marked differences in the theoretical frameworks used to understand conduct disorder/severe antisocial behaviour. This has hampered inter-agency strategic planning. This work will be done by the Experts' Group (Action Area One).
- A shared model for the identification of children and young people with conduct disorder/severe antisocial behaviour, for the assessment of the needs of those children and young people, for their referral to specialist services, and for the delivery of comprehensive, integrated behaviour-change services. This model will be established during the implementation of the comprehensive service for 3-7 year-olds and can then be adapted for use by other agencies and for older age-groups. In particular, a common screening tool for use in the classroom and by care and protection workers, the youth justice sector and health workers will be agreed. This work will be guided by the Experts' Group (see Action Area One).
- A joint approach to workforce planning and training. This will consider training and capacity demands across the whole age spectrum and across agencies. This work will focus on providing training for interventions that have been shown to be effective in the treatment of conduct disorder/severe antisocial behaviour. This work will be co-ordinated by the Ministry of Social Development.

Box Five: Action Area Four Implementation Timeframe

Phase One 2007–2008
• Experts' Group to develop common language, framework and approach to conduct disorder/severe antisocial behaviour. • Experts' Group to advise on the development of common screening and eligibility tool. • MSD to initiate a joint workforce development work programme.

Appendix 1: Existing Services

Detailed Description of Specialist Behavioural Services

Ministry of Education

Specialist behaviour intervention services provided through Vote Education can be summarised as follows:

<table>
<tr><th rowspan="2">Specialist behaviour intervention</th><th colspan="6">Approx no. children receiving behaviour service during 2005 (by age at 1 July 2005)</th></tr>
<tr><th><5</th><th>5-7</th><th>8-12</th><th>13-14</th><th>15-22</th><th>TOTAL</th></tr>
<tr><td>Severe behaviour initiative</td><td>148</td><td>989</td><td>2,500</td><td>954</td><td>235</td><td>4,826</td></tr>
<tr><td>Early intervention – behaviour</td><td>492</td><td>39</td><td>-</td><td>-</td><td>-</td><td>531</td></tr>
<tr><td>Early intervention – comprehensive (based on estimate of 20% of services)</td><td>804</td><td>90</td><td>-</td><td>-</td><td>-</td><td>894</td></tr>
<tr><td>Ongoing and reviewable resourcing schemes (ORRS)</td><td>-</td><td colspan="5">Unknown (7,000 students in ORRS but impossible to separate behaviour services)</td></tr>
<tr><td>Residential behaviour schools and offsite centres</td><td>-</td><td>-</td><td colspan="2">180*</td><td>-</td><td>180</td></tr>
<tr><td>Project Early</td><td colspan="2">75</td><td>-</td><td>-</td><td>-</td><td>75</td></tr>
<tr><td>TOTAL</td><td colspan="2">2,637</td><td colspan="2">3,634</td><td>235</td><td>6,506</td></tr>
</table>

*Some of these children may receive a service from the severe behaviour initiative within the same year.

Many other education services are available to support children with behaviour, attendance and/or learning problems. These include Resource Teachers: Learning and Behaviour, activity centres, funding for interim response. These initiatives do not deliver behaviour interventions to individuals to address severe behaviour difficulties.

Severe Behaviour Initiative

In August 1998, Cabinet agreed that the Behaviour Specialist Support Service should be implemented nationally and set out that this initiative was designed to:

- provide immediate intervention to help schools manage crisis situations relating to individual students
- provide interventions (through specialists, expert teachers and discretionary resourcing) to schools which have exhausted their own strategies, which significantly reduce the inappropriate behaviour of the targeted students and enable them to achieve sound learning outcomes in the long term
- co-ordinate across non-education government and non-government agencies
- help schools to develop proactive strategies and systems for students with behaviour difficulties which will reduce the percentage of students presenting with severe behaviour problems.

Children are referred by educators, Resource Teachers:Learning and Behaviour and other special education specialists. The operational criteria for service are that behaviour:

- jeopardises the physical safety of the student or others
- threatens to cause, or causes, significant property damage
- severely limits the student's access to ordinary settings and interferes with social acceptance, sense of personal wellbeing and their educational performance.

Interventions provided by the Severe Behaviour Initiative may include:

- advice and specialist support for students with severe behaviour difficulties, their schools and their families
- provision of evidence-based parenting programmes
- provision of funding or support workers to help the school and the family to implement a programme of support
- Centres for Extra Support that provide day provision of withdrawal settings.

Early intervention services

In 1997 Cabinet agreed that Special Education 2000 should include an initiative for resourcing the early childhood sector. This was built on existing services that were intended for children from birth to entry into the school system, for children who have an intellectual or physical disability, a significant speech or language difficulty, a behaviour difficulty or learning difficulty, or who are deaf, hearing-impaired or vision-impaired.

Early intervention services are provided for children with special education needs from birth to the time they start school. Children do not need to attend an education service to be eligible. Referral may be from the family, health professionals or early childhood education services.

Sometimes early intervention services are recorded as specific behaviour interventions (531 in 2005). This will involve psychologists and special education advisors who provide advice and specialist support for students with severe behaviour difficulties, their early childhood education services and their families on specific behaviour programmes.

However, in most cases services are recorded as a "comprehensive" service (4,018 in 2005). This will include a range of services addressing a range of needs. If the child has behaviour needs then the comprehensive service may include a behaviour intervention. We do not hold good information on this. However, it is estimated at least 20% of these cases involve a significant behaviour component.

Ongoing and Reviewable Resourcing Schemes (ORRS)

In 1995, Cabinet agreed in principle to the concept of individual portable entitlements to be created for students with the highest needs – what we now know as ORRS.

Students are deemed eligible for ORRS through a centrally-administered verification system. They are assessed in relation to detailed criteria that set out different types of educational need and verified as "high" or "very high" need. It was not intended that a child with behaviour difficulties would meet the criteria for ORRS unless they also had other special needs.

In 1998 adjustments were made to the criteria in response to concerns about the exclusion of children with autism spectrum disorder (ASD). Additional criteria were added as "needs arising from severe disorder of both language use and appropriate social communication". This may have led to an increase in the number of children who required behaviour services.

ORRS students are entitled to an ongoing package of resourcing. The entitlement is intended to cover all services that are necessary to enable the student to participate in and gain benefit from the school programme. This includes additional staffing for their school, and a cash component that is used to provide a combination of specialist and teacher aide support. Specialist support may be provided by the Ministry of Education, Group Special Education or by another provider such as a special school. This may include specialist behaviour support but we do not collect this information.

Residential behaviour schools and other off-site support

Residential behaviour schools and other off-site support centres provide education provision to children who are unable (or unwilling) to attend regular school. They have the objective of supporting the child to the point where they are able to transition back into their regular school. Off-site centres serve small groups of children in a few localised areas.

Some children are referred to a residential school through the Severe Behaviour Initiative or directly by the schools/Resource Teachers:Learning and Behaviour. The residential schools have their own criteria to assess whether placement at the school will be beneficial. This usually includes a requirement for parent and regular school commitment to the programme, and for this reason they may refuse children with complex social/family needs.

Local off-site centres usually receive referrals of children from schools, the police and other agencies. These children have a range of behaviour, attendance and social problems. Some will have severe behaviour difficulties.

Residential behaviour schools and other off-site support provide education programmes designed and delivered to support children with behaviour difficulties. Alongside their education programme they also provide behaviour support for the individual child. Some centres may also provide support to parents or to the regular school, although this is highly variable and the centres/schools are not specifically funded to deliver this support.

Project Early

Project Early is an early intervention programme designed to help 3–7 year-old children with behaviour problems. It exists only in two school clusters: one in Auckland and one in Christchurch.

Children are referred by participating schools when they have behaviour difficulties. Case-workers work with the teachers and parents of children with challenging behaviour to develop strategies to modify the children's behaviour and implement education outcomes.

Further information

In 2004, an analysis was done of the previous six years of data on behaviour services to provide more information on the nature of behaviour interventions provided.

This analysis was based on the Severe Behaviour Initiative school-based services, and those early intervention services that were recorded specifically as behaviour support (ie it did not include behaviour services delivered as part of a comprehensive early intervention service).

Over the six-year period 21,707 children and young people received 36,686 interventions.

This analysis revealed characteristics of children receiving services:

- ethnicity: Māori 35.5%, New Zealand European 53.7%, Pacific 4.6% and other groups 6.2%
- gender: 72% male, 28% female
- average age at first intervention: 10.6 years.

On average children and young people received 135 total hours of support (47 hours specialist intervention and 88 hours behaviour teacher aide). This may have been provided through a number of interventions over the six years:

Number of interventions	Percentage (%) of individual children
1	65.4
2	18.4
3	7.9
4	3.8
5	2.1
6 or more	2.5

The average duration of an intervention was 7.6 months.

The duration and intensity of support increased slightly for children who have already received multiple interventions:

Intervention	Average duration (hours)	Intensity (hours per month)
1st	21	3.6
2nd	36	4.8
3rd	39	5.2
4th	40	5.6
5th	40	5.2
6th and subsequent	35	5.1

Ministry of Social Development (Child, Youth and Family)

A large component of the demand for Child, Youth and Family services arises from concerns about young people's behaviour. As a consequence, Child, Youth and Family both provides, and contracts for the provision of, a number of specialist conduct disorder programmes. Recent investment has focused on:

- two intensive residential treatment programmes for 52 12–16 year-olds diagnosed with conduct disorder
- two group homes for 10 12–16 year-olds with behavioural/conduct disorder behaviours in Hamilton and Te Atatu
- multi-systemic therapy (MST) for up to 80 10–16 year-olds at medium/high risk of re-offending and 14–16 year-olds at high risk of re-offending in Auckland
- one-to-one specialist placements with trained caregivers for 40 12–16 year-olds with behavioural/conduct disorder behaviours
- three national bed-night providers offering specialist treatment services for 40 12–16 year-olds with extreme behavioural disturbance, including conduct disorder
- high-cost case funding is available in exceptional cases for children and young people in the care of Child, Youth and Family where local resources are insufficient to meet need and where there are not high inter-sectoral needs[28] – in 2005, of 88 approved applications, 52% were for extreme behavioural disturbances including conduct disorder
- case-by-case funding to purchase additional services where local resources are insufficient – in 2005 funding was awarded for the purchase of specialist treatment services for 148 12–16 year-olds with serious behavioural disturbances

[28] Where there are high inter-sectoral needs across agencies, the High and Complex Needs unit funding is available for applications with the highest and most complex needs.

- community-based therapeutic treatment programme for 100 12–16 year-olds at-risk of offending in Auckland
- therapeutic programmes for 75 14–16 year-old youth offenders delivered by iwi providers.

The Ministry of Health and District Health Boards

Child and Adolescent Mental Health Services (CAMHS) do not provide treatment services that specifically address conduct disorder/severe antisocial behaviour alone. Service specifications for all mental health services are set out in the Nationwide Service Framework 2001 (NSF). The NSF includes among the list of exclusions services for people whose problems are solely as a result of criminal activities (antisocial behaviour) and conduct disorder.

It is rare for children and young people to present with conduct disorder and no other co-morbid mental health problems. Therefore CAMHS, youth alcohol and other drug services and other health providers (including paediatric services) do assess and treat those with mental health problems and conduct disorder or other behaviour problems. Many mental health interventions for children and adolescents are delivered in a family context and may include parenting/behaviour management components to help parents to support the young person's developmental and mental health needs. However, conduct disorder/severe antisocial behaviour is not the primary focus of intervention. CAMHS and youth alcohol and drug services are not resourced and many clinicians are not trained to provide the range and intensity of evidence-based interventions required for this client group. Separate data on the number of children and young people with mental health problems who are treated in CAMHS for co-morbid behavioural problems is not available. However, a significant proportion of the 20,000 children and adolescents who receive specialist mental health services each year have behavioural problems.

Similarly, other health providers, particularly many Well Child and paediatric services, intervene with children and young people with behavioural problems, but separate data on this is not kept.

High and Complex Needs Unit

The Intersectoral Strategy for Children and Young People with High and Complex Needs (HCN strategy) provides the framework for the Ministries of Health, Education and Social Development to work together to address the needs of those children and young people who have needs so high, complex and mixed up across sectors that it is unreasonable to expect single sector interventions will work (even with effective co-ordination).

The HCN strategy includes:

- Case co-ordination, building from local co-ordination initiatives such as Strengthening Families.
- Joint services responses: integrating existing services, development of additional service capabilities, or developing new joint services.
- Exceptions funding: for those with the highest and most complex unmet needs in two or more sectors. The HCN unit manages the Exceptions Fund which funds individualised interventions for between 60–80 children and young people (aged 0–21 years) at any one time. A key component of the Exceptions Fund approach is joint planning and delivery of intervention across agencies and domains, supported by intensive case management.

Appendix 2: Proposed Service

Core Components of Specialist Service for 3–7 Year-Olds

- **Systematic screening processes.** Key agencies are currently developing and assessing screening and eligibility tools to help in the identification of children with conduct disorder/severe antisocial behaviour. The tool will focus on the identification of conduct disorder/severe antisocial behaviour rather than children who simply exhibit those behaviours (all children are expected to exhibit some antisocial behaviour at certain stages of development).
- **Comprehensive needs assessment.** Children identified as having severe behavioural difficulties will be referred for a comprehensive assessment of their needs. Assessment will cover the family, educational environment, previous interventions, additional risk factors and possible protective factors. It will also include physical health, mental health, truancy and educational difficulties and psychosocial and family relationships. The assessment will include consideration of the behavioural factors in the family/whānau and other settings that reinforce conduct disorder/severe antisocial behaviour and which need to change. It will identify those cases where the conduct disorder/severe antisocial behaviour is likely to be caused by abuse and engage Child, Youth and Family to ensure the child's safety. Assessment of the child's cultural needs and the way in which programmes should be delivered will be included. The assessment will be carried out by qualified professionals who can identify co-morbidities that need clinical-level management including involvement with specialist mental health clinicians.
- **Intensive behaviour-change programme.** Children identified as having severe behavioural difficulties will then be offered a behaviour-change programme. The programme will include an evidence-based parenting programme and child and teacher components. It will also ensure the child has access to specialist mental health treatment services, where indicated. Following intensive interventions, and if the child has become detached from mainstream services, there would need to be a transition plan for the withdrawal of intensive support and intervention. During and after the provision of intensive services local co-ordination and universal services will be used to support the inclusion of the child in their school, home and community. Cultural issues should be considered as culturally-competent delivery will be vital for Māori, Pacific peoples and others.

- **Case co-ordination.** Some form of case co-ordination will also be added to the behaviour-change programme to address the needs of family/whānau that put at risk the parent's or child's ongoing participation in the programme. This will include how issues such as parental mental health, drug and alcohol issues, housing, and income support should be covered. While the plan does not envisage new ways of addressing these issues, it does envisage collaboration and co-ordination with the providers of these services. Co-ordination of behaviour-change programmes with existing services for children with disabilities who exhibit conduct disorder/severe antisocial behaviour will be required.
- **Ongoing monitoring and reporting.** Every intervention will be accompanied by monitoring the changes in the behaviour of the child ie, their increasing pro-social and decreasing antisocial behaviours.

Appendix 3: International Examples

Examples of prominent, international, evidence-based interventions

Incredible Years series: The Incredible Years comprehensive programme is an American intervention that includes parent, teacher and child-training components for children aged 1–12 years with conduct disorder/severe antisocial behaviour. The programme uses group discussion, videotape modelling and rehearsal intervention techniques. The programme has been shown to be highly effective in the prevention and treatment of conduct disorder/severe antisocial behaviour and these results have been successfully replicated for parents of different ethnicities and have been demonstrated in a number of countries. This includes a study carried out in New Zealand (Tauranga).[29] Elements of the programme are currently used in New Zealand by some Child and Adolescent Mental Health Services (CAMHS) providers, in some Ministry of Education Group Special Education regions, and by a small number of non-government organisations.

Positive Parenting Programme (Triple P): The comprehensive interventions in the Triple P series include parenting programmes for the parents of children 1–14 years with conduct disorder/severe antisocial behaviour. Triple P has five levels of intervention of increasing strength from the provision of universally available instructional material to comprehensive parent training including home visits. Triple P is an Australian programme and is widely used there and has been evaluated in a cultural setting with many similarities to New Zealand. Some New Zealand practitioners have been trained in Triple P.

Multi-systemic therapy (MST): This involves individualised interventions that target subsystems that seem to have the greatest effect in maintaining the adolescent's difficulties (school, family, peers, neighbourhood and organisations the young person connects with). This is a short-term (five to six month) intensive, community-based intervention. Practitioners have low caseloads (three to six), are on call 24/7 and provide an intensive level of client contact (multiple contacts per week, in person or by phone), especially early in the intervention process. Service delivery can be out of hours to accommodate family needs. Practitioners are rigorously supervised by MST trained supervisors to ensure interventions are goal focussed, adhere to the nine principles of MST and are evidence-based. Overall efficacy for MST has been established through a recent meta-analysis; initial dissemination and evaluation in New Zealand has produced similar findings, supporting MST as capable of significantly reducing offending and family/peer-related risk factors.[30]

---

[29] Lees & Ronan, 2007.

[30] Curtis, Ronan, & Borduin, 2004; Curtis, Ronan, Heiblum, & Crellin, 2007.

Two NGOs (Youth Horizons Trust and Richmond Fellowship) have formed MST (NZ), a partnership that holds the franchise from MST in the United States, and this local organisation provides training and supervision for the increasing number of New Zealand MST teams.

Multi-dimensional treatment foster care (MTFC): Community families are recruited, trained and paid to provide placements for young people as an alternative to group homes. Foster parents are provided with weekly group supervision with other foster parents facilitated by a supervisor. They also receive daily telephone calls covering problems during the previous 24 hours. The young person receives weekly individual therapy focussed on building skills in problem solving, social skills and non-aggressive means of expression. When it is planned for the young person to return to the care of biological family, weekly parenting training is provided. The young person is closely monitored, especially to prevent contact with delinquent peers. Supervisors are on call 24/7, which reflects the level of support required for foster parents caring for such difficult to manage young people in therapeutically effective ways. At least one NGO is considering the use of MTFC in New Zealand.

Functional family therapy (FFT): This is a short-term behavioural intervention that involves 12–24 hours of therapist contact with family seeking to change the patterns of family interaction and communication in such a way that adolescent conduct disorder/severe antisocial behaviour is no longer functional. FFT is designed to improve communication and reciprocity between family members and includes many of the evidence-based interventions that are part of parent training programmes like Incredible Years, adapted for adolescents. There are currently few practitioners trained in FFT in New Zealand.

Appendix 4: Reviews of Current Practice

Focus areas for Agencies' Reviews of Current Practice

- **Ministry of Education.** The Ministry has completed a review of its practice with younger children and this work informs the proposals under Action Area Three. The Ministry is now in the process of completing an analysis of evidence-based interventions for children in the 8–12 year age range on the antisocial developmental pathway. This work looks at contributing factors to antisocial development, evidence-based interventions, current practice within Group Special Education, and what future evidence-based practice might look like. Other specific issues that will be considered by the Ministry are (i) whether access to specialist behavioural services should be extended to young people who are still in school, but beyond Year 10 (ii) improving practice around the ongoing support provided to children and young people with behavioural difficulties, particularly during major life-events and school-transition points, and (iii) the effectiveness of alternative education policies for children and young people with behavioural difficulties.
- **Ministry of Health.** The Ministry will review the role of CAMHS and youth alcohol and other drug services in service provision for young people with conduct disorder/severe antisocial behaviour to take account of the work of this plan. It will also work with district health boards to develop a service description for youth forensic services. Additionally, as part of the work arising from Te Tahuhu, the Second New Zealand Mental Health and Addiction Plan, the Ministry of Health will update the framework for child and youth mental health services to address maternal and infant mental health. Children under three years will also be included in the Ministry of Health's review of Well Child/ Tamariki Ora services that will consider depression and infant mental health.
- **Ministry of Social Development.** The main focus of the Ministry's review will be on the behavioural services provided to clients of Child, Youth and Family. The Ministry will review whether Child, Youth and Family caregivers and foster carers are accessing behavioural support services for children and young people who are in school, and will consider the level of training required for foster carers in the management of behavioural difficulties in children and young people. The Ministry will also provide ongoing updates to the Inter-agency Governance Group on findings from existing evaluations, in particular the Reducing Youth Offending pilot. Finally, the Ministry also has responsibility for a number of early intervention programmes for vulnerable families, and will consider the role of these programmes in providing parents with the skills to manage their young child's difficult behaviours.

- **Ministry of Justice.** The Ministry, in conjunction with the Youth Horizons Trust, is establishing a new treatment programme for serious youth offenders (Te Hurihanga) in Hamilton. The programme will involve a residential component and community-based component using MST to reduce youth offending. The programme is being evaluated by the Ministry and findings from the evaluation with be shared with the Inter-agency Governance Group.

Bibliography

Church R J (2003) *The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties:* A Review of Research, Ministry of Education: Wellington.

Church R J (1996) *The Prevalence of Children with Behaviour Disorders in Canterbury Primary Schools,* Department of Education, University of Canterbury in association with the Canterbury Primary Principals' Association: Christchurch.

Curtis N M, Ronan K R, Borduin C (2004). Multisystemic Treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18*, 411–419.

Curtis N M, Ronan K R, Heiblum N & Crellin K (2007). *Multisystemic Treatment in New Zealand: Dissemination, preliminary outcomes, and benchmarking.* Manuscript submitted for publication.

Curtis N, Ronan K R, Heiblum N, Reid M & Harris J (2002). Antisocial behaviours in New Zealand youth: Prevalence, interventions and promising new directions. *New Zealand Journal of Psychology, 31*, 53–58.

Farrington D P and Coid J (eds) (2003) *Early Prevention of Adult Antisocial Behaviour,* Cambridge Studies in Criminology, Cambridge University Press: Cambridge.

Farrington D P and West D J (1993) Criminal, penal and life histories of chronic offenders: risk and protective factors and early identification, *Criminal Behaviour and Mental Health,* 3, 492–523.

Fergusson D M, Horwood L J and Lynskey M (1994) The childhoods of multiple problem adolescents: a 15-year longitudinal study, *Journal of Child Psychology,* Vol 35 No 6 pp1123–1140.

Fergusson D M, Horwood L J and Ridder E M (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood, *Journal of Child Psychology and Psychiatry,* 46 (8), 837–849.

Fergusson D M, Swain-Campbell N and Horwood L J (2004) How does childhood economic disadvantage lead to crime? *Journal of Child Psychology and Psychiatry,* 45:5, 956–966.

Fonagy P, Target M, Cottrell D, Phillips J and Kurt Z (2002) What Works for Whom? A Critical *Review of Treatments for Children and Adolescents,* The Guilford Press: New York.

Frick P J (2006) Developmental pathways to conduct disorder, *Child Adolescent Psychiatric Clinics of North America,* Vol 15 (2), 311–331.

Frick P J (2004) Developmental pathways to conduct disorder: implications for services for youth who show severe aggressive and antisocial behaviour, *Psychology in the Schools,* Vol 41(8), 823–833.

Frick P J (2001) Effective interventions for children and adolescents with conduct disorder, *Canadian Journal of Psychiatry,* Vol 46, 26–37.

Frick P J (1998) *Conduct Disorders and Severe Antisocial Behaviour,* Plenum Press: New York.

Gérardin P, Cohen D, Mazet P and Flament M F (2002) Drug treatment of conduct disordered young people, *European Neuropsychopharmacology,* 12, 361–370.

Kazdin A (2002) "Psychological treatments for conduct disorder" in P E Nathan and J M Gorman (eds) *A Guide to Treatments that Work* 2nd edition, Oxford University Press: Oxford and New York.

Lees D & Ronan K R (2007) Engagement and effectiveness of Parent Management Training (Incredible Years) for solo high risk mothers: A multiple baseline evaluation. Manuscript submitted for publication.

Lochman L (2006) National Institutes of Health State-of-the-Science Conference Statement on Preventing Violence and Related Health-Risking Social Behaviours in Adolescents, October 13–15, 2004, *Journal of Abnormal Child Psychology,* 34, 457–470.

Rubin J, Rabinovich L, Hallsworth M and Nason E (2006) *Interventions to Reduce Antisocial Behaviour and Crime: A Review of Effectiveness and Cost,* Rand Corporation: Europe.

McLaren K L (2000) Tough is Not Enough – *Getting Smart about Youth Crime,* Ministry of Youth Affairs: Wellington.

Ronan K R & Curtis N M (2007) Systems interventions with antisocial youth and families. In VandeCreek, L. (Ed.), *Innovations in clinical practice: Focus on group, couples, and family therapy.* Sarasota: Professional Resource Press: in press.

Scott G (2003) *The Economic Benefits of Rehabilitating Chronic Adolescent Antisocial Males* Proceedings of a Conference July 1–2, 2003, Youth Horizons Trust, University of Auckland.

Silverthorn P, Frick P J and Reynolds R (2001) Timing of onset and correlates of severe conduct problems in adjudicated girls and boys, *Journal of Psychopathology and Behavioural Assessment,* Vol 23 (3), 171–181.

Vermeiren R (2003) Psychopathology and delinquency in adolescents: a descriptive and developmental perspective, *Clinical Psychology Review,* 23: 277–318.

Welsh B (2003) Economic costs and benefits of primary prevention of delinquency and later offending: A review of the research in Farrington D P and Coid J (eds) (2003) *Early Prevention of Adult Antisocial Behaviour,* Cambridge Studies in Criminology, Cambridge University Press: Cambridge.

Werry J S (ed) (2003) Severe Conduct Disorder (Juvenile Psychopathy): *toward an evidence-based national strategy for care and prevention* Proceedings of a Conference July 1–2, 2003, Youth Horizons Trust, University of Auckland.

New Zealand Government