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Can Severe Behaviour Problems be Prevented ?

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Abstract

This study examines the etiology of antisocial behaviour and explores the biological and environmental factors which influence its development. The aim of this research is to look at whether early detection of severe problem behaviour in children, coupled with appropriate intervention, may prevent the possibility of antisocial behaviour patterns becoming firmly established during the adolescent years. Using the framework of an ecological model this study examines the various layers at which behaviour is influenced. Social policy reforms in New Zealand during the past fourteen years (1984-1998) are outlined and the impact they have had upon families and social work practice within the Children, Young Persons and their Families Service (CYPFS). The policy and procedural changes within CYPFS are evaluated. Current literature on antisocial behaviour, treatment, interventions and prevention, post traumatic stress disorder and attachment, is reviewed.

This is an exploratory research design and uses the method of file content analysis to examine 306 retrospective case records which were referred to a local CYPFS office between 1990-1995, under the category of Problem Behaviour. The findings from this study are related to the wider context of research in the literature. There was an over representation of Maori within the study sample, compared to the Maori population from the local community. There were marked gender differences for behaviour categories, with an over representation of males in the severe antisocial behaviour accompanied by recidivism and recidivist offending only categories and an over representation of females in the adolescent/peer related behaviours. Children and young people who fared the worst came from families with multiple problems and environments where there was domestic violence and child abuse. One third of the young people from this study had severe antisocial behaviour and/or recidivism. Most of them did not receive an early or timely intervention and many of them required long term placements, estimated to be costly to CYPFS. The overall findings from this study suggest that a timely intervention on the first referral to CYPFS may have prevented ongoing re-referrals and costly placements. Further research is recommended in order to test these findings.

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Chapter One

Introduction

1.1. The Reason for the Study

This study emerged due to concern regarding the number of severe behaviour problems, especially among young adolescent males who were being referred to CYPFS, and who displayed uncontrollable patterns of persistent antisocial behaviour and offending.

Some of the common factors underpinning severe behaviour problems are a direct consequence of :

1. Attachment related difficulties: *“attachment insecurity tends to develop between children and adults when there are serious difficulties in meeting each other’s needs. Some attachment disturbances manifest with symptoms similar to conduct disorder (hostile & aggressive behaviour) or personality disorder (serious difficulty in reciprocating trust, closeness or intimacy)”* (Kney1998:5).
2. Domestic family violence: During 1996/1997 there were 1,146 assaults on a child, resulting from domestic violence, which were reported to the N.Z. Police. Infants are potentially extremely vulnerable to harm caused through domestic violence, due to their limited cognitive ability and resource for adaptation. Frequently infants who witness spousal violence suffer behaviours such as poor sleeping, excessive screaming, poor health, and their basic needs for attachment maybe significantly disrupted (James, 1994; Jaffe *et al* 1990). Early experiences of stress form a kind of template around which later brain development is organized (Perry, 1996). Shepherd (1995) found from her studies that children of battered women scored significantly higher on behavioural and emotional problems (e.g. aggression, anxiety). Her studies reported 50% of children witnessing wife assault were rated

as evidencing behavioural and emotional problems similar to children in mental health settings, in contrast with only 5% of comparison children. Similar findings were found in the Christchurch Child Development Study (N.Z.), where young people who reported exposure to harsh or abusive treatment during childhood, had elevated rates of violent offending, alcohol abuse, suicide attempts, and being a victim of violence by the age 18 years of age (Fergusson & Lynskey 1997).

Conduct disorder is one of the most intractable mental health problems of childhood and adolescence. Its prevalence is estimated to range from approximately 4% to 10% of the child and adolescent population, with higher rates in males rather than females. (Bierman *et al* 1992; Clarkson, 1994; Lösel & Bliesner, 1994). However, most research has concentrated on externalized problem behaviours, which are more apparent in males, with less exploration of internalizing behaviours such as eating disorders and depression, frequently associated with females. Clarkson (1994) estimates that conduct disorder (CD) is four times more common in males than females and among the young males seen in psychiatric clinics, CD is by far the most common problem. There is a view, however, held by Werner & Smith (1992), that girls are more resilient than boys during childhood, but more vulnerable in adolescence when problems such as eating disorders and depression arise.

The literature indicates that childhood and adolescent CD tends to be chronic, frequently leading to criminal and antisocial behaviour. It includes excessive non-compliance, stealing, truanting, absconding, physical violence, cruelty, sexually coercive behaviour, drug/alcohol dependence, and depression in women (Loeber & Schmaling 1985; Clarkson, 1994). Marked and persistent delinquency appears to be predicted relatively well, and a core group of chronic offenders is responsible for nearly one-half of the criminal acts (Blumstein *et al* 1988; Pulkkinen, 1988; Wolfgang *et al* 1972).

Subsequently, many people suffering from severe antisocial behaviour problems require long term treatment/care from our mental health and CYP&F services. This, combined with the enormous cost to society through offending and recidivism, prompted this study, in order to assess common themes associated with CD and ascertain appropriate

interventions which may prevent antisocial / CD behaviour patterns from becoming firmly established during the adolescent years.

However, prior to and during the 1980's, there was general agreement that serious and persistent antisocial behaviour was resistant to treatment (Kazdin, 1987; Lösel *et al* 1987), and early intervention/prevention was ineffective (Lösel 1987; Kazdin 1987; Lytton 1990). This belief appears to have influenced some of the practice associated with severe behaviour problems.

According to Bierman *et al* (1992) the problems with past intervention efforts have been:

1. Most interventions have lacked a developmental focus that is attentive to age related stressors i.e. PTSD, insecure attachments in early childhood, (Perry 1996; Ainsworth 1989), and the need for continued intervention over long periods (Cicchetti 1984). CD is a chronic disorder which requires monitoring and focused intervention during high stress times such as primary school entry.
2. Some past interventions have failed to articulate and evaluate a developmental hypothesis of how intervention aimed at a short term, proximal goal will lead to long term prevention of CD. To be successful, intervention efforts must be based on a comprehensive theory of the developmental psychopathology of CD.
3. One of the main reasons for the "*nothing works*" mentality toward CD is because past intervention efforts have been directed to a single component of CD i.e. focus on the child's behavioural deficits only or parental discipline practices only, in isolation of other ecological factors. Given that CD usually develops in a context of multiple determinants, like family stress, parenting deficits, alienation between school and family, child's social skill deficits, academic failure and so on, it is not surprising that limited focus interventions have limited effects (Bierman *et al* 1992). Thus preventative intervention should be comprehensive and attentive to the social fields of the peer group, classroom and family, as well as connections between the family and school. (Comer, 1980; Hawkins & Weis 1985).

4. There is a need to differentiate between relatively successful measures of treatment and the less successful ones. (Andrews *et al* 1990; Lipsey, 1992; Lösel, & Köfel 1989). Researchers must either develop preventative models that apply to multiple groups i.e. persons of diverse ethnicity and cultural backgrounds, gender differences, subtypes of behavioural difficulty, or evaluate which interventions are successful with particular groups (Bierman *et al* 1992).

Preventative intervention and programmes need to focus on the characteristics known to increase the risk of CD, such as family discord as evidenced by hostility, coercive parent-child interactions, unresponsiveness, poor communication, PTSD, insecure attachments in early childhood, child maltreatment, parenting/child social skill deficits, and alienation between school and family. (Wolf, 1985; Wolkind & Rutter, 1985; Offord, 1989; Ainsworth 1989; Bierman *et al* 1992; McDowell, 1995; Perry, 1996).

1.2. The Hypothesis and Research Design

The purpose of this study is to ascertain if the degree of severe antisocial behaviours among young people can be reduced through early preventative intervention.

This is an exploratory study designed to hypothesise “*that early detection of severe behaviour problems in children, coupled with appropriate intervention will, in a majority of situations, prevent problem anti-social behaviour patterns from becoming firmly established during the adolescent years, by which time positive change is either extremely difficult or impossible*”.

This research study focuses on retrospective case records classified as “problem behaviour” notifications, referred to CYPFS Waitakere between 1990 and 1995 and it examines the relationship between CYPFS interventions in the lives of children deemed to have a problem behaviour, who are the subject of a Care and Protection (CP) notification, and the long term outcomes for these children. However, due to the fact that the level of knowledge accumulated in this particular field within CYPFS is

extremely limited and because there is no certainty between the correlation of the dependent variable (outcome) and the independent variable (intervention), it is considered appropriate to use an exploratory form of research design, the purpose of which would determine the magnitude of the problem, ascertain the variables and common themes.

The objectives are:

- To determine the degree in which CYPFS has gradually changed its threshold, categories and criteria for accepting referrals for behaviour problems since 1989.
- Ascertain the number of re-referrals, reasons and subsequent level of intervention.
- Analyze the data, and compare with other studies, in order to establish whether initial early intervention could have prevented subsequent re-referrals, crisis situations, youth offending etc.
- Assess common themes, family dynamics such as stress, parenting abilities, social isolation, alienation between school and family, child social skill deficits, academic failure, poverty etc., in order to indicate potential risk factors.

This research is intended to provide an overview of the theories and risk factors associated with antisocial behaviour and offer a guide for further ongoing research, which will assist in gaining insights into preventing the onset of antisocial behaviour. An ecological model forms the framework for analysis. This perspective takes account of the effects of the complex environment upon the child and stresses the importance of the conceptualization of contextual levels, offering a mult-level analysis, such as:

1. The microsystem: refers to family, school and peers.
2. The mesosystem: which is the quality and type of relationship among the microsystem of home, school and peers.
3. The exosystem: refers to the type of community in which the child lives, extended family, the form of employment opportunities, and other wider social factors which impinge upon the child and family.
4. The macrosystem: refers to socio-economic factors and cultural differences which impact upon the beliefs and ideologies of the child (Bronfenbrenner 1979).

The following chapters provides this foundation. Chapter 2 addresses the exosystem and macrosystem and highlights the significant political, economic and legislative changes which have occurred during the last ten years, and the impact these have had on 'at risk' children, families and social service delivery, Chapter 3 defines conduct disorder, describing its symptomology, aetiology and comorbidity with other disorders. Chapter 4 addresses the micro and meso systems and outlines theoretical explanations of severe antisocial behaviour disorders and discusses protective and resilience factors. Chapter 5 discusses effective interventions and therapeutic responses to conduct disorder, including the role of CYPFS. Chapter 6 explains the research method, data collection, procedures and findings and chapter 7 analyses the findings, highlights the limitations and suggests recommendations.

The conclusion attempts to demonstrate that the social and economic costs associated with childhood conduct disorder and its adult outcomes, make it one of the most important social and health problems within social services and the mental health sector, here in New Zealand. Little evidence exists that our treatments are effective, although according to Kazdin (1997) some promising techniques have been identified.

The objective of this study, therefore, is to explore preventative measures which are most likely to reduce the incidence over time, of the development of disorders within our population.

Chapter Two

Political, economic and policy changes during the past ten years.

2.1 Introduction

Many families, within New Zealand have been severely disadvantaged by the economic reforms which have occurred during the past fourteen years (1984-1998). On November 1st 1989, the Children Young Persons and their Families Act 1989 (CYP&F Act 1989) was introduced. This new and innovative legislation has been stated to be in response to Puaote-Ata-tu, the Ministerial Review of a Maori perspective for the Department of Social Welfare (1986). The principles underpinning the CYP&F Act 1989 are to ensure the care and protection for children by providing appropriate resources and empowering families and whanau to take responsibility, by using the family/whanau decision making process, through Family Group Conferences (FGCs), involving wider family, whanau, hapu, iwi and community. For delinquent out-of-control young people, diversion and minimal state intervention is a key principle of the CYP&F Act 1989, aimed at keeping young people "out of the system" and providing the use of community alternatives, rather than institutional care. Minimal intervention rapidly gained popularity from parents and young people because it was proposed to be empowering and less stigmatizing. From the Government's perspective, it cost less. This section examines these reforms and the impact they have had upon families and Children Young Persons and their Families Service (CYPFS) social work practice.

2.2 Economic reforms between 1984 and the 1990s

The mid 1980's represented a turning point for the social and economic future of New Zealand. From 1984 the newly elected Labour Government began work on the legislative agenda associated with the philosophy of economic rationalism and political interests referred to as "neo-liberalism" or "New Right". This view supports a move

away from public services and proclaims the virtues of privatization, free market, individualism, self-reliance, freedom of choice, and a focus on structural changes which promote efficiency and cost effectiveness. These reforms are based on the theories of Hayek, an Austrian economist (1899-1992). He proclaimed the virtues of the free market and highlighted the perils of state intervention, believing individual self interest and well-being can best be gained through the free market, rather than the State, as a central institution.

The neo-liberals, also referred to as economic rationalists, wanted to reduce the power of the state in order to encourage a free market. Dependency on the welfare state would be diminished and competition would create a dynamic and efficient economy in the South Pacific (Cheyne *et al* 1997).

This agenda evolved to embrace trade reform (removal of exchange controls, production subsidies, import, export regulation), labour market and State sector reform. A new vocabulary of economically reductive 'corporate speak' emerged to describe the 'new order' - restructuring the state sector, user pays, customer (not client) services with a focus on purchaser / provider, funder / provider separation, privatization, contestability, and accountability. Government was to be made more responsive to the market (Cheyne *et al* 1997).

The private sector type managerial accountability has been fostered by two legislations. The State Sector Act 1988, a reform based on Treasury's 1987 briefing papers, was modeled on the private sector to improve their efficiency and accountability. The Public Finance Act 1989 emphasized inputs and outputs. Inputs or the amount of money a department or Crown agency could secure, to define the identification of and accountability for outputs, which would form the basis of the department's or agency's corporate plan (Kelsey 1993).

These two Acts have significantly impacted upon and altered the service delivery of CYPFS, because the essential interventions and resources required to effect change with multi-problem families are not available, nor are they able to be accurately reflected in the simplistic outputs designed to achieve performance targets.

Consequently, the service has been driven by outputs which are easily measurable, rather than driven by client needs.

During the 1980s there was a rising level of unemployment, followed by a control in wages through the introduction of the Employment Contract Act 1991, which was designed to disempower unions and control wages. Kelsey (1993) noted that between the May and August quarters of 1992, average weekly earnings fell by almost \$15.00 due to reductions in weekly overtime earnings.

In July 1992 Department of Social Welfare (DSW) services were split into four separate 'business units'. Income Support, Community Funding Agency, Social Policy Agency and CYPFS, in an attempt to impose more stringent controls on public expenditure and to reduce the role of the State in the provision of welfare. These reforms, combined with the Income Support Benefit cuts in April 1991, have had an enormous impact on families and client service delivery, especially within CYPFS.

"The market economy...monetarism has had one of the most profound effects on social work. The notion that we look after each other in times of need has gone. And the view that the individual has responsibility for his or her own life has taken over. This has led to unrealistic expectations about what individuals can control in their own lives. The social welfare climate has become more judgemental and more punitive in the criteria for offering assistance. This has led to a restriction in the provision of what have been seen as core services. We see the demise of collective welfare which has been replaced by an individual responsibility approach" (Munford & Nash 1994:431).

A recent illustration of this doctrine is the public discussion document towards a "Code of Social Responsibility", distributed to every household during February 1998. The Government identified eleven issues which they considered important to address :

1. Looking after our children.
2. Pregnancy care.
3. Keeping children healthy.
4. Learning for the under - 5s.

5. Getting children to school ready to learn.
6. Young offenders.
7. Sharing parenthood.
8. Training and learning for employment.
9. Work obligations and income support.
10. Managing money.
11. Keeping ourselves healthy.
- 12.

However, Government Policy seems to be at odds with the goals of family and individual responsibility supposedly being pursued. Two examples highlight the contradictions in numbers 1 and 5:

- Number 1. Looking after our children: *"Parents should, love, care for, support and protect their children...."*. Resources, however, for families in the lower socio-economic sector, have diminished greatly during the last ten years. Chatterje (New Zealand Listener, 8 August 1998:18) found *"Inequality is rising faster here (N.Z.) than almost anywhere else in the entire OECD club of developed nation"*. This factor combined with rising unemployment, makes it extremely difficult for families to survive. Currently pressure is being applied for beneficiaries to work-for-the-benefit, however, there is limited child care funding, which is likely to result in more children being left 'home alone', thereby, creating a contradiction to this goal.
- Number 5 *"Parents will take responsibility for seeing their children are well prepared for school, and attend every day ready to learn"* The Government has never researched what amount of money signifies a sufficient benefit. *"The pervasiveness of poverty, the tentacles of which extend to all aspects of peoples lives - their leisure, their health, their personal and family relationships, their capacity to utilise educational opportunities to name but four areas"* (O'Brien, 1994:397) Attached to goal number 5 (Code of Social Responsibility Discussion Document 1998:15) is an ostensibly ominous question: *"What else can the Government do to make sure that children regularly attend school? e.g. should parents who receive a benefit be required, as a condition of benefit, to get their children to school?"* Does this mean a parent will have their benefit cut if their

child does not attend school? If this is to be the intention, then children are likely to be placed further 'at risk'.

As a consequence of this philosophy, social services are faced with exercising social control with respect to families and resources. This concept is punitive for both client and staff. CYPFS is conceptualized as a system designed to deliver "outputs" purchased by the Government to achieve desired "outcomes". This coupled with shrinking resources and an increase in notifications for "at risk" families, has resulted in threshold changes for intake categories. This factor has precluded CYPFS from undertaking any preventative practice or assessment of behaviour problems, in the absence of abuse.

The basic principle of economic rationalist theory is "*a new responsible world could be attained by the erosion of the welfare state and its alleged encouragement of dependence*" (Rees 1991 : 51). This economic rationalism, however, is in direct contrast to the underlying principles of the Children, Young Persons and their Families Act 1989, Section 13 (b) (i) which states that "*A child's or young person's family, whanau, hapu, iwi and family group should be supported, assisted and protected as much as possible*" to protect their children. If families and whanau are empowered and adequately resourced, they will in turn become independent, rather than the current theory of individual responsibility and choice, with a focus on failure if one does not succeed, frequently resulting in dependency.

2.3 Children, Young Persons and their Families Act 1989

The Children, Young Persons and their Families Act 1989 (CYP&F Act 1989) replaced the Children and Young Persons Act 1974, on the 1st November 1989. Major re-structuring of the 1974 Act took place in the areas of family decision making process, cultural issues and the separating of care and protection and youth justice concerns.

Challenges occurring from Maori during the 1980s

A report written in November 1984, by Women's Anti-Racism Action Group (WARAG) and concerns raised by staff within the Department of Social Welfare on Institutional Racism, challenged the white, middle class, Pakeha ideals and values within the Department of Social Welfare. This report addressed areas of concern surrounding staffing, the predominance of Pakeha working with clients who were non-European, for example, 62% of the residents under the age of 17 were Maori, where as 78% of the staff were non-Maori. There was no staff training on racism and no recognition of Maoritanga or the needs of other ethnic minorities.

During this time, the Maatua Whangai Programme was introduced in 1983, following discussions in Cabinet, when a partnership was formed between permanent heads of Social Welfare and Maori Affairs Department. The outcome was that the Department of Social Welfare in November 1983, grafted the Maatua Whangai concept onto its existing child welfare services (Bradley, 1994). This programme emphasized the importance of the kinship base of whanau, hapu and iwi and their right to have their mana restored and be involved, from the beginning, in decisions regarding their children.

In 1986 a report prepared by the Ministerial Advisory Committee on a Maori perspective, for the Department of Social Welfare, known as Puaoteata (Daybreak), highlighted a range of complaints from Maori concerning practice within the Department of Social Welfare (DSW). The Ministerial Review Committee, chaired by a distinguished kaumatua John Rangihau from Ngai Tuhoe, visited 34 tribal meeting places, DSW Offices and other institutions between 1985-1986, "*collecting oral accounts about the care of Maori children and young people by the State*". These hui revealed "*...a profound misunderstanding or ignorance of the place of the child in Maori society and its relationship with whanau, hapu, iwi structures.*" (Tait-Rolleston *et al* 1997). The policy and recommendations from this report, underpinned the basic principles in the CYP&F Act 1989.

Negotiations during the re-drafting of the 1974 Act and the implementation of the CYP&F Act 1989:

- Child Protection Bill 1982, started negotiations regarding mandatory reporting and a multidisciplinary approach to decision making. This, however, became a controversial issue among social workers, some of whom supported the notion, while others felt it was a threat to their competence and ability to make decisions. This division continued through the entire process leading up to the 1989 Act.
- C&YP Bill 1984, started to address some of the cultural changes and involvement of family /whanau, but still advocated multidisciplinary teams for decision making. A snap election in June 1984 prevented this Bill from being tabled. However, the working party report of this 1984 Bill, requested by Ann Hercus, sought to alter aspects of the decision making process in favour of the family/whanau.
- C&YP Bill 1986, incorporated the multidisciplinary approach to child abuse. This, however, had implications for a number of Government Departments, with concerns regarding the cost of resourcing the Bill, which was estimated to be in excess of \$48 million, involving a large increase in the fiscal deficit. Treasury, therefore, advised their Minister to reconsider central aspects of the Bill, including mandatory reporting, because this would increase the number of referrals and further escalate costings.
- The 1986 Bill was referred to the Social Services Select Committee and submissions were heard between April - July 1987, but the committee did not report back to the House prior to the 1987 general election. The new Minister of Social Welfare Dr. M. Cullen, announced the establishment of yet another working party of officials to advise on ways in which the Bill could be re-cast so that it was simpler, more flexible, cheaper and more culturally appropriate. (Cockburn, 1994).
- Michael Cullen expressed his views regarding the re-drafting of the Bill, opposing mandatory reporting and the proposed composition and role of child protection teams. A report was published by the working party and the Minister of Social

Welfare, Dr. M.Cullen, in December 1987 and invited submissions for this latest report, also from Feb - May 1988, the committee travelled to a series of hui in different parts of New Zealand and also met with groups of Pacific Island people (Cockburn, 1994).

During 1988 and early 1989, substantial redrafting of the Bill took place, after which there was no further consultation. The Children, Young Persons & their Families Bill had its second reading took place in April 1989 and consequently took effect from November 1st 1989.

The objectives of the 1989 Act aim to:-

- Protect children from abuse and neglect while ensuring that decisions about their care will be in their best interests.
- Increase parental accountability and encourage parents to accept responsibility.
- Encourage community care rather than the use of institutions where ever possible.
- Make families central to all decision making processes involving children and young people, for both care and protection and youth justice matters.

The rights and needs of indigenous people have been taken into account in drafting the legislation, which emphasizes the importance of culturally appropriate processes and provides for the use of Maori structures and institutions in decision making and service provision (Office of the Commissioner for Children June 1991).

Whanau/family decision making, through Family Group Conferences are the central mechanism for resolving care and protection issues, and youth justice matters, relating to children and young people 0 - 17yrs who come to the attention of CYPFS.

The changing climate, during the introduction of the CYP&F Act 1989:

The CYP&F Act 1989 Act is far reaching and innovative and is aimed at encouraging family responsibility for children and young people by using Family Group Conferences (FGC) in order to return decision making back to families. The FGC was designed to empower different cultural understandings of children's needs and of the family itself

(Cheyne *et al* 1997). However, special costs under the CYP&F Act, such as the funding of decisions of FGCs, payments for counselling and alternative placements have been placed under tighter control (Cockburn, 1994).

When the 1989 Act was instituted, it was stated that the focus would be on the establishment of iwi and cultural social services, in order to provide the necessary assistance and support required for whanau to become responsible for their children. Funding, for these services, was to be obtained from the closure of 18 out of the 23 child welfare institutions. It is, however, now eight years since the Act was introduced and Maori are still waiting for the appropriate funding for these services.

The 1989 CYP&F Act, was introduced during a cycle of poverty and high unemployment, "*unemployment increased from 56,000 in 1984 to 153,000 in 1989*" (Cheyne *et al* 1997:201). This impacted significantly upon Maori, "*unemployment had a particularly significant impact on Maori, with Maori male unemployment increasing from 10 per cent in 1986 to 20.8 per cent in 1989. There were comparable figures for Maori women 12.5 percent to 19.2 percent for the same period*" (Cheyne *et al* 1997:201). This, coupled with the State Sector Reform 1988, Public Finance Act 1989 (which have influenced the delivery of publicly funded social services), benefit cuts and the raising of the age for youth allowance, resulted in fewer resources available to empower, and advance the well-being of families, children and young persons, as members of families, whanau, hapu, iwi and family groups, one of the basic principles of the CYP&F Act 1989. It became evident the 1989 Act had been fiscally, rather than culturally driven. Economy and efficiency have replaced care, justice and self determination (Shirley 1997).

Financially, the CYP&F Act has been a great saving to the State, due to the transfer of responsibility from the state to the family. This has implicated women, who are expected to carry out the domestic and caring role within the immediate and wider family, also pressure has been placed on the over-burdened community to provide support and assistance. Thus, services for children and families have become subordinate to the fiscal policy goals, and are determined by the availability of resources, not by the needs of the children and their families. "*The family, therefore,*

becomes a very useful alternative means of providing resources when the state will not do so" (Cheyne et al 1997:212).

2.4 CYPFS Strategic Directions 1996

Departmental plans must conform to the Government's own strategic plan, investing in our future (Cheyne *et al* 1997). A Department's strategic plan, therefore, outlines the vision, mission, value statements, key functions, desired outcomes, actual and proposed expenditure. This, then provides a system for reviewing the performance of each Department and ensures there is transparency of public accounts, so that reliable financial information is available on which to make policy decisions, in accordance with the Fiscal Responsibility Act 1994. This, however, has become another control of public sector resources (Cheyne *et al* 1997).

CYPFS plan and vision, is that all families are meeting their care, control and support responsibilities by the year 2005. "*Our purpose is to move people from Welfare to Well-being*" (DSW Strategic Directions 1996:12).

However, what does this really mean?

Since the introduction of the 1989 Act, the Department underwent many organizational changes, restructuring and name modifications, which was extremely unsettling for both staff and clients, and caused widespread public confusion as well as despondency among front-line professionals (Cheyne *et al* 1997).

Included in these changes was the separation of the Department into business units in 1992, at which time the service became known as the N.Z. Children and Young Persons Service (changed again in 1996 to Children, Young Persons and their Families Service). Following this, a review was commissioned by the Director General, during 1993/1994, to address the Department's overspent budget. This was undertaken by Andrew Weeks (an external consultant), later referred to as the Weeks Report. This

review resulted in changes to the computer recording system, introducing key performance indicators (KPI's), rather than effective practice outcomes, as a measure of output categories. According to Shirley (1997), the New Zealand experience demonstrates that the primary focus of the new managerialism has been on outputs rather than outcomes.

Since 1994, CYPFS computerized system (now known as SWis, Social Work information system) has continued to dictate social work practice, into outputs and desired outcomes. KPI's represent key performance dates for social work action and financial plans for all expenditure. KPI's are also linked to pay for performance bonuses. This recording and measuring system supports the argument of neo-liberalism or economic rationalism, for the need to measure productivity and provide accountability. A natural consequence, however, from a fiscally driven environment such as this, is a tendency to minimize intervention and assessment of risk factors within families/whanau. *"If the needs of children, young persons or their families do not fit into a particular output category, then they are not eligible for assistance"* (Cheyne et al 1997:211).

Consequently, social workers who are currently assessing family situations, identify many areas of concern which require addressing, but they are rendered powerless due to fiscal constraints. These concerns were reinforced by repeated reports confirming CYPFS was demoralized, underfunded, understaffed and unable to follow-up adequately on child neglect and abuse (Kelsey 1997).

The Weeks review, however, highlighted a 5% reduction in funding compared with previous years, compounded by a 59% increase in referrals since 1991. *"The deficit, estimated to be \$1,766 million, was to be absorbed into departmental budgets through reduced administration and reduced spending on 'non-core services'. The response to increased demands and a reduced budget was not to determine whether the budget was sufficient in relation to demands, but to require that the budget be managed better. Eventually the shortage of resources was acknowledged in December 1995 when an additional \$2.2 million was granted to CYPS* (Cheyne et al 1997:213).

The CYPFS goal to move people from welfare to well-being and place the total responsibility for the care of children with their families, is being introduced at a time when families are already under pressure. This is because it is a period of low economic growth, high unemployment and when real purchasing power is declining along with incomes. Due to high unemployment, families are also faced with additional responsibilities for older unemployed teenagers and adult children. The 1991 census figures showed that a quarter of all children belonged to families where the parent or parents did not have paid work, and 60% of children living with one parent were in the lowest 20% income group (Kelsey 1997).

Considering these factors are sometimes combined with generational abuse, natural families are not always the safest place for children, as was highlighted in an editorial in the (New Zealand Herald 19 January 1998) on "putting children first" *"means disabusing the Children, Young Persons and their Families Service of the dangerous doctrine that children are always best cared for in their natural families, no matter how dangerous those surroundings may be"*.

- ✓ A disproportionate number of domestic aggressors, come from low socioeconomic backgrounds often combined with alcohol abuse. There is considerable evidence to indicate that domestic violence is passed from one generation to the next. Berkowitz (1993) noted that, social science discussions of family violence have broadened from an initial focus on the supposedly 'defective' personalities of the abusers to the consideration of the role of societal norms and values and, more recently, to a growing recognition of the interacting influences of a multiplicity of factors. Research has now demonstrated that conditions in society at large, in the personalities of individual family members, in the family relationships and even in the immediate situation can all operate together to affect the chances that any one person will assault others in the household.

The reviewed research on poverty provides compelling evidence that poverty is a major contributor to depression, psychological distress, insensitive or abusive parenting and negative child outcomes in low-income populations. It follows therefore, that alleviation rather than intensifying such stressors is likely to reduce mental health

problems in mothers/fathers, enhance parenting and contribute to positive socioemotional functioning in children (McLoyd 1995).

The goal of well-being, under neo-liberalism, is steeped in the belief there is no external cause of need, rather it is a matter of individual choice and disparities of income and wealth serve to provide incentives for those who are less well off, therefore, individuals are and should be responsible for their own destiny. Neo-liberals argue that welfare services should be provided either by voluntary groups, private charity or by the family, the State, therefore, having simply a residual role (Cheyne *et al* 1997).

Kelsey (1997) sums it up claiming that people have been made dependent (not by choice) but by the disabling policies of structural reform. This shortsighted, cost-cutting mentality undermines the educational opportunities, health and emotional well-being of the next generation. A prosperous, healthy economy would require a future adult population that would be skilled, confident, well-adjusted and employed.

2.5 The Key Functions of CYPFS

The key function of CYPFS, as outlined in the post-election briefing paper 1996, is the provision of statutory social services focused on children and young persons who need care and protection, break the law, or are involved in adoption processes. These services are authorized and constrained by legislation and operate in the area of state intervention in family life. The Social Welfare Ministerial Briefing Papers 1996 states the following:

1. Care and Protection Services:

These services aim to ensure children and young persons are safe from abuse or neglect and are adequately cared for by their families. The work balances the child's need for safety and well-being with their right to belong and be connected to their family. This is achieved through:

- Investigating reports alleging abuse and neglect (notifications) and other situations which cause concern for a child or young person's welfare.
- Assessing new and existing cases for risk and the need for care and protection, and representing that assessment in a Family Group Conference or Court.
- Initiating the level of action judged necessary, including urgent removal from home.
- Working with families to resolve the care and protection needs identified, through informal agreements, Family Group Conference or Court ordered plans.
- Working with children and young persons placed in the care, custody or guardianship of the Director General and with their families.
- Ensuring the provision of residential and caregiver services to meet the needs of those placed in the care, custody or guardianship of the Director General.

These services are provided under the CYP&F Act 1989. Similar services are provided, as required, under the Guardianship Act 1968, the Family Proceedings Act 1980, the Immigration Act 1987, Domestic Violence Act 1995.

2. Youth Justice Services:

The purpose of these services is to confront children and young persons about their offending, to hold them accountable and to do this in a way which recognizes their youth and vulnerability, diverts them away from the criminal justice system, stops their offending behaviour and supports and maintains them in their family. This is achieved through:

- Working with police to explore options for young offenders' accountability to ensure that only cases necessary in the public interest are brought into the formal system.
- Providing appropriate placements for young people who are arrested.
- Working with families and Police (or other enforcement agency) to make Family Group Conference Plans which will emphasize to the young person the consequences of the offending and reduce the probability of future offending.
- Assisting the child or young person, family and others to carry out Family Group Conference or Court ordered plans.
- Providing custodial services.

These services are provided under the CYP&F Act 1989 in relation to offences under any other statute that can result in criminal prosecution.

3. Public Awareness Services:

In addition to the direct work with children and young persons and their families, the Service is involved with activities which:

- Raise public awareness about children's needs for care, protection and control; and
- work with other relevant agencies and groups to achieve consistent, high quality and integrated services for children and young persons who are, or may be, in need of care, protection or control.

4. Adoption Information and Services:

These services advance the interests of children involved in adoption, and promote informed choices by all parties to the adoption process. Services are provided under the Adoption act 1955 and the Adult Adoption Information Act 1985, Official Information Act 1982, Privacy Act 1993, and are achieved through:

- Counseling people considering placing a child for adoption.
- Educating, preparing and assessing adoptive applicants.
- Issuing placement approvals
- Monitoring and reporting adoption placements to the court (both nationally and inter-nationally).
- Developing protocols and agreements with sending countries for inter-country adoption.
- Providing post-adoption services for parents affected by adoption with children under 20 years of age.
- Providing information to parties of previous adoptions.
- Assisting and mediating contact between parties of previous adoptions.

2.6 The separation of care and protection and youth justice

The 1989 CYP&F Act clearly separates youth justice (YJ) from care and protection (CP), based on dissatisfaction and concern about the effectiveness of the criminal youth justice system and the belief that a small group of people engage in antisocial behaviour of one sort or another at every stage of their life (known as life-course persistent), while most are anti social only during adolescence (known as adolescent

limited) (Moffitt 1993). Evidence also suggests that whatever the type of crime or the characteristics of the person, offending peaks in late adolescence or early adulthood (Britt 1990, Greenberg 1991, Osgood *et al* 1989). As a result of these opinions, it was advocated that a shift should be made away from the previous welfare model to a justice model.

Welfare Model: This model is based on the young person's welfare, or the 'needs' and 'best interests' of the child/young person. It assumes that something has gone 'wrong' when a young person commits an offence and that the offence is seen as a symptom of an underlying disorder that is influenced by background factors such as family, school and neighbourhood. (Maxwell & Morris 1993).

The decisions about the young person's welfare, were usually made by people in authority, outside of the family. In fact, family contact was often discouraged. This frequently resulted in young people being placed in institutional care.

Youth Justice Model: This model involves the family in the decision making process and focuses on the young person taking personal responsibility for the offence, rather than on their underlying needs. All aspects of social disadvantage, background family information and reasons for committing the offence are ignored.

The main goals of the Youth Justice system is to divert young people away from courts and the criminal system, make them accountable for their offence, enhance their well-being and strengthen their families, by involving victims, family/whanau in a culturally appropriate setting for decision making, regarding possible outcomes and retribution. These decisions are usually made at a Family Group Conference (FGC).

This approach assumes that former life experiences do not influence or have an affect on adolescent offending. According to Moffitt (1993), most adolescent offending is probably peer related and this is just a maturation phase in their life, unrelated to early childhood problems. However, current trends within CYPFS indicate a large number of young offenders have had previous care and protection concerns (Maxwell & Robertson, 1994) This is sustained by other research.

For example: Widom, (1989, 1991), began research to address the relationship between early child abuse/neglect and later delinquent and violent criminal behaviour. She completed a cohort design study, where children who were abused or neglected approximately 20 years earlier, were followed up through an examination of official criminal records and compared with a matched control group of children with no official record of abuse or neglect. Findings indicated that early childhood victimization significantly increased a child's risk for an arrest during adolescence by more than 50%. Abused or neglected children, furthermore, began their official criminal activity approximately 1 year earlier than the control subjects. For females, the risk of juvenile arrest increased from 11% to 19% an increase of 73%, and for males the increase was from 22% to 33%, a 50% increase.

There is, however, a mixture of evidence linking childhood abuse or neglect to adolescent violence, and findings have been inconsistent. Some studies provided strong support for the cycle of violence (Geller & Ford-Somma 1984; Lewis *et al* 1985; Vaughan & Hogg 1995) and indicated that children who were abused or from violent families were prone to future violence compared to children from a non-violent environment. Other studies, found there was no significant difference between abused and non-abused children (Widom 1989). Widom (1991), however, found that overall, children who were neglected had the highest arrest rates for violence and physically abused females had the highest arrest rates for violent offences. Research, therefore suggests that early childhood abuse increases risks for both genders becoming a delinquent adolescent but not necessarily a violent delinquent.

One of the difficulties in associating childhood abuse or neglect with adolescent offending, is the co-occurrence of other adverse problems, such as alcoholism, marital violence, parental criminal behaviour, poor parenting. Andrews *et al* (1993), studied (microsocial behaviour patterns) day to day interactions of children with their social environment and parents. They found, along with other social learning theorists, that aversive and aggressive behaviour in children is stimulated by negative coercive cues from their parents. They also discovered that aggressive, negative and coercive behaviours that emerge early in life have been shown to be most stable and rigorous

predictors of delinquency, substance abuse, school failure and psychiatric disorders. These findings are also supported by Patterson *et al* (1989).

Bowers (1990), from her studies on female delinquency, believed acting-out behaviour of young females is a symptom of the primary traumas of physical and sexual abuse and secondary traumas, when society responds with blame or disbelief. She therefore considered, *“Acting - out is often a post-traumatic adaptive response to primary and often secondary trauma, a survival and coping strategy to sustain significant relationships”* (Bowers 1990:401).

So how does this information correspond with the youth justice model? The youth justice model is an excellent process for addressing juvenile offenders who do not exhibit a disposition for ongoing recidivism. However, in my opinion, it is not adequate for persistent offenders, who have a history of abuse or antisocial behaviour. The youth justice model tends to be further confounded by the evidence indicating that offending tends to peak during adolescence, yet this is consistent with both persistent and juvenile offenders (Gottfredson & Hirschi 1990) and therefore cannot be used to authenticate this model.

The youth justice model, also overlooks the wider societal factors which impinge upon adolescents such as their functioning, survival and the reasons why they act-out. *“When social problems relating to oppression in the community effect the family which effects its members and then the adolescent acts out in the community, a cycle is generated, often to become sustained through the generational cycle of abuse”* (Bowers 1990:399).

A comprehensive and well resourced alternative integrated model, which is able to offer preventive programmes that focus on the development of self control, esteem, lessen childhood trauma/abuse/neglect, increase effective parenting, and assist the development of secure attachments during the early years of life has the best chance of producing meaningful reductions in problem behaviours (Gottfredson & Hirschi 1990; Ainsworth 1989; Widom 1989; Andrews *et al* 1993; Perry 1996).

- **Public Awareness Services:**

The 1994 amendments to Section 7 of the 1989 CYP&F Act required CYPFS to develop (in the absence of mandatory reporting) child abuse reporting protocols with key agencies and groups involved with children and youth. CYPFS subsequently produced an interagency guide covering indicators of child abuse, procedures for reporting, outcomes of reporting, key service providers and how to access them. This amendment also required the Director General to launch a promotion on public awareness and prevention of child abuse.

Prevention, therefore, has become a public awareness action, rather than a social work practice outcome, thereby shifting the responsibility back onto the community. Consequently, prevention is encouraged through the national media, educational services and other community organizations involved with children and youth, raising public awareness on child abuse through the "Breaking the Cycle" campaign as seen on TV and community promotion. *"The positive goal of the campaign is to intervene to Break the Cycle"* (CYPFS Post-election Briefing Plan 1996).

CYPFS appointed 18 Community Liaison Workers, nation - wide, to negotiate and implement child abuse reporting protocols and maintain liaison with agencies and groups who work with children and young people. They also promote "Breaking the Cycle" initiatives, such as the booklets "Cool Kids Cool Parents", "There are no Super parents", and a video "Parenting without hitting". The latter three are presented in Maori, Samoan and English and appear to deliver an excellent message that should be considered recommended reading for all parents.

It is estimated in the DSW Strategic Plan Post-election Briefing Paper 1996 that 45% of N.Z. families are at risk with 5% in a cycle of disadvantage. The list of indicators outlined in this plan are low income, unemployment, low educational attainment, poor housing, poor health status, transient life styles, single parents, violence and lowered aspirations. When there are intergenerational cycles of disadvantage and abuse, how realistic is it for these families to see an ad on TV and set about initiating "Breaking the Cycle", when most of these families are so oppressed and do not understand any other

way of coping? Existing research is inadequate to determine whether counselling and parenting education alone, without supporting interventions, produce positive and enduring changes in parenting behaviour in low-income populations (Dornbusch *et al* 1993).

While it is both necessary and important to educate people publicly and heighten awareness about the ill effects and total non-acceptance of abuse and violence, this alone is not going to address the problem, without a comprehensive, holistic, integrated and empowering intervention, which endeavors to *break their cycle*.

However, this is no longer reflected in current social work practice. "*Indeed the continuing narrowing of the output categories in which social service delivery in the Department must be located makes effective application of these* (preventative clauses of the CYP&F Act 1989) *impossible*" (Cheyne *et al* 1997:208). "*The social services are exposed to market forces in the belief that competition between service providers will result in greater efficiencies, which in plain language means a reduction in Government spending*" (Shirley 1997:13).

Responsibilities associated with financial resourcing and social security, have been transferred from the State to the individual and family with a clear statement from CYPFS "*All families are meeting their care, control and support responsibilities*" (CYPFS Ministerial Briefing Papers 1996:6).. Consequently, the family has become a basic and private unit to be preserved from State interference, particularly in the role of welfare provisions. Implication, therefore, is that women will carry out the domestic and caring role within the family, with little or no help from the State, but instead are made to rely on the over burdened community or the wider family for assistance. This, however, is contradictory to the principles of the 1989 CYP&F Act, which advocated adequate resourcing for families, in order to empower them to take responsibility for the care and protection of their children.

2.7 Summary

Since the mid 1980s there has been a significant paradigm shift in child welfare service delivery, as New Zealand has moved into neo-liberalism, based on a reduction in State responsibility. This has impacted heavily on families, Maori and other ethnic minorities, women, community, education, health and social services. A greater burden has been placed on the family, and especially women, as part of a wider strategy of cutting back State responsibility for welfare provision (Rodger 1996).

As a result unemployment has increased and there has been a substantial reduction in living standards for those dependent on social welfare. It is these families who are frequently referred to CYPFS with complex social problems. However, the fiscal constraints imposed by the State Sector Act 1988 and the Public Finance Act 1989, has dictated the type of service delivery to be administered by CYPFS, based on designated output categories. Thus social work services for children, young people and their families, within CYPFS, is determined by particular output categories and available resources, rather than client needs. It has also precluded preventative intervention. This has resulted in many child and young people 'falling through the cracks', especially clients presenting with problem behaviour, because they do not fit into a particular output category.

Much of the evidence suggests that antisocial behaviour is unquestionably associated with economic hardship. Studies have repeatedly shown that poor urban areas produce vastly more young people with conduct disorder than richer neighbourhoods or rural areas. Poverty, unemployment, racial discrimination and other factors which tend to marginalise individuals and groups of people can lead to frustration and alienation in those people, who then see little reason or need to co-operate with the rules of the wider society (Clarkson 1994). Evidence, as discussed in Chapter 5 suggests that early intervention and primary prevention of antisocial behaviour are the only effective means of addressing the problem. The next two Chapters 3 and 4, outline some of the symptoms associated with conduct disorder, attention deficit hyperactivity disorder, post traumatic stress disorder and depression and discusses certain theoretical

concepts which attempt to explain some of the possible causes associated with the onset of antisocial behaviour.

Chapter Three

What is Conduct Disorder?

3.1 Introduction

Conduct disorder (CD) is a large and serious problem affecting approximately 5 - 10% of children in the general population (Costello, 1989; Kazdin, 1987). Common indicators are physical aggression, little consideration for other people's property, stealing and lying. The DSM 1V classification for CD (outlined below) is the most commonly used and forms the benchmark for identification and diagnosis. However, there is a degree of overlap (comorbidity) with other disorders, especially surrounding attention deficit hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD) and depression. The purpose of this chapter, therefore, is to define CD, understand the nature of the disorder and the degree of overlap with other disorders, in order to gain greater insights into the possibility of preventative intervention and determine the children who should become targets of intense early intervention.

3.2 Conduct Disorder

In the fourth edition of the "*Diagnostic and Statistical Manual of Mental Disorders*" (DSM 1V) defines conduct disorder a "*repetitive and persistent pattern of conduct in which either the basic rights of others or major age appropriate societal norms or rules are violated*" (DSM 1V : 45). At least three of the following behaviours should be evident and apparent during a 12 month period, with at least one present during the past 6 months.

3.2.1 Repetitive Behaviours

The (DSM 1V :85, 90), suggests these behaviours fall into 4 main groupings and subsequent categories:

Aggressive Conduct ~ diagnosed as causing or threatening physical harm to other people or animals such as:

- often bullies, threatens or intimidates others.
- often initiates physical fights.
- has used a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife, gun)
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity.

Destruction of Property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- has broken into someone else's house, building or car
- often lies to obtain goods or favours or to avoid obligations (i.e. "cons" others)
- has stolen items of nontrivial value without confronting a victim (e.g. shoplifting, but without breaking and entering, forgery).

Serious violation of rules

- often stays out at night despite parental prohibition, beginning before age 13 years
- has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- is often truant from school, beginning before 13 years.

The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.

3.2.2 Age of Onset

The age of onset is only defined for young people 17 years or younger therefore, individuals 18 years or older, do not meet the criteria for antisocial personality disorder. Childhood onset type is determined by at least one criterion characteristic of CD prior to age 10 years and adolescent onset type is determined by the absence of any criteria characteristic of CD prior to age 10 years.

Severity

The severity is specified as, **mild** defined by few, if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others, **moderate** defined by the number of conduct problems and the effect on others, intermediate between mild and severe and **severe** defined by many conduct problems in excess of those required to make the diagnosis or conduct problems causing considerable harm to others.

3.3 Attention Deficit/Hyperactivity

“Hyperactivity is a developmental disorder of age- appropriate attention span, impulse control, restlessness and rule-governed behaviour that develops in late infancy or early childhood (before age 6), is pervasive in nature, and is not accounted for on the basis of gross neurologic, sensory, or motor impairment, or severe emotional disturbance”

(Barkley 1990:6).

The onset of hyperactivity is very early, usually in the first 2 years of life. In order to determine and diagnose this condition, there is a need for persistent complaints from a parent, caregiver or teacher (during a period of at least 12 months) regarding evidence of inattentiveness, restlessness or impulsiveness, behaviours which differ significantly from the normal range relative to children of the same age. Parents / caregivers are issued with a questionnaire (devised by Conners, cited in Barkley 1982:108) consisting of 48 items, ten of which are considered significant. However, before

attempting a diagnosis, it is important to rule out the possibility of mental disability, epilepsy, deafness, sleeplessness or severe emotional disturbances.

The majority of children diagnosed are boys with the ratio being approximately 5:1 boys to girls. Studies completed in Britain by Franklin (1988:52) discovered that many of the children were fair-haired and blue eyed, irrespective of the hair colouring of the parents and many came from family backgrounds with physical symptoms associated with behavioural problems. They also depicted, a greater than expected number of allergic symptoms, both in the parents and children, leading to a number of environmental triggering factors being identified, such as, food chemicals, synthetic plastics, environmental aeroallergens etc. However, a genetic factor had not been determined. Other symptoms which have been identified are excessive thirst (Barnes & Colquhoun 1984:15).

Hyperactivity has been found to be strongly associated with conduct disorder in children, and a number of studies have found children with hyperactive behaviour to be at excessive risk of developing antisocial behaviour. Results from studies completed by Satterfield, (1987) and Loeber, (1990), found that a large number of both cross-sectional and longitudinal research studies support the connection between hyperactivity and anti social behaviour. Early hyperactivity is recognised as a main precursor of delinquency. Farrington *et al* (1990) observed that a hyperactive-impulsivity-attention deficit measure, obtained at age 8 and 10 years, was especially predictive of future chronic offending.

3.4 Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) describes symptoms observed in many individuals who have survived traumatic events during their life.

Diagnostic and Statistical Manual of Mental Disorders (DSM-111-R: American Psychiatric Association 1987) categorised the signs and symptoms of PTSD into three main areas:

1.The traumatic event is persistently re-experienced in at least one of the following ways:

- recurrent, intrusive and distressing recollections of the event, flashbacks, dreams, repetitive play etc.
- sudden action, panic or feeling as if the traumatic event were recurring;
- intense psychological distress at exposure to events that symbolise or resemble the trauma, such as smells, similarity to an abuser, anniversaries, recollections due to similar places or portrayals etc.

2.There is persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, indicated by at least three of the following:

- avoiding thoughts or feelings associated with the trauma, and/or avoiding activities that arouse recollections of the trauma;
- repressed memory and an inability to recall traumatic events;
- loss of interest in age appropriate activities may result in a regression of behaviour (i.e. toilet training);
- feelings of disassociation, withdrawal or detachment from others;
- a restricted range of emotions;
- in adolescents, a sense of loss of self and/or depression.

3.Persistent symptoms of increased arousal are indicated by at least two of the following:

- physiological hyperactivity
- sleep difficulties;
- irritability, anxiety or aggression;
- difficulty in concentrating;
- hypervigilance;
- increased startle responses;

- physiological responses such as increased heart rate and sweating when exposed to events that symbolise the traumatic event.

In addition there may be evidence of poor self esteem, extreme depression, acting out behaviours and substance abuse which mask the diagnosis of PTSD.

Evidence suggests a history of intense abuse and violence, correlates highly with PTSD. Childhood sexual abuse (Murray 1993), severe domestic violence, natural man-made disasters and traumatising medical procedures (Koziol & Stout 1994), result in a strong association between PTSD in early childhood and subsequent behaviour or psychiatric problems during adolescence or adulthood.

These traumatic experiences have an impact on a child's emotional, cognitive, behavioural, social and physical development (Schwarz & Perry 1994). Children are particularly vulnerable, especially from birth to 3 years of age, during which time the brain is developing specific neurotransmitter receptors. If severe traumatic situations (outside the normal human range) are experienced during this developmental phase it is likely to distort and disrupt the functional units of these neurotransmitters, which in turn will affect the way the individual processes and responds to information. (The theoretical constructs / concepts will be discussed in the following chapter).

Frequently the features of PTSD such as a history of severe trauma, re-exposure to the traumatic specific stimuli and hyperarousal were evident in children who exhibited psychotic, anxiety and symptoms of disordered conduct e.g. aggression. Clinically, this is very easily seen in children who are exposed to chronic neurodevelopmental trauma. These children, however, are frequently diagnosed as having attention deficit/hyperactivity disorder. This is somewhat misleading, because there may be different types of attention deficit disorder, and certain children tend to be hypervigilant rather than inattentive. *"Some of these children have behavioural impulsivity and cognitive distortions that are consistent with over interpretation of non-verbal cues as well as physiological hyperarousal and hyperactivity"* (Perry & Pate 1994:137). These children are frequently observed to have increased muscle tone,

a low grade increase in basal body temperature, an increased startle response, profound sleep disturbances and hypertension (Perry 1993).

3.5 Depression

Depression in young children is extremely difficult to detect, because of their immature cognitive and personality development. Most researchers and clinicians, however, believe that childhood depression does exist, but they are unable to determine the exact symptoms, due to the fact that many of the indicators such as appetite changes, sleep disturbances and crying occur with such high frequency among most children, at some stage in their development (Lefkowitz & Burton 1978; Kazdin 1989; Cantwell 1990).

Depression is an internalized disorder, which is frequently associated with females and is rarely diagnosed among children under the age of 10. However, the diagnosis rises dramatically during adolescence and adulthood (Seligman 1973).

Depression during adolescence is concomitant with an increase in the rate of suicide (Cantor 1983). A community study in Otago N.Z. looked at the effects of physical, emotional and sexual abuse in childhood in women and found that those who had experienced: sexual abuse as a child were nearly 4 times more likely to have attempted suicide; and emotional abuse were around 2.5 times more likely to have attempted suicide (Mullen *et al* 1996). This is supported by the Christchurch Child development Study (N.Z.), which reported a significant association between childhood and family adversity and youth suicide (Fergusson & Lynskey 1995).

The link between depression in parents and children has received considerable analysis and discussion in the research literature. Children of depressed parents are more likely to have higher rates of depression, separation anxiety, academic failure, ADD and conduct disorders (Compas & Hamman, 1992; Weissman *et al* 1984; Beardslee *et al* 1983). The main reasons given for these findings is that depressed mothers were found to be more tense, less attached/bonded to their children, disorganised, resentful, ambivalent,, more negative, and less responsive and affectionate with their children

(Radke-Yarrow *et al* 1985; Downey & Coyner 1990). This section, therefore has highlighted the detrimental affects of early life trauma and its role in a variety of different neuropsychiatric disorders, including major depression (Lloyd 1980).

3.6 Summary

The most common categories of disruptive behaviours are ADHD and CD with estimates of 3% - 5% being pure ADHD (Barkley 1990), and 4% - 10% being pure CD (Kazdin 1987; Rutter *et al* 1976).

However, comorbidity among these behaviours is extremely common, reported patterns vary as follows: CD among children with ADHD range from 20% (Barkley 1990) to 60% (Biederman *et al* 1987) and the reverse is greater among ADHD in children with CD, which is reported to be as high as 90% (Abikoff *et al* 1987).

It is, therefore difficult to identify pure conditions of ADHD and CD, possibly due to confusion resulting in changes, from DSM 111 to the removal of certain criteria in DSM 111-R, for diagnosis for ADHD. Assessment outcomes may differ depending on the setting, for example a school environment may produce a different diagnosis to that of a clinical or multiple surroundings.

Nevertheless, there is evidence that pure ADHD children are more easily identified (Reeves *et al* 1987), because ADHD is usually associated with lower IQ, lower academic performance and substantially lower rates of parental psychopathology. (Lahey *et al* 1988; McGee *et al* 1984; Werry *et al* 1987).

However, in children with pure CD, the diagnosis was less easily identified, because the large majority were comorbid for ADHD, although diagnosis with CD children is usually associated with maternal rejection (inferior attachment/bonding), poor parental supervision (Lobar *et al* 1990) and paternal alcohol abuse (Reeves *et al* 1987; Stewart *et al* 1980). Aside from these differences several studies have indicated that childhood

ADHD, especially its persistence, is a risk factor for later CD in children/adolescence (Gittleman *et al*, 1985; Lobar *et al* 1991; Mannuzza *et al* 1991; Schachar & Wachsmuth, 1990).

The next section, chapter four, will attempt to discuss some of the theoretical and contributing factors associated with antisocial behaviour, in order to gain a better understanding of why people behave as they do and provide some insights into the diverse psychological view points surrounding genetic, environmental and ecological factors, which underpin the value base of practice, intervention and therapy.

Chapter Four

Theoretical Concepts

4.1 Introduction

New-born infants seem helpless. However, this is not entirely the case, as they are much more responsive than they appear, as the following research and theories will indicate. The question therefore, must be asked, as to how permanent are effects of early stimulation, secure or insecure attachment, trauma or deprivation? This chapter explores five approaches which have influenced psychological theories and offers two theoretical perspectives which give different accounts of antisocial behaviour, specifically factors associated with attachment, post traumatic stress disorder and resilience.

4.2 Overview

Since 428BC, Plato, Aristotle and other philosophers, have asked some of the basic questions of psychology such as "*are people born with certain personalities?*" (genetic factors) or "*do personalities develop because of experience and learned behaviours?*" (environmental factors). The quest for these answers has resulted in many psychological viewpoints, each offering a somewhat different explanation of why individuals act as they do. The five approaches are :

1. Psychoanalytic theory
2. Behavioural theory
3. Neurobiological theory
4. Cognitive theory
5. Phenomenological theory.

1. Psychoanalytic Theory

During the 19th Century, there was a focus on mental illness, which prompted theorists like Freud (1856 - 1939) to bring attention to instinctual drives and unconscious motivational processes, which he believed determined people's behaviours, rather than the nature of cognition in itself. This emphasis on the content of thought and on the dynamics of motivation exerted a strong influence on the course of modern psychology, such as psychodynamic and psychoanalytic theory. These theories perceive personality as the certain constancy that prevails the way the ego chooses for solving the tasks of drive satisfaction and ethical motivation, and makes assumptions about the nature of internal unobservable states. During the 1920s, Darwin's "Instinct Theory" was replaced by "The Drive Reduction Theory" of motivation and attachment, the concepts were based on drives which are an aroused state, resulting from a biological need like food, water, sex, pain avoidance. It is, therefore, these aroused states, due to chemical changes in the blood, which motivate the individual to satisfy the need.

Many other theorists such as Erikson, Bowlby, Ainsworth, have made significant contributions, which have influenced the individual's awareness of the identity society/family accords them and the sense of identity of self, which in turn has underpinned many of the theories relating to attachment/bonding.

2. Behavioural Theory

By the 20th century, another school of thought emerged, which concerned itself with behaviour rather than the mental processes. This originated from John Watson (1878 - 1958) and his belief in behaviourism, which assumed all significant emotional, cognitive or motivational aspects of an individual were observable and learned responses, subject to modification by proper manipulation of the stimuli that controlled them.

Watson's theory underpinned (a) Pavlov's theory of classical conditioning where an organism learns that two stimuli tend to go together e.g. a baby learns that the sight of a breast (one stimulus) is associated with the taste of milk (another stimulus) and (b) Skinner's operant conditioning, in contrast to classical conditioning, states that behaviour is controlled by its consequences. Skinner, therefore believed that

behaviour, initially, simply happened. Once the behaviour occurred, however, the likelihood of it being repeated depended on the consequences or reinforcement of each particular behaviour.

3. Neurobiological Theory

Neurobiological or physiological psychology, is in principle the basis of all psychological events occurring in humans, due to the fact that all actions are represented in some manner by the activity of the brain and nervous system. This approach, therefore, seeks to specify the neurobiological processes that underlie behaviour and mental events. Recent discoveries have made it dramatically clear, that there is an intimate relationship between the brain's activity and behaviour, especially highlighted in the latest studies by Perry on the effect of Post Traumatic Stress in infants 0 - 3 years old. *"A growing body of evidence suggests that the developing brain organizes in response to the pattern, intensity, and nature of sensory, perceptual and affective experiences during childhood and adolescence. A child's brain is undergoing critical and sensitive periods of differentiation. During this time, stressor-activated neurotransmitters and hormones can play major roles in neurogenesis, migration, synatogenesis and neurochemical differentiation"* (Schwarz & Perry, 1994:313).

4. Cognitive Approach

This approach argues that humans are not passive receptors of stimuli; the mind actively actions the information it receives and transforms it into new forms and categories. These inputs initiate neural processes that transmit information to the brain which result in seeing, reading remembering etc. The cognitive theories developed partly in reaction to the narrowness of the behaviourists view, which rejected the subjective study of mental life, in order to make psychology a science. It also conceived human actions solely in terms of stimulus input and response output, which may be adequate for the study of simple forms of behaviour, but lacks a focus on the human functioning of thinking, planning, making decisions on the basis of remembered information and selectively choosing among stimuli that require attention. The cognitive theories, therefore, focused on "the information processing system of the brain" and the notion of a "mental model of reality".

5. Phenomenological (Humanistic) Theories

This approach emphasizes the subjective experience and is concerned with the individual's personal view of the world and interpretation of events. It therefore focuses on the internal mental processes and understanding the inner life experiences of individuals, like self-concepts, feelings of self-esteem and self-awareness, rather than with developing theories or predicting behaviour. According to humanistic theories "an individual's principal motivational force is a tendency toward growth and self-actualization" (Royce & Mos 1981).

Summary:

During the last 90 years there have been many differing theories and paradigm shifts, in an attempt to explain why individuals act as they do.

In a flood of criticism aimed at psychoanalysis, there came the behavioural or social learning/environmental theorists of the 1960s, followed by the cognitive revolution, during the 1970s, and currently a biological thinking. In addition, during the 1950s, at the time the swing away from psychoanalytic theory was occurring, Bowlby (1958), proposed an alternative to the psychoanalytic "*drive/reduction theory of attachment*" which focused instead on the attachment mother/child relationship in his seminal paper (1958) "The Nature of the Child's tie to its Mother" this concept will be discussed in more detail later.

However, theories about personality development, anxiety or disruptive behaviours, should integrate learning, biological and cognitive factors, family relationships and family interactions prior to the onset of the problem, as this would enable the clinician to assess both the form and meaning of significant behaviours. "*The challenge now is to integrate learning, biology and family relationships into detailed developmental models that prove themselves in prevention and intervention contexts*" (Greenberg et al 1993).

4.3 Factors relevant to interventions

How do we become a social being? Competing paradigms continue around the debate about the extent to which human behaviour is biologically innate or socially learned, genetically inherited or culturally acquired.

4.3.1 Biological Factors

The biological perspective considers the individual's behaviour to be genetically determined, which develops along a specified direction, prescribed by the genetic blue print. This viewpoint acknowledges that social, economic difficulties and trauma etc. add extra stress to an individual and may contribute to behaviour which may have otherwise remained dormant, but it is considered that these factors are incidental catalysts, rather than actual causes.

Supporting evidence for this view is held by (Block *et al* 1988) who suggested that recent lines of inquiry indicate that the behavioural foundations for problem behaviours are already present in childhood and may be substantially genetic. Other expressed views are as follows:

"When such considerations are absent from investigations of adolescent problem behaviours, situational and environmental factors in adolescence will appear to be strong determinants of problem behaviours, when they are really only immediate pathways through which more fundamental predisposition's of individuals are expressed. If we see adolescents primarily as responding to situational forces around them, we will misunderstand why some are deep into problem behaviours and some are not" (Udry 1994:105).

"It is quite likely that genes do truly play a substantial role in determining the particular environments to which people are exposed" (Rutter & Rutter 1993:19).

Therefore, IQ ability, disposition, aptitude, behaviour, idiosyncrasies etc. are a product of our genes, not our experience. Rutter and Rutter (1993:88) considered affectional

qualities such as cheerfulness or shyness are probably genetically determined. Cadoret *et al* (1985a,1985b) found from their studies with adopted children that, anti-social problems and alcohol abuse in biological birth parents predicted the increased incidence of antisocial personality and alcohol abuse in adoptees. Kety *et al* (1978) and Rosenthal *et al* (1971) discovered more schizophrenic disorders have been identified in the biological relatives of schizophrenic adoptees than have been found in control groups.

Overall, the biological approach believes that genetic determinants are expressed through the process of maturation and behaviour, personality etc. develops with experience not from experience.

4.3.2 Environmental Factors

The environmental perspective believes individuals are a product of their experience, such as the specific culture, social/socioeconomic group, and family in which we are nurtured. By coping and trying to make sense of our social and physical environment, we develop our attitudes, beliefs, dispositions and behaviours. John Locke (1632-1704) English philosopher, who founded the school of Empiricism, argued that the child is born with a "*tabula rasa*" (blank slate) and believed that anything is possible, depending on how the environment reacts to the child's behaviour. (Dodge 1980). The social learning theorists hold strongly to this view, emphasizing the importance of environmental or situational determinants of behaviour, which is the result of a continuous interaction between personal and environmental variables, shaping behaviour and personality through learning. There is much evidence to support the effects of socioeconomic factors, such as poverty, the impact of violence and abuse upon children and families. "*Poverty is generally found to have detrimental effects on children and families*" (Gelles 1992:271). Langer *et al* (1977) found that children from very poor families tend, on average, to be more aggressive than children from middle or upper class homes. McLoyd (1995) states "*The reviewed research provides compelling evidence that poverty and its attendant chronic and acute environmental stressors are major contributors to depression, psychological distress, insensitive or abusive parenting and negative child outcomes in low income populations*" (McLoyd 1995:281). Merry & Andrews (1994) found from children

who had experienced horrendous sexual abuse, 12 months after disclosure, that of the 66 children assessed, 63.5% warranted a clinical diagnosis of a disorder. According to Dishon *et al* (1991) a deficient parental / family or peer environment, can shape deviant and antisocial behaviour. They found that poor parental monitoring, inappropriate use of parental consequences, and association with deviant peers are among the environmental conditions which can help initiate or maintain movement along the trajectory toward criminality.

Individuals are powerfully shaped by a vast array of circumstances in their world, making it impossible to note all the conditions and situations which influence children, young people and adults. However, it is clear that the biological and environmental factors are inseparable, as the hereditary potential with which an individual is born is very much affected by the environment they encounter. Current estimates suggest that genetic influences account for anything between 30 - 70% of the variation between individuals (Dunn 1993; Rutter & Rutter 1993).

4.3.3 Combination of Genetic and Environmental Factors (Ecological Model)

The ecological model believes that human development is viewed from a person-in-environment perspective, consequently, persons and settings are in a dynamic interaction and both proximate and distal environments may affect the course of development such as:

- **Microsystem:** situations which the child has face to face contact with influential others, like family, school, peers, church.
- **Mesosystem:** relationships between microsystems, the connection between situations such as, home↔school, home↔church, school↔neighbourhood.
- **Exosystem:** settings in which the child does not participate, but in which significant decisions are made, affecting the child or adults, who do interact directly with the child, examples of these are: parents place of work, schoolboard, local borough councils, parents' friends.
- **Macrosystems:** Outlines for defining and organising the institutional life of the society. These are represented by political ideology, social policy, shared assumptions about well-being . (Bronfenbrenner, 1979).

How an individual copes and adapts to these systems, characterizes the dominant means of change.

Research has, therefore, indicated that both biological and environmental factors impact upon a person's personality, behaviour etc., for example the adoption studies by Cadoret *et al* (1990) indicated that many behaviours have an inherited quality, but that the expression of those behaviours may be modified, suppressed, or enhanced, by the quality of the social environment, such as IQ levels, where adopted children nurtured in environments which were more socially advantaged than those of their siblings, who were not adopted, the difference being up to a 12 point IQ advantage. *"Biological maturation, is influenced by experience"* (Rutter & Rutter 1993 : 12 & 211).

Rutter (1991) discovered that as risk factors stack up, the chances of inadequacies or failures multiply many times, i.e. one risk factor had no connection to failure in adulthood, but, two risk factors quadrupled the chances of serious failure and 4 risk factors increased the chances tenfold. However, according to Weissbourd (1996), rather than focus on static risk factors as indicators of behaviour, he believes in an *"Interactive model which helps illuminate the shifting nature of childhood vulnerability and resilience. Complex interactions between family and peer dynamics over time, similarly direct a child's development, but these two worlds are often treated separately. Frequently it is a chain of complex interactions among home, school and peers that through a child's life out of joint"* (Weissbourd 1996:33).

There are also many cultural differences in behaviour, while smiling, crying etc., progress naturally in babies and children, there can, however, be marked cultural differences in situations which engage certain behaviours, such as eye contact with Samoan children. Cultures differ in their methods of childrearing, for example, among the Utku Eskimos of Hudson Bay, aggression is regarded as an undesirable characteristic. When the child is about 2 or 3 years old, Utku parents begin to discourage expressions of anger by the means of the silent treatment (Briggs 1970).

Minority cultures, with different cultural values to the predominant culture, frequently result in behavioural difficulties and parental conflicts, when their children reach

adolescence. Weissbourd (1996) found that in some Asian communities today many teenagers become estranged and some seek to sever themselves from their parents entirely, because their parents values clash so severely with the values of their peers.

To conclude, from birth, children are cultural entities, there is, therefore, a dynamic relationship between the genetic and cultural predispositions for the individual to make sense of his or her environment. As infants develop and determine what is occurring around them, they create models and cognitive structures, which assist them to understand, interpret and make sense of the world. It is the dynamic combination of genetic programming, innate temperament, family interaction and environmental experiences that moulds an individuals particular character and behaviour patterns. Hinde (1989) argues *"the futility of a dichotomy between the biological and social aspects of human nature is now generally recognised"* (Hinde 1989:251). *"Biological approaches must encompass psychosocial influences; people are thinking beings and they are heavily influenced by the way they process the experiences which they undergo"* (Rutter 1991:338).

It is the quality, therefore, of these experiences that become extremely important and significant.

The Features Associated with Conduct Disorder (CD)

Unlike other major psychiatric disorders such as depression and schizophrenia, conduct disorder almost always begins in prepubescent childhood and continues into adulthood (Robins 1966).

Despite the fact that CD appears to run in families, there is little evidence supporting a genetic factor. However, there are several parent, family and environmental conditions which are associated with CD. According to Kazdin (1997), the following parental and family characteristics are consistently linked with children who have CD.

- Criminal behaviour and alcoholism.
- Parent disciplinary practices and attitudes are frequently harsh, lax, erratic and inconsistent.

- Dysfunctional relationships are also evident, such as less acceptance of the children, less attachment, warmth, affection and emotional support. Lack of participation in family activities.
- Frequently there is dominance of one family member, unhappy marital relationships, interpersonal conflict, aggression and poor parental supervision.

CD is repeatedly associated with unfavourable living conditions, such as large family size, overcrowding, poverty, unemployment, poor housing, and disadvantaged school settings. The net effect of these stress factors impacts upon the parent-child interaction, resulting in parents inadvertently engaging in patterns which sustain or accelerate antisocial and aggressive behaviours (Kazdin 1995, Dumas & Wahler 1983, Patterson *et al* 1991).

These families often experience other problems which are linked to impoverished conditions, like dangerous neighbourhoods, geographic isolation, poor public transport, health risks, and adversarial contact with outside agencies.

Children with CD are likely to demonstrate academic deficiencies, truancy, poor reading and social skills. There are also likely to be distortions in cognitive problem-solving skills, displays of hostility, resentment and suspicion. Patterson *et al* (1989) observed that the single best predictor of adolescent delinquency, particularly for boys, is the relationship the adolescent has with his parent/s. The better the relationship, the less likely he is to engage in delinquent behaviour. The more strained, hostile, and rejecting the relationship, the greater the likelihood of delinquency.

There is widespread agreement and evidence that a pattern of antisocial behaviours can be identified and has correlates related to child, parent and family functioning. Moreover, antisocial behaviours included in the constellation extend beyond those recognised in diagnosis e.g. substance abuse, associating with delinquent peers (Kazdin 1997). *"Family life, therefore, is our first school for emotional learning, some parents are gifted emotional teachers, others, however, are atrocious"* (Goleman, 1996:189).

Most of the studies surrounding CD, however, have focused on males, with a paucity of studies of CD involving females. There are several reasons for this:

1. Due to the lack of appropriate criteria, especially in the DSM 111, which has been derived from studies on males.
2. A perception that CD among females is rare, because of this studies have concentrated almost exclusively on males.
3. Most of the research has come from the criminal justice system. Because males have a much higher arrest and imprisonment rates and also commit more serious crimes than females, relevant research has tended to concentrate on males (Robins *et al* 1991; Rutter & Giller 1983).
4. Females with CD are more likely to be found in settings outside the psychiatric or criminal justice system, leading to underestimations of the prevalence or seriousness of the disorder (Zoccolillo 1993).
5. The DSM 111 R, removed the distinction between aggressive and non-aggressive, patterns of acting-out, non-aggressive behaviours are more frequently associated with females who may have been abused (Bowers 1990).

Evidence, however, suggests that CD is the second most common psychiatric disorder in adolescent girls. A critique of the literature, completed by Zoccolillo (1993), indicated there were different outcomes for males and females with CD, with women having much higher rates of internalizing disorders, such as depression and emotional disturbances. Robins & Price (1991) found that the prevalence of internalizing disorder increases in females from 18.7% in those without CD symptoms to 50% in those with 5 or more conduct symptoms, there are similar trends with men i.e. 8.6% with no CD and 22.1% in men with 5 or more conduct symptoms. The ratios therefore, are similar, however, indications are that internalizing disorders are more common in women than men with CD.

Overall, Zoccolillo (1993) found that CD is associated with similar correlates in males and females, such as violence, aggression and anti social behaviour, once base rate differences by sex are taken into account or if the effect of CD on a variable is examined in females only. However, females are less likely to manifest criminal behaviour, particularly aggressive criminal behaviour and are more likely to have

somatization disorder, like hysteria, either alone or in conjunction with other antisocial symptoms or antisocial personality disorder.

The Development of Social Understanding and Empathy:

“When a parent consistently fails to show any empathy with a particular range of emotion in the child (i.e. joy, tears, cuddling) the child begins to avoid expressing and perhaps even feeling, those same emotions” (Goleman, 1996 :101)

Without social empathy, our attempts at social competence are weakened and our moral skills are severely limited. Experience is gained by exploration and exploration requires a secure base (Humphrey 1986; Ainsworth et al 1978; Main, 1991).

Humphrey (1986) believes that the key to the success of human beings is their social and emotional intelligence, but this self understanding needs a coherence of thought and a well integrated sense of self. However, in order for parents to be effective mentors, they must have a fairly good grasp of the rudiments of emotional intelligence themselves.

A series of studies completed at the National Institute of Mental Health showed that a large part of the difference in empathetic concern had to do with how parents disciplined, played and interacted with their children (Goleman 1996:99).

Harris (1994:20) observed that very disturbed children rarely engage in pretend play. In contrast, securely attached children play a good deal and their mothers often participate in their games and imaginative ventures. The broad findings now emerging are that children who are able to engage in pretend play on their own, with siblings and with their parents are better able to *“mentalise”*, to develop social empathy and to imagine how the world might look from another’s perspective. Children who do not play well together or who do not engage in much make-believe play, fail to develop deep levels of understanding and this is reflected in their failure to develop a strong moral sense and they may be unable to show any concern when another person is in distress.

Sroufe (1988) reported that, compared to securely attached children, the play of children who had experienced unresponsive, rejecting or indifferent parents, lacked complexity, elaboration, fantasy play, social empathy and there was evidence of a greater degree of conflict. In fact, the literature indicates, these children frequently showed negative empathy, such as, if another child was hurt the insecure child would further aggravate the pain and walk away smiling.

This lack of social empathy suggests a lack of moral sense, resulting in these children being capable of pretty horrific behaviour. Feshbach (1989:353) found "*A lack of social empathy appears to be associated with an increased tendency to show aggression without remorse.*" Feshbach (1989) in her review of the literature on empathy and the physical maltreatment of children found that physically abused children have difficulties in social interaction skills that mediate or are mediated by empathy.

4.3.4 Attachment

This theory has generated a great deal of interest for researchers and clinicians, because it has assisted practitioners to go beyond the "drive/reduction theory of attachment" and understand how and why children develop emotional relationships with their caregivers.

Attachment theory, as an alternative to the "drive/reduction theory", was first introduced by Bowlby during the 1950s, whose goal was to preserve psychoanalytic insights about the mother/child relationship, because he believed this was the "gateway" to knowledge and understanding about child personality, behaviour and social relationships. He therefore purported that attachment behaviour was separable from other instincts such as feeding and sexual activity (Bowlby 1958).

Bowlby was influenced by two ethnologists

1. Harlow (1958) who studied Rhesus monkeys and demonstrated the importance of early experience for later behaviour. He separated 60 monkeys from their mother 6 - 12 hours after birth and suckled them on bottles. One group was fed by a laboratory

wire mesh mother monkey, made warm by radiant heat. A second group was fed by a similar "mother" which also had cloth on it. Harlow found that the contact comfort of the cloth was of overwhelming importance in the development of emotional responses in the monkeys, even more important than lactation. The suggestion, in contrast to what might have been expected from psychoanalytic theory, was that the primary function of nursing as an affectional variable was that of ensuring frequent and intimate body contact of the infant with the mother. Beyond this, however, and in support of the innate approach of psychoanalysis, Harlow found that the monkeys deprived of a real mother as infants became helpless, hopeless and heartless mothers, almost devoid of emotional feelings.

2. Lorenz (1981), interested in instinctive behaviour, studied animals in their natural environment rather than in the laboratory. He was able to demonstrate how young ducklings followed him instead of their mother, because he was the first moving object they saw after they were hatched.

However, there will not be a focus on Bowlby, but instead close attention will be given to the works of Ainsworth and Perry.

Ainsworth was a colleague of Bowlby's and expanded further on his work, exploring thoroughly the various types and qualities of attachment relationships. Perry has completed a great many studies on the impact of trauma and violence on a baby's developing brain and how the brain organises itself in a specific way, in response to the environmental conditions. Both these researchers are mutually compatible as they both give credence to the theory that infants, who have a balanced exposure to frustration, gratification, and control during times of tension and anxiety and who are subsequently able to return to a stable, consistent and welcoming state with their mother or caregiver, will establish an appropriate neurochemical milieu for the development of a secure sense of self, and a flexible adaptive personality.

Attachment theory holds that the newborn infant possesses a system of species-characteristic behaviours that has evolved to promote proximity to a care giver. (Ainsworth 1989). This behavioural system is believed to be organised within the

central nervous system in a flexible way so as to make it initially sensitive to environmental influences. (Bowlby 1988). As the infant develops it can clearly distinguish the primary care giver, making it possible to differentiate the attachment toward this person, from others.

As cognitive development proceeds, this continual interaction with the primary care giver, sets a pattern of expectations in regards to consistency, accessibility and responsiveness from the care giver and the ability for the infant to evoke these behaviours from the care giver. (Ainsworth 1989; Bowlby 1988) referred to these internally organised expectations as "working models" and asserted that working models become integrated into the personality structure and dictate to a large extent how one anticipates and construes self, others and the environment (Bradford *et al* 1993).

How Do Children Organise Their Emotional Experience?

Attachment theorists believe children build an "*internal working model*" in an attempt to make sense of the emotional and relationship environments. From this internal frame of reference, they form expectations of other people's mental states and their relationship style. "*The early established working model is then projected outward by the child and is used to guide emotional reactions toward persons outside the immediate family, even when these expectations have limited validity*" (Harris 1994:4). According to this theoretical perspective, secure and insecure attachment patterns, are in effect modeling the emotional character of the parent-child relationship. Another supporting point of view, is that of the neurobiological theorists who believe traumatic events, neglect, violence etc. in early childhood, have such an impact upon the developing brain that they are subsequently stored in the "*working memory*." Children from such environments are at highest risk for problems like impulsivity, academic failure, anger, high anxiety, alcoholism, criminal behaviour etc. LeDoux (1993) believes the role of the working memory has long been a basic tenet of psychoanalytic thought: that the interactions of life's earliest years lay down a set of emotional lessons based on the attunement and upsets in the contacts between infant and caretakers.

These internal working models or memories, formed during actual interactions with significant caregivers, are new thought formulations, and can become templates for future relationships. Bowlby (1980) proposed that the internal working models operate largely outside of conscious awareness and are, therefore, resistant to change. Crittenden (1990) believed that internal working models of attachment figures are dynamic, complex representations of early relationships, operating at different levels of the individual's memory system, including semantic, episodic and procedural. Internal working models are therefore considered to be a crucial concept in attachment theory.

Attachment continues to develop and evolves rapidly during the first few years of life. Attachment to a primary figure is increasingly mediated by the child's growing use of language, the development of social empathy and the inner working model, which enables the child to understand that relationships continue to exist even when the other is absent. This growth in security, however, is upset if the parent or caregiver is unable to show social empathy and finds it difficult to communicate feelings and motivations. This in turn frustrates the child's need to build coherent models of self and others, resulting in trust and mutual understanding failing to develop in social relationships.

Ainsworth (1989) During the 1960s - 1970s Ainsworth explored the conceptual significance of a secure base and quality of attachment between infant and primary caregiver. Studies were conducted on infants in a laboratory setting, using a "Strange Situation Test", where infants were exposed to two separations and reunions with the caregiver. This test lasted 20 minutes, during which time, the infant's responses to these separations and reunions were recorded as secure or insecure.

Ainsworth and her colleagues, identified three primary patterns of infant behaviour that are believed to be directly related to the individual's internal "working model". Based on responses to separation and reunion, the following classifications have been made:

Secure Attachment - In this category, a child maintains a smooth balance of proximity seeking and exploration prior to separation, contact seeking and maintaining, and easily

soothed upon reunion. As securely attached children approach adolescence, they find it relatively easy to get close to others, and feel comfortable depending on them, without fear of abandonment. Adults with secure attachments, approached their work with confidence, with less fears of failure and did not allow work to interfere with relationships.

Individuals who are capable of forming sustained, close, intimate, stable, responsive and reciprocal social relationships, demonstrate strong feelings of self confidence and self worth, coping mechanisms stay intact under moderate levels of stress and anxiety. They have trust in others and are able to empathize, they are socially competent and acceptable.

Insecure Attachment - a child may cope with a stressful situation by:

Avoidance - by exhibiting a high degree of independence with little reference to the primary care-giver prior to separation, minimal distress during separation, and avoidance upon reunion. However, heart rate studies by Sroufe & Waters (1982) indicated arousal during this time. Continuing into adolescence and adulthood, this group find it uncomfortable being close to others, difficult to trust completely and depend on others. Because they feel nervous when anyone gets too close, they tend to use work to avoid social interactions.

Individuals avoid emotional closeness. These people display compulsive self-reliance, but they are emotionally brittle during moderate levels of anxiety and are unable to maintain this outward self-reliance. Their emotional relationships are usually shallow and they may become hostile and rejecting when faced with other people's emotions. They are unable to empathize with others, they lack self worth, confidence and can often be depressed.

Anxious/ambivalent attachment - the infant compromises exploration by remaining close to the caregiver prior to separation, is very distressed during separation and shows a combination of contact seeking, contact maintaining, temper tantrums and avoidance upon reunion and during comfort times with the caregiver (Biringen, 1994). In adolescence and adulthood, this group find that others are reluctant to get as close

as they would like and have concerns that others will not like them. They fear rejection for poor performance and usually allow their relationships to interfere with work performance.

These people often recognise the need for closeness and intimacy, however, their availability cannot be taken for granted, because in the past their close relationships have been inconsistent and unreliable, therefore closeness and responsiveness do not last.. They often have feelings of anxiety which is most evident at times of separation, fears of abandonment, self doubt, being unwanted and unloved. Clingingness, jealousy, and possessiveness result. However, this causes ambivalent emotions because to be dependent creates feelings of anger. There is a tendency to blame one's own emotional state on other people. There is a desperate need for love, but they feel they cannot trust others to give them this love. These people are often surrounded by emotional drama and denial of their feelings.

Disorganised Classification - this is a separate group and one where the infant adopts no organised strategy toward the attachment figure. The child may show resistant, avoident or secure behaviour patterns on reunion with caregiver. This category is more commonly associated with insecurity, primarily because of its prevalence in such high-risk samples as abused children (Cicchetti & Carlson 1989). Relationships with other people are confusing, no emotional independence, they are often present in situations but emotionally unavailable, complaisant but incapable of showing reciprocity.

4.3.5 Post Traumatic Stress Disorder

Perry (1996) Over a period of many years there has been a great deal of discussion, research and study on neuropsychiatric syndromes, which develop as a result of extreme trauma, known as Posttraumatic Stress Disorder (PTSD) (outlined in Chapter 3: 35). However, the majority of this literature has involved adults, especially in the areas of "combat/war veterans" (Da Costa 1871; Krystal et al 1989; McDonald *et al* 1995), "rape" (Block 1990) "domestic violence, battered women" (Briere 1994; Kemp et al 1995) "disfigurement or life threatening illness, such as breast cancer" (Cordova

et al 1995) "emergency services work and disaster recovery" (Mitchell & Everly 1993) and many more studies, such as child sexual abuse, recent research, indicates that a number of psychosocial problems are more common among adults molested as children than among those with no such childhood experiences (Briere 1992).

It is only during the last five years, however, that childhood PTSD has been widely observed in various populations of traumatised or maltreated children.

As outlined in the above section on attachment theory, when a child's development is enhanced by structure, predictability, focused nurturing, enriched emotional interactions, and stimulated social and cognitive experiences, he or she will evolve into a contented, secure, productive, insightful and empathetic adult.

It is therefore, the family setting, that provides a child's nourishment, protection, education (formal and informal), moral values and the cultural belief systems, in which the non-genetic DNA of the culture is transmitted from generation to generation, allowing the amazing process of socio-cultural evolution (Perry 1996).

However, all too often, there is an intergenerational cycle of violence within families where children are subjected to a high degree of destructive experiences.

In America, intrafamilial abuse, neglect and domestic battery account for the majority of physical and emotional violence suffered by children (Koop & Lundberg 1992; Horowitz *et al* 1995; Perry 1996). The adolescents and adults responsible for this violence, developed their behaviours as a result of intrafamilial violence during their childhood (O'Keefe 1995; Myers *et al* 1995; Mones 1991; Hickey 1991; Loeber *et al* 1993; Lewis *et al* 1989; Perry 1996).

However, often undetected, is a greater degree of emotional violence, such as humiliation, coercion, degradation, threat of abandonment or physical assault, which may be more, toxic and harmful than other forms of violence and abuse (Vachss 1993).

“Children who have been exposed to trauma may have a range of PTSD symptoms, behaviour disorders, anxieties, phobias and depressive disorders” (Schwarz & Perry 1994:316). “Traumatic experiences in childhood increase the risk of developing a variety of neuropsychiatric symptoms in adolescence and adulthood. It is the brain that mediates all emotional, cognitive, behavioural, social and physiological functioning” (Perry 1995:278).

How, Then, Do These Traumatic Events Effect The Brain?

A newborn baby is equipped with virtually all the brain cells, he or she will have when they reach adulthood. However, the newborn developing brain is not “*programmed*”, because this process occurs in accordance with the environment, during the first three years of life. During this period, neurons divide, migrate, specialize and differentiate in response to chemical “microenvironmental cues” (morphogens), which confer information to and direct specific differentiation of the cell. (Perry 1996).

These “microenvironmental cues”, therefore, are responsible for determining where or how often a neuron divides, the location it migrates to, and how it decides the expression of the genetic component. Cell to cell contact with other neurons or glial cells, exposure to certain hormones and stimulation of specific neurotransmitter receptors, all contribute to the array of extracellular signals which tell the cell which genes to express and which genes to inhibit (Perry 1996).

This theory supports the belief that environmental factors are responsible for determining the final phenotype of the developing brain, due to the key role neurotransmitters and hormones play in response to environmental components, such as severe or prolonged stress caused by PTSD, the symptoms of which are:

- Recurring intrusive recollection of the traumatic event, such as dreams and flashbacks.
- Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness.

- Persistent symptoms of increased arousal characterized by hypervigilance, increased startle response, sleep difficulties, irritability, anxiety and physiological hyperactivity. (Perry 1994)

Distinguishing features which were noted by Murburg (1994), in children who exhibited psychotic behaviours, anxiety, disordered conduct, aggression and affective symptoms such as, dysphoria, irritability, and a hyperactive sympathetic nervous system (SNS), were as follows:

- documented history of a severe traumatic event or events.
- exacerbation of symptoms with re-exposure to trauma-specific stimuli.
- autonomic nervous system (ANS) hyperarousal (Murburg 1994).

Brain Activity

During the 1980's LeDoux discovered the role of the amygdala, an almond shaped cluster of interconnected structures perched above the brainstem, near the bottom of the limbic ring. He detected that the amygdala perceived, remembered and orchestrated fear, independently of the neocortex and some emotional reactions and emotional memories can be formed without any conscious cognitions at all (LeDoux 1992).

Therefore, when an emotional alarm of fear is noted, the amygdala sends urgent messages to every major part of the brain, during which time it triggers the secretion of the body's freeze, fight or flight hormones such as ACTH adrenocorticotrophic hormone, epinephrine (adrenaline) and cortisol. At the same time, neurotransmitters, cardiovascular system, liver and muscles are also activated.

The neurotransmitters, called monoamines or biogenic amines, such as norepinephrine, epinephrine, dopamine and serotonin, play a central role in mediating the alarm action (Perry 1996). Consequently, persistence of a threat such as through trauma or abuse, has the capacity to "redefine" the baseline level of the CNS involved in the stress response, resulting in a dysfunctional or maladaptive set of brain activities. Perry (1996) indicated that the neurotransmitters known to play a major role in PTSD,

anxiety disorders and affective disorders, are the brain stem catecholamines which mediate the CNS stress response (Perry 1996).

Trauma-related alterations in catecholamine activity during childhood, therefore, may alter brain development, subsequently modifying the functional capabilities of the traumatized brain. In general, the earlier and more pervasive the trauma, the more neurodevelopment will be disrupted.

LeDoux (1992), believes, the role of the amygdala, (which matures quickly and is nearly fully developed at birth), in childhood, supports the basic tenet of psychoanalytic theory, regarding the impact of life's earliest years on the formation of emotional feelings/responses, to the attunement, attachment and interactions between infant and caregiver/s. However, while these feelings are powerful, they are stored as wordless emotional memories, thereby, leaving chaotic and baffled feelings about certain emotional responses.

To conclude, emotional attachments are extremely sensitive to environmental influences and the type of interaction a newborn baby has with his/her primary caregiver is of extreme importance.

Children who experience severe emotional trauma or abuse in early childhood, may be behaviourally impulsive, hypervigilant, motorically hyperactive, withdrawn, depressed, display sleep difficulties, dissociative disorders, anxiety and persisting physiological hyperactivity.

It appears clear, that early life trauma or stress plays an important role as an expressor of genetically determined vulnerabilities to a variety of neuropsychiatric disorders, including schizophrenia (Garmezy 1978), major depression (Lloyd 1980) and Tourette's Syndrome (Leckman *et al* 1990).

There can be many reasons for disturbed emotional attachments, some of which can be strongly linked to early trauma, abuse or violence. A more common reason, however, can be connected with post-natal depression, a condition which requires early

detection. This has, therefore, become an area of concern as the health sector continues to encounter further cuts to their services, such as post-natal care, like Plunket (New Zealand Herald 21 November 1997) and maternity services from GP's (New Zealand Herald 14 June 1997).

4.4 Resilience or Protective Factors

Clearly not all children from multiple and economic disadvantaged families develop poor outcomes. The presence of certain factors appear to mitigate the risk and provide protection or resilience. These include:

- bonding and social factors such as strong relationships with family members, teachers or other significant people who demonstrate positive attitudes and behaviours.
- healthy beliefs and standards, such as having a set of clearly established rules and developmentally appropriate expectations which help make connections between behaviours and consequences.
- environmental factors including positive school-home relations and quality schools.
- a child's individual characteristics such as cognitive skills, strong coping skills, high self esteem and temperament (Weissberg & Greenberg 1997; Fitzpatrick 1997).

"Resilience is concerned with individual variations in response to a similar exposure to risk factors" (McDowell 1995:38).

There have been a great number of studies completed on risk factors associated with conduct disorder and anti social behaviour, such as: insecure attachments (Karen 1994; Ainsworth 1989; Greenberg *et al* 1993) marital discord, (Offord 1982; Rutter & Giller 1983), posttraumatic stress disorder PTSD in early childhood (Perry 1996), socioeconomic stress (Offord *et al* 1986), criminal or psychopathological parental

traits (West & Farrington 1973) and punitive / inconsistent discipline methods (Campbell *et al* 1986, Patterson 1982).

McDowell (1995), in her risk research study on emotional abuse, made a distinction between “*proximal and distal variables*”. Proximal variables, which are non-genetic risk factors, such as medical care, family violence etc., impinge upon distal variables, which may be generationally linked, such as socio-economic status. However, says McDowell, (1995:37) “*While any environmental risk factor can fall anywhere on the distal-proximal continuum, it cannot be assumed that it will carry equivalent levels of risk to all children exposed to it, nor can it be assumed that it will carry the same level of risk to the same child at different life stages.*”

The question, therefore, is why do some people become deviant in such circumstances while others remain healthy? According to Lösel & Bliesener (1994) protective factors may operate through both direct and indirect effects. Resilience results from complex nature-nurture interactions and is not a fixed quality, but can vary across time and circumstances.

Resilience or protective factors, refer to an ability to develop personal and social resources, which assist an individual to cope and deal with high risk environments. Garmezy (1985) reviewed the literature and classified potential protective factors into three broad categories:

1. Dispositional attributes of the child such as personality, positive temperament, high level of confidence and good sense of self.
2. Family cohesion, such as secure emotional attachments and a non-violent environment.
3. Availability and utilization of external support systems and resources.

If a balance exists between stressors and protective factors, which are manageable, an individual can cope successfully. However, if there are extreme changes in either domain, behavioural or emotional disorders may result. According to Lösel & Bliesener (1994) long lasting or repeated noxious influences shift the fluctuation level to a pathological one, thus producing a risk personality. In this case, additional

disturbances become an overload for the adaptive coping mechanism of the individual and according to Werner & Smith (1992) appear to have a cumulative, rather than a directly additive affect. Other components and attributes of the child which can enhance protective and resilient factors are:

1. Birth order: A longitudinal study completed by Werner & Smith (1992) found most resilient young males were first born, thereby suggesting that the primary caregiver(s) were able to focus on the child's needs and form a secure attachment
2. Temperament: Werner & Smith (1992) also found that children who had an easy personality, but had experienced traumatic stress factors, were able to positively adjust. This possibly indicates that children with a difficult temperament, are harder to relate to and as a consequence suffer greater abuse.
3. Intelligence: In some studies of high risk individuals, a high IQ has been shown to be a stabilizing, protective factor (Garmezy, 1985; Werner & Smith, 1992). This may empower the child to be more resourceful and seek information which helps to rationalize the abusive/violent situation. According to Dunn (1993), information may, in some situations, help the child to understand that the abuse is unintentional, possibly beyond the control of the parent and most importantly, the child is not responsible.
4. Self-esteem and self-confidence: A belief in one's own sense of self is a protective factor cited in (Garmezy, 1985; Werner & Smith, 1992). This enables a child to believe they are worthy of being loved.
5. Environmental factors: Werner & Smith (1992), found the presence of a male partner in the home and the mother's emotional support of the child, were the two most important environmental factors in shaping children to become less vulnerable to the effects of maltreatment. McLoyd (1995) found that supportive social networks such as family contributed positively to good parenting.

To sum up, Kaufman & Zigler (1987) found the following correlates important in the prevention of intergenerational transmission of abuse, from abused parents: to their children:

- a good relationship with a caregiving adult in childhood
- high IQ

- special talents
- physical attractiveness
- social skills
- a supportive spouse
- current financial security
- social supports
- strong religious affiliations
- positive school experiences
- therapy.

4.5 Summary

Overall, the long term effects of childhood emotional trauma remain relatively unexplored, partly due to a greater focus on physical and sexual abuse, with less emphasis on the impact of emotional abuse, poor parental attachment and the effects of a violent and hostile environment, and partly because of the controversy over repressed memories in regards to childhood emotional disturbances, because their expressed chaotic feelings are often vague and unable to be accurately recalled verbally.

This chapter has attempted to highlight the importance of secure emotional attachments, protective factors and the relationship between early life experiences and cognitive, emotional, social and physical well-being. *"In order to prevent the development of impulsive, predatory or violent children, we need to dedicate resources of time, energy and money to the complex problems related to child maltreatment"* (Perry, 1996:10).

Unless practitioners working with children and families, have an understanding of these problems, they will be unable to identify the early warning signs, in order to provide proactive intervention and prevention. These aspects are discussed in the following chapter.

Chapter Five

Effective Intervention

5.1 Introduction

It has been well established that entrenched, disruptive behaviour patterns during the early childhood years are more likely to increase the risk for later antisocial behaviours. (Moffit 1993; Farrington 1991; Karen 1994; McCord 1991; Tremblay *et al* 1994; Eron 1990). Without intervention, children who are diagnosed with CD are likely to become trapped in a snowballing pattern of negative interactions with family members, teachers and peers. Their possibilities for adaptive change become increasingly narrow over time as they consistently alienate themselves from many essential socialising influences and supports (Coie & Jacobs 1993). This chapter discusses the risk factors which contribute to antisocial behaviour and the level of family assessment required to determine the risks and type of intervention. This section explores the various treatments and education programmes and assesses their effectiveness and also examines changes currently occurring in social work delivery within CYPFS.

5.2 Overview

The search for aetiology of antisocial behaviour has been wide and varied, and some of the theoretical concepts are:

- Biological factors, which consider the individual's behaviour to be genetically determined (Udry 1994; Rutter & Rutter 1993).
- Environmental factors, which considers the individual is a product of their experience (Langer *et al* 1977; Dodge 1980; Gelles 1992; McLoyd 1995).
- Ecological model which believes that human development is viewed from a person-in-environment perspective (Bronfenbrenner 1979; Hinde 1989; Weissbourd 1996).

- Hormonal factors associated with aggression, (Olweus *et al* 1988), found a link between hormone levels (testosterone) and aggression. However, there have been many debates and theories regarding the etiology of aggression. Other studies have disputed the hormonal theory, Dabbs and Morris, (1990) supported a relationship between testosterone levels and antisocial behaviour, but found that this connection was also influenced by low socioeconomic status. Rubin (1987) found little supporting evidence in a reduction of non-sexual violence, in men who had been castrated.
- Types of aggression. Dodge and Cole (1987) distinguished between two types of aggression. Proactive aggression, which is a way to meet goals. This type of aggression has its origins in experiences that enhance a child's repertoire of aggressive tactics and leads the child to evaluate aggressive behaviour in a positive way. In contrast reactive aggression, is where the child is angry and volatile and troubled by others. The source of this type of aggression is usually due to experiences of life-threatening danger and PTSD and frequently results in hypervigilance (Perry 1996).
- Attachment /Bonding between parent and child (Karen 1994; Ainsworth 1989).
- Domestic violence and PTSD (Shepherd 1995; Perry 1996).
- Emotional, sexual and physical abuse (McDowell 1995).
- Parental separation and other parental social and contextual factors (Fergusson *et al* 1993; Rodgers & Pryor 1998).

According to Eron (1990) and Berkowitz (1993) aggressive antisocial behaviour crystallizes at approximately 8 or 9 years of age. Consequently it follows that interventions aiming to reduce this type of behaviour, should centre on 'at risk' children before this developmental period. The first stage, therefore, for effective treatment, is the identification of 'at risk' children.

5.3 Identification of 'at risk' children

The most immediate setting for a child's early development is his/her microsystem or family. It is the family arena which determines the type of interaction a child will have with significant others and the type of environment the child will grow up in.

As outlined in the introduction section of this study, the overwhelming impact of adverse environmental conditions on child development has been well documented and recurrent findings are children most 'at risk' come from families marked by a combination of factors that include insecure attachments (Karen 1994; Ainsworth, 1989; Greenberg *et al* 1993), marital discord (Offord 1982; Rutter & Giller 1983), posttraumatic stress disorder (PTSD) in early childhood (Perry 1996), socioeconomic stress (Offord *et al* 1986), criminal or psychopathological parental traits (West & Farrington 1973), punitive and inconsistent discipline methods (Campbell *et al* 1986; Patterson 1982), and child maltreatment which conveys messages of how they are valued (McDowell 1995).

According to Dodge (1993), longitudinal studies have suggested at least three major predicting factors which could serve to identify children at high risk of CD.

1. Adverse early child-rearing environment, such as financial deprivation, poor housing, unemployment, family adversity and dysfunction including lone parents, domestic violence, parental psychopathology, child abuse, inept parenting, such as poor monitoring and little positive reinforcement.
2. Children who display aggressive behaviours during the first few years of pre or primary school.
3. Those children whose aggressive behaviour leads them to experience social rejection from peers.

Dodge (1993) stresses that these factors do not destine a child for ultimate CD, but, most errors in prediction are likely to be ones of false positives, suggesting that very

few individuals with chronic adolescent CD have not experienced at least one of these factors.

Dodge (1993), Church (1994), Berkowitz (1993) and Patterson *et al* (1991), believe that (a group of) children who are at high risk of severe CD can be identified by the time they begin elementary school. In addition, from a treatment perspective, CD represents a very broad domain involving child, parent, family and contextual conditions. Furthermore, comorbidity in children with disruptive behaviour disorders, compounds the treatment recommendations and response outcomes, due to the fact it is unclear whether a disorder such as ADHD exists in a pure form or coexists with CD, will respond to the same treatment.

Ecological Approach:

This approach is based on the assumption that there are multiple causes and correlates for problem behaviour and youth antisocial behaviour is related to important processes occurring in multiple settings, including families, peer systems, schools and communities. Interventions, therefore, should take these factors into account and focus on empowering children/young people and their families with resources which will promote and sustain positive change.

Family Assessment:

Other sections of this research study have identified children and families most likely to be 'at risk' of developing problem behaviour. This section, therefore, will focus on family assessment and appropriate intervention.

In order to work effectively with 'at risk' families, it is both important and necessary for social workers to have a strong knowledge base and understanding about the following:

- Our own beliefs, values and social work practice. We require appropriate theoretical perspectives to assist us in examining why and how we do what we do.

- All forms of child abuse, behavioural indicators and identification of 'at risk families'.
- Family dynamics such as boundary setting, discipline, collusion, denial, grieving, powerlessness, oppression etc.
- The effects and underlying issues relating to family violence, poor attachments, PTSD, abuse, generational abuse, and the impact these situations have on children, women, men and families in general.
- Legal statutes, role and responsibilities of the social work agency.
- Cultural and related practice differences
- Available resources
- The dynamics of empowerment.
- Ability to analyze the wider context of power, politics, poverty and the impact these have on social justice.

This list is not exhaustive, but rather an outline of the basic requirements.

Social work assessment, consequently, is a critical component in identifying key issues within a family and should consist of the subsequent basic steps:

1. Identification of the problem, obtained through a historical overview.
2. An assessment of the current situation, analyzing the problem in order to ascertain 'what is going on'.
3. Identification of support people, extended family, significant others and other social issues.
4. Devise a plan, outlining changes which require attention, how these can be made, who is involved and discuss realistic goals.
5. Type of intervention appropriate to generate change and methods by which the goal can be achieved.
6. Arrange a review and evaluation period, in order to assess the effectiveness of the planned intervention and ascertain whether a new plan is required.

However, this form of practice has been made more difficult for social workers, due to the current climate of economic rationalism and erosion of the Welfare State. This combined with pressure of work, sometimes poor supervision, the complex dynamics

of families and limited training, frequently, makes it easy for social workers to misunderstand or minimize problems within families. "*The frenetic pace of statutory work, crisis driven, and accountable to deadlines set by courts, discourages a culture of reflection and examination*" (Bunston 1997:68). Unfortunately poor diagnosis of a family situation is not always immediately apparent, and may not become evident until the problem has intensified significantly. As a result intervention often becomes more difficult.

Engaging families in an assessment process can often be difficult and the implementation of a therapeutic treatment near impossible. Several studies have shown that multiple personal and environmental stressors experienced by families, make them more resistant and less likely to participate in treatment programmes. Families from lower socio-economic status and depressed mothers are prone to 'drop out' of treatment, especially if they have been referred by an agency rather than self referred.

Kazdin (1990) assessed characteristic features of families who dropped out of treatment and found that families who dropped out had children and adolescents with a greater number of symptoms of conduct disorders and delinquency, lower educational and occupational status and lower income. Mothers in 'dropout' families reported more depression and higher life event stress scores. These findings have been supported by Hawkins and Netherhood (1987) and Johnson (1988) who reported dropout rates of over 50% for treatment studies with families of conduct disordered children.

Wahler and Dumas (1987) conducted a series of studies which examined the relationship among family socioeconomic disadvantage, isolation and effects on outcome. They found after a one year follow-up assessment, that the probability of treatment failure, steadily increased as a function of low socioeconomic status and/or social isolation. This evidence is supported by Kazdin (1997), who found, that the accumulation of multiple child, parent, family and contextual components, such as early onset and more severe child antisocial behaviour, comorbid diagnoses, child academic impairment, socioeconomic disadvantage, poor parenting techniques and parental stress, increased the risk for poor outcome in treatment. However, despite

this prognosis, treatment was found to be more advantageous and beneficial to families, than no treatment at all. As Kazdin (1997:172) expresses: *“Our own work has shown that even those youths with multiple risk factors still improve with treatment, but the changes are not as great as those achieved for cases with fewer risk factors”*.

Correspondingly, Dadds and McHugh (1992), found, that if the parent had a close relative or supportive friend, this factor improved treatment responsiveness. Literature reviewed by Chamberlain and Rosicky (1995), suggested that inclusion of specific components designed to enhance social support, increased the effectiveness of family treatment. However,... *“these studies were conducted with families of younger children with conduct problems and may not be generalizable to adolescent populations”* (Chamberlain & Rosicky 1995:449). It was also found by Dishon (1984) that family therapy interventions are more likely to be successful with younger children than for adolescents, who are displaying conduct disordered behaviour.

Administering the most appropriate and effective treatment, can be a difficult task for the following reasons:

- Treatment recommendations are influenced by the clinicians theoretical view about the cause and subsequent treatment of behaviour disorders.
- With a few hundred or so treatments available for children, it would be helpful to know which among these are effective. However, the vast majority of treatment approaches have not been evaluated empirically. Many treatments for CD might seem conceptually justified as interventions, because CD is a dysfunction with pervasive features and one can point to virtually any domain and find aberrations, deficits and deficiencies (Kazdin:1997).

According to Kazdin (1997) no single treatment among those available, adequately addresses the following criteria, necessary to provide an effective treatment:

Conceptualization: A theoretical rationale that notes how the dysfunction such as CD, comes about and then how treatment redresses the dysfunction.

Basic Research: Refers to studies that examine conduct problems and factors which lead to their onset, maintenance, exacerbation, amelioration or attenuation, such as studies of the family that demonstrate specific interaction patterns among parents and children that provoke aggression within the home. This evidence would provide a justification for treatments that would aim at particular interaction patterns.

Preliminary Outcome Evidence: Evidence which demonstrates that the treatment can effect change. Randomised controlled clinical trials would be the most effective strategy to provide this type of information.

Process-Outcome-Connection: Indication in outcome studies, showing a relationship between the change in processes alleged to be operative in the clinical outcome. Therapeutic change would be shown to covary with the extent to which these processes were altered in treatment (Kazdin 1997:163).

5.4 Treatments and therapy approaches

The most commonly used approaches are:

1. Individual and microsystem interventions such as medication, play therapy, cognitive problem-solving skills training.
2. Family and/or mesosystems which may or may not include the school such as behaviour therapy (combined with parent management training), family therapy, and the more comprehensive and least used multisystemic therapy.
3. Exosystem such as public awareness and education.

5.4.1 The use of Medication or Pharmacotherapy

The use of pharmacologic treatment of disruptive behaviour disorders began more than fifty years ago. However, other treatments were also being explored and it was not until the 1960s that pediatric psychopharmacology began again in earnest. The last decade has seen a marked rise of an interest in biomedical measures and concepts (such

as DSM 111) which reflects the rapid growth of underlying neurobiologic and molecular biologic sciences (Werry 1994).

Pharmacotherapy, however, centres on the symptoms rather than the causes of disruptive behaviour disorders. It is not the intention of this study to focus on an assessment of drug effects, but instead to acknowledge the benefits and limitations of the use of medication in treatment.

Of the various psychoactive medications that have been used to treat disruptive behaviour disorders, the most commonly used drugs are psychostimulants, such as amphetamines and methylphenidate (Ritalin). There is little doubt that psychostimulants improve the behaviour of about seventy five per cent of all hyperactive children, at least in the short term (Cantwell 1980; Richardson *et al* 1988; Werry 1994).

The following benefits may be gained by the use of psychostimulants:

- They cause an increase in zest, vigilance, attention and quietness.
- An improvement in psychomotor, academic and motor performance.
- Compliance and overall behaviour become better organised.
- A decrease in impulsive aggression, less restlessness, distractibility, impulsive oppositional behaviours and an increase in socially acceptable behaviours. (Werry 1994)

However, the commonest adverse effects are an increase in core symptoms (i.e. paradoxical worsening) tearfulness, emotional brittleness, abdominal pain, insomnia, pallor, irritability. Suppression in physical growth, can occur with long term use (Werry 1994; Dulcan 1986; Conners & Werry 1979).

Hyperactive children who are placed on medication are no better off in the long run, than hyperactive children who never receive it (Jacobvitz *et al* 1990).

“Although research demonstrates that the short-term beneficial effects are obvious, however, substantial compliance tends to diminish sharply with time and there is no

good evidence that they influence long term outcome, behavioural or academic.” (Werry 1994:331).

The use of medication for children with problem behaviour, in isolation of any other integrated family approach, can be both beneficial and damaging. The beneficial effects may be gained by the family viewing the child in a more positive light, while he/she is on medication, thereby improving their interaction together, and it is a quick cost efficient short-term solution. However, the damaging effects can result because the child is identified as having a problem, or indication may be given that the behaviour disturbance is a “disease”, thereby labeling the child and removing responsibility from other family members, who may need to address other issues, which, along with other environmental factors, may be contributing to the child’s behaviour.

“It is necessary to stress that, even when highly effective, pharmacotherapy is unlikely to be the complete answer on its own and that good practice generally requires a multimodal, multisystem, multidisciplinary approach if it is to reflect personalised, holistic medicine” (Werry 1994:322).

5.4.2 Play Therapy

Play therapy is a form of psychotherapy and is frequently used with young children, who have limited ability to express themselves verbally. Children are encouraged to participate in free play with toys provided by the therapist, and the goal is to assist the child to gain insight into his/her unconscious impulses and conflicts. This, in turn provides the therapist with a picture of the underlying factors contributing to the problem. There is little evidence suggesting that this approach is particularly effective in isolation (Kazdin 1997; Borduin *et al* 1995). Kazdin (1988) noted that, of the 230 documented psychotherapies available for children and adolescents, the vast majority have not been studied. Among those that have, none has been shown to controvert conduct disorder and its long term course. However, it can be a very useful means of building a trusting relationship with the child and many clinicians believe, when combined with other interventions it can be an effective therapeutic tool.

5.4.3 Cognitive Problem-solving Skills Training

Cognitive processes refer to a broad class of constructs that pertain to how the individual perceives, codes and experiences the world. Individuals who engage in conduct disorder behaviours, particularly aggression, have been found to show distortions and deficiencies in various cognitive processes (Kazdin 1997).

Social cognitive interventions focus on the relation between cognition and affect (thoughts and emotions) and behaviour. The assumption is that changing or enhancing cognition and affect will lead to changed or enhanced behavioral adjustment. Deficits in problem-solving skills, perceptions, self-statements and attributions have been shown to be associated with disruptive and antisocial behaviour (Offord & Bennett, 1994). In comparison with their non-aggressive peers, aggressive children more often misperceive neutral social cues as having an aggressive valence (Abikoff & Klein, 1992).

A wide diversity of intervention approaches have been developed, including problem-solving skills (Spivak and Shure, 1978; Wiessberg *et al*, 1991), anger control, coping skills and social skills (Novaco, 1986; Deffenbacher, 1988).

However, there are many factors which can impact upon cognitive development in early childhood, such as:-

- The influence of earlier attachment relationships is most notable in exploratory behaviour and problem solving styles (Ainsworth 1989). Insufficient or inconsistent nurturing produce deficits in the self-building function of attachment relationships. These often result in distorted self-constructions, which produces deficient skills in affect regulation, resulting in powerlessness and feeling out of control of one's internal experience. This intensifies the poor sense of self and the continual feeling of being overwhelmed, which often results in aggression, withdrawal or drug, alcohol abuse. According to Stosny (1995) it is hard to imagine finding a anger-addicted person who does not suffer from self-perceived defectiveness as a lovable and loving person.

- Traumatic experiences such as family violence and child abuse, have an impact upon a child's emotional, cognitive, behavioural, social and physical development (Perry 1996). The brain develops and organises itself as a reflection of the developmental experiences. If stressful events are of sufficient duration, intensity or frequency, there will be long-term changes in the responsivity of target areas in the brain and in the peripheral nervous system, which in turn impacts upon all aspects of emotional, cognitive and behavioural functions and perceptions of the world.

The literature on the effectiveness of cognitive problem solving skills training is variable and difficult to interpret, because:

1. Strength of study design i.e. Spivak and Shure (1978) who had positive findings, did not include blind outcome assessments in their studies. Subsequent studies, by Weissberg *et al* (1991) (using a modification of Spirak and Shure's approach) found a statistical significant improvement in problem-solving skills, but the relation between problem solving skills and improved adjustment was negative.
2. Diverse beliefs in the role of the therapist Novaco (1986) believed the therapist should take an inactive role, whereas Deffenbacher (1988) emphasizes that the therapist should be active, persistent, supportive and confrontive. However, they both sustained that a combination of cognitive treatment and relaxation training was effective in controlling anger and aggression. Cognitive problem solving / behavioural therapy has been most supported by the literature for the treatment of PTSD (Solomon *et al* 1992). Perry(1996) believes that for PTSD, the therapeutic model which emphasizes predictability, nurturance, support as well as cognitive / insight interventions, which make the child feel safe, comfortable and loved are the most effective. This is supported by Herman (1992) who believes most treatment paradigms fit a three stage model: Firstly establish a safe stable environment, secondly, allow the client to tell the story of the trauma and integrate the memories and feelings and thirdly, promote re-connection to significant others and society. This form of therapy is also advocated for children who have attachment problems. Pearce and Pezzot-Pearce (1994), found many children with a history of an

insecure attachment attempt to provoke the therapist into rejecting or abusing them, by hostile and sometimes outrageous behaviours, that may continue unabated for lengthy periods or they may treat the therapist as a non-entity. Therapists, therefore, who treat these children need to have a solid understanding of why they respond negatively to friendly and helpful overtures. If the therapist terminates the sessions or responds inappropriately, their reactions reinforce the child's negative and pessimistic internal working models of other people.

3. The age of the child or client. Some evidence suggests that older children profit more from treatment than do younger children (Durlak *et al* 1991), possibly due to their cognitive development being more advanced. Other evidence suggests early intervention for infants and toddlers, which focus on desensitization of reactions to cues that trigger PTSD responses and the essential role of parents in the child's positive development, are more effective (Amaya-Jackson & March 1995; Gaensbauer & Siegel 1995). However, it is difficult to ascertain the success of interventions, because many children traumatised as young children seem to make satisfactory progress until they become 12 or 13 years old, at which time symptoms of hypersexuality, aggressive or assaultive behaviours, impulsivity and anxiety re-emerge (Perry 1996).

4. Adverse parent and family characteristics. Conduct-disordered children who show comorbid diagnoses, academic delays and dysfunction, lower reading achievement and who come from families with high levels of social impairment, respond less well to treatment than youths with less dysfunction in these domains. "*Much further work is needed to evaluate factors that contribute to responsiveness to treatment*" (Kazdin, 1997).

Durlak *et al* (1991) concludes that the evidence for effectiveness is mixed and that the link between cognitive change and behavioural change has not been demonstrated. Other reviewers such as Schneider (1989) and Kazdin (1997) argue in favour of further experience and evaluation of these types of approaches.

5.4.4 Behaviour Therapy and Parent Management Training:

Behaviour therapy is an approach which has been derived from the principles of social learning theory derived from operant conditioning, which is a procedure for changing the probability that a certain response will be exhibited and involves repeatedly following the response with the same consequence.

The basic goal of behaviour therapy is to teach the child new ways of behaving through changing the environment, teaching new skills or changing cognitive and emotional processes.

Parent management training refers to procedures in which parents are trained to alter their child's behaviour, with the intention of promoting prosocial behaviour and decreasing deviant behaviour. This training is based on the premise that conduct disorder is inadvertently developed and sustained in the home by maladaptive parent-child interactions. There are multiple facets of parent-child interactions that promote aggressive and antisocial behaviour. These patterns include directly reinforcing deviant behaviour, frequently and ineffectively using commands and harsh punishment and failing to attend to appropriate behaviour (Patterson *et al* 1992).

The critical role of parent-child discipline practices has been supported by correlation research, relating specific discipline practices to child antisocial behaviour and by experimental research, showing that directly altering these practices reduces antisocial child behaviour (Dishon *et al* 1992).

Research has also indicated treatment outcomes to be very effective. Follow-up assessments have shown that the gains are often maintained 1 - 3 years after treatment (Kazdin 1997) and one programme reported maintenance of gains 10 - 14 years later (Long *et al* 1994).

Parental management requires the development of several different parenting behaviours, such as the establishment of clear rules and boundaries for the child to follow, providing positive reinforcement and attention for appropriate behaviour, ignoring or developing time-out strategies for deviant behaviour. As the child gets

older, procedures can be modified or refined. This form of management is adaptable for all environments and a major advantage is the availability of treatment manuals and training materials for parents, significant others and professional therapists, along with the development of self administered video tapes of treatment (Sanders & Dadds, 1993).

This form of therapy can be effective both in the home and at school, such as daily report cards, which allows teachers to give parents daily feedback regarding their child's classroom behaviour.

According to Kazdin (1997), siblings of children referred for treatment also improve. This is an important outcome because siblings are often at risk for developing severe antisocial behaviour. In addition Kazdin found maternal psychopathology, especially depression, to decrease systematically following parental management training, suggesting this approach may improve multiple aspects of dysfunctional families.

Treatment, however, appears to be more effective with pre-adolescent youths (Dishon *et al* 1992). The reasons for this could be attributed to:

- parents of adolescents being less willing to change their disciplinary practices and less committed to treatment;
- adolescents spend a greater time outside of the home and more in the company of their peers, as a result they are usually less willing to adhere to parental management; and more deeply entrenched behaviour patterns.

Duration appears to influence outcome, and brief and time-limited treatments (10 hours or less) are less likely to show any significant benefits (Kazdin 1997). Families characterized by many risk factors associated with socioeconomic disadvantage, marital discord, parent psychopathology and poor social support, tend to show fewer gains in treatment (Dadds & McHugh 1992).

This form of therapy, however, is demanding and very time consuming. It requires a determined commitment for change and a comprehensive knowledge of social learning

and behavioural principles, and is totally contingent upon consistency for implementation of the rewards and consequences being used to modify behaviour. For without consistency, behaviour patterns are likely to become unpredictable and more resistant to change. *“The partial-reinforcement effect has far reaching practical implications. For example, a parent who occasionally reinforces their child’s temper tantrums by giving into the child is ensuring more potent and persistent tantrums than a parent who always gives in. The child with a history of partial reinforcement of tantrums will emit them with remarkable persistence even when the parent attempts to extinguish the tantrums by ignoring them. What the parent should have been doing all along, is reinforcing the child’s appropriate behaviour, not the tantrums”* (Atkinson et al 1983 :202).

5.4.5 Family Therapy

In family therapy the child is viewed as a part of the family system, and the child’s behaviour as an expression of an underlying family disturbance or general family dysfunction.

The symptoms expressed by the child are thought to serve to maintain an equilibrium in the family. The assumption is made that problem behaviour evident in the child is the only way some interpersonal functions (e.g. intimacy, distancing, support) can be met among family members (Kazdin, 1997). When the ‘symptom’ is removed, it may precipitate a distressing crisis and a need to reorganise and re-stabilize the family system. The goal of treatment is to alter interaction and communication patterns in such a way as to foster more adaptive functioning and focus on increased reciprocity and positive reinforcement among family members (Kazdin 1997).

There are various schools of family therapy, each based on a different theoretical base:

- Social learning theory, concepts and procedures such as identifying specific behaviours for change and reinforcing new adaptive ways of responding, combined with empirically evaluating and monitoring change.

- Cognitive approach, which refers to the attributions, attitudes, assumptions, expectations and emotions of the family, such as blaming others or themselves. Alexander *et al* (1994) found that families of delinquents showed higher rates of defensiveness in their communications, both in parent-child and parent-parent interactions, blaming and negative attributions, as well as lower rates of mutual support, compared to families of nondelinquents.
- Narrative therapy, developed by White and Epston (1990), has been a recently used method during the past ten years and is worth mentioning, due to its recent contribution to family therapy. This approach suggests that individuals live their lives according to the stories they tell themselves. This story is usually full of troubles or difficulties and gets in the way of allowing the development of positive solutions by the client/family. Narrative therapy encourages the family/client to 'externalize' the problem, i.e. to separate the problem, trouble or difficulty from the client/family. By doing this, the client/family is freed up to begin looking for examples of adequacy and success. This method provides support, a structure and reframing techniques (i.e. recasting the attributions and bases of the problem) and assists in influencing family responsiveness and removing blame from others.

Functional family therapy, therefore, reflects an integrative approach to treatment that has relied on systems, behavioural and cognitive views of dysfunction (Alexander *et al* 1994). Outcomes of functional family therapy have indicated that this approach produced significantly better results than client-centred, psychodynamic or no treatment control groups, both in terms of client recidivism and on measures of family interaction. One study found the long term effects were still evident, 3 years after intervention. It was also found that siblings from functional family cases had significantly fewer court contacts than siblings in the client-centred, psychodynamic or no treatment control groups (Chamberlain & Rosicky, 1995).

This method has been adapted to fit culturally specific values and beliefs, because it can define and target intergenerational and culturally determined behavioural conflicts prevalent for ethnic minorities, within a dominant culture. However, more research

would be required in order to determine what type of interventions would be appropriate to address cultural differences (Chamberlain & Rosicky, 1995:448).

5.4.6 Multisystemic Therapy

CD usually develops in a context of multiple determinants such as, family stress, parenting deficits, alienation between school and family, child social skill deficits and academic failure (Bierman *et al* 1992). Because of this, preventative intervention should continue across a child's developmental periods, rather than centring on one set theoretical perspective which focuses on a single component such as cognitive skills, behavioural deficits or parental dysfunction, as these limit the attention given to other aspects of the determinants of antisocial behaviour. Interventions, which focus on a single component of CD, however, have been effective in short-term change, but, little success has been documented in the maintenance of this change across time and in cross-setting generalization (Bierman *et al* 1992).

Various researchers have found that successful interventions efforts, Bierman *et al* (1992); Cicchetti (1984); Comer (1980); Prinz and Miller (1991) and Kazdin (1997), must be based on:

- a comprehensive theory of the developmental psychopathology of antisocial behaviour;
- interventions must have a developmental focus which is attentive to age related stressors and the need for continued intervention over long periods;
- preventative intervention should be attentive to the social fields of the peer group, classroom, and family as well as the connections between the family and the school;
- interventions must attend to the heterogeneity of the population of high risk children, because the needs and treatment responsivities of high-risk children and their families are variable, due to diverse gender and cultural differences.

The multisystemic approach is, therefore, based on an ecological model that a child is embedded in a number of systems including immediate family, extended family, peers, school, neighbourhood and wider community and society. This form of treatment can

be viewed as a package of interventions that are constructed with children and their families.

The focus of the treatment is on interrelated systems and how they affect each other, because children and young people with CD, experience dysfunction at multiple levels including individual performance, family, peer group interactions, schooling and parent employment. Multisystemic therapy begins with the view that many different areas are likely to be relevant, hence, need to be assessed, evaluated and addressed as required in treatment. *“Domains which may be addressed, for example, parent unemployment, because they raise issues for one or more systems, such as, parental stress, increase in alcohol consumption, and in turn affect how the child is functioning due to marital conflict and child discipline practices”* (Kazdin, 1997:168).

The following are three examples of a multisystemic approach:

1. A randomized trial with youths who displayed serious antisocial behaviour

Henggeler *et al* (1996) used this approach in a successful substance abuse treatment for high risk youths. Sample size was 118 youths and their families who were disadvantaged and presented with substantial clinical problems. Seventy five per cent of the youths had other behaviour disorders such as conduct disorder (35%), social phobia (19%), oppositional defiant disorder (12%) and major depression (9%). A high percentage of their parents had reported problems with alcohol or other drugs.

This was a randomized clinical trial which compared home-based multisystemic therapy with the usual community drug and alcohol treatment services, 58 of the 118 were randomly selected for the multisystemic therapy.

The features underpinning multisystemic treatment therapy:

1. It encouraged involvement from all family members, who were viewed as full collaborators in the treatment.
2. It focused on the strengths of the family. Therapists articulated and stressed the positive qualities of the youths, parents and family. The goals were primarily set by the family. The project team assumed responsibility for treatment and the achievement of clinical outcome.

3. It addressed the family's social ecology and the diffuse array of barriers to the attainment of treatment goals.
4. Services were individualized to meet the multiple and changing needs of youths and their families.
5. Principles of the service delivery model used was: home based, low case loads, times were tailor made to meet the families needs, and good team support and supervision was available to address barriers and problems as they arose and in order to develop other alternative and creative strategies necessary for achieving the desired outcomes.
6. Therapists were available 24 hours a day, 7 days a week.

The results from this study were very encouraging. Ninety eight percent of the families in the multisystemic therapy completed the full course of treatment, which lasted on average 130 days and families received on average 40 hours of direct contact with a therapist. In contrast, the community treatment dropout left after 42 days. This group received fewer substance abuse or mental health services, 78 per cent received neither substance abuse nor mental health services. Moreover, when this group did receive services, relatively low quantities were provided.

This study, however, did not discuss the duration of success for either treatment, perhaps due to the fact it is a relatively recent trial.

Several outcome studies have evaluated the multisystemic approach, primarily with groups of youth who have displayed extreme antisocial and aggressive behaviour. Henggeler's (1994) findings, through follow-up studies of separate samples, have shown that youths involved in multisystemic therapy have lower arrest rates (sustained over 2, 4, and 5 years) than youths who receive other services. *"Results have shown multisystemic treatment to be superior in reducing delinquency, emotional and behavioural problems and in improving family functioning, in comparison to other procedures"* (Kazdin 1997:168).

2. The FAST Track Programme (Families And Schools Together)

Bierman *et al* (1992) used this programme which also has a multisystemic focus and furthermore, the intervention is structured in a manner which recognizes that CD is a developmental problem and is unlikely to be solved in a single developmental period. This programme is the subject of a six year study, still continuing in four community sites in America (1) rural Pennsylvania, (2) Nashville City, (3) Durham and (4) Seattle. The final composition across the four sites and three cohorts consists of 447 children in the high risk intervention condition, 445 children in the high risk control condition and 396 in the normative community comparison condition. This programme is based on what is currently known about the early signs and indicators for the development of CD problems in children. The primary aim is to develop, implement and evaluate a comprehensive intervention to prevent severe and chronic conduct problems in a sample of children selected as high risk when they first enter school. This approach is a synthesis of developmental, sociological and clinical models.

- The developmental model combined with a sociological perspective, is critical for determining and analyzing the pathways to CD and understanding the importance of the interactions a child has with his/her micro, macro and exo-systems. The focus of the early intervention programme is on building positive behavioural and cognitive skills in the school and family environment and on changing the patterns of interaction among members of the child's social fields such as family, school and peer group, in order to promote consistent expectations for the child's performance. This model suggests a prevention strategy that encompasses the first six or seven years of schooling (starting preferably at pre-school) for high risk children, with particular intensive interventions during the transitions between pre-school and primary and intermediate and secondary schools.
- The clinical features of FAST Track involve the parents and other family in the process of helping their children succeed and provides integrated interventions through parent training, home visiting, case management, social skills training, academic tutoring, teacher-based classroom intervention and Promotes Alternative Thinking Strategies (PATH). The critical features within this model, involves parent participation combined with school personnel and the regular home visiting.

Bierman *et al* (1992) noted that this is a prevention model and it is important to approach parents as participants, not as parents of 'identified cases'.

3. The Childhaven Programme

A twelve-year follow-up study of maltreated and at-risk children who received early therapeutic child care at Childhaven was completed by Moore *et al* (1998). This study assessed a 12 year follow-up investigation of a randomized controlled clinical trial of at-risk infants and toddlers.

In 1977 Childhaven Day Care in Seattle USA, developed a programme that became the first therapeutic child care model in Washington State, for children aged between one month and five years of age, who had been referred by Child Protection Services, because of abuse or neglect. Childhaven adopted an ecological perspective with aims to mitigate the long-term detrimental effects of maltreatment, by improving child development and behavioural status and reducing the likelihood of recidivism. The programme addresses parent/child interaction (involving all family) designed to help the parent become more accepting of the child, assesses family risk factors for abuse, and builds the parental social support system within a protective, nurturing and therapeutic environment.

From a sample size of 61 children, aged between 12 - 24 months, during 1980 -1981, were randomly assigned to either Childhaven's therapeutic child-care programme ($n = 32$) or a standard community services programme, the control group ($n = 29$). Siblings were assigned to the same respective groups and on average children remained in the programme for 23 months.

Extensive efforts to locate the study families were made by Childhaven 12 years later, and 35 of the original sample were located, 21 from the therapeutic programme and 14 from the control group participated in the follow-up study. The youths were at this stage, aged between 12 and 14 years of age.

The findings from the twelve year follow -up on this study, appear to be encouraging despite the small sample size:

Treated Group (<i>n</i> =21)	Control Group (<i>n</i> =14)
Home environments significantly more supportive of adaptive child development	School records revealed a significant increase in disciplinary actions from middle to late childhood.
Youths were functioning more positively and rated themselves as more socially accepted	Youths had more difficulties in areas of aggression, anxiety, depression and social functioning and displayed an earlier onset of delinquency.

Overall, the long term outcome for the early intervention group, was one of family strengthening, improved parent-child interactions, in which there was more responsive and positive parenting and less difficult child behaviour. Moore *et al* (1998) found that strong interpersonal skills are a significant protective factor for high-risk adolescents.

However, with studies such as FAST Track and Childhaven, which use both experimental and control groups and provide a longitudinal process of analysis, there are some methodological problems such as:

Attrition. Some families find it difficult to follow through with commitments to a programme due to change in location, life stresses, or they may decide the participation is too demanding. The largest 'drop-out' rate among treatment families in the Childhaven study, was significantly greater among:

- parents whose involvement in the intervention was major;
- families who had to rely on public transport;
- those whose children had experienced neglect and were female and whose mothers had histories of abuse or neglect (Moore et al 1998:14).

Therefore, if these families had been included, the study may have found quite different results in the overall findings, because these families appeared to have many of the adverse environmental conditions which are related to 'high risk families' for CD.

Other problems were in relation to inconsistent involvement from teachers within the local school setting and the small sample size for the Childhaven follow-up study may

make it difficult to ascertain whether the early intervention was the reason for an overall favourable outcome or whether these families may have been more resilient regardless of the intervention.

To conclude, there is a great deal of evidence in support of early intervention, indicated through a number of studies which have documented that children who have received early intervention services have fared better and shown a positive impact on delinquency and related behaviours compared with their control co-equals. For example, the Perry Pre-School Project (Berrueta-Clements *et al* 1987), where high-risk black 3 and 4 year old preschoolers were randomized to either receive early childhood education, teacher home visits and monthly parent-teacher small group meetings were compared with a control group given no intervention. At age 19, the intervention group had higher secondary school education, 67% versus 49% for the control group. Criminal offences reflected similar findings, 51% of the control group had been arrested or charged for a transgression as opposed to only 31% of the intervention group. Further studies, however, are needed in representative samples of children with, or at risk of conduct disorder. *“The pay off of discovering a successful prevention programme for CD will not only be reduced levels of antisocial behaviour in childhood and adolescence, but lower frequencies of adult criminality and probably also a wide array of psychosocial disturbances”* (Offord and Bennett 1994:1076).

5.4.7 Public Awareness and Education

In 1995 CYPFS introduced the concept of social marketing as the application to educate the public on child abuse prevention. This transpired from pressure from the Government in 1994 instructing the Director General of Social Welfare to introduce a statutory responsibility for CYPFS to educate professionals and the public about child abuse as an alternative to mandatory reporting. This resulted in CYPFS promotion of “Breaking the Cycle” campaign which highlights the indicators of abuse, procedures for reporting abuse, and outlines the structure, responsibilities and processes within CYPFS. This public-awareness message has been delivered to schools, health, doctors, police and many community groups through out New Zealand. There have been many stages to this campaign, such TV adverts and the introduction of booklets “Cool

Kids, Cool Parents”, “There are no Super-parents” and a video “Parenting without hitting”, all of which deliver an excellent message and should be circulated to all parents and parents-to-be, through ante-natal classes.

Education and public awareness on signs and symptoms is essential. However, these campaigns have a greater focus on sexual and physical abuse with less emphasis on emotional abuse, which underpins all aspects of abuse, neglect, trauma and antisocial behaviour.

5.4.8 Training

Extensive training in the field of emotional abuse, risk and behavioural indicators, should be given to all social workers, early childhood workers and teachers, especially targeting pre-schools and schools in lower socio-economic areas. This would assist workers to identify ‘at risk’ children in order to involve these children and their families in appropriate early intervention, and developmental programmes to address the identified problem areas.

O’Brien-Caughy *et al* (1994) found from their research that early day-care intervention improved the cognitive development for children from impoverished environments and Kupersmidt *et al* (1990) found that children who come to school ill prepared to learn to read are at risk for both behaviour problems and peer social rejection.

However, effective programmes of this nature are expensive and further research would be essential to determine the cultural necessities, qualities and characteristics required from pre-school interventions to enhance child development under conditions of risk.

5.4.9 Peer Influences

Parents/ primary caregivers clearly play a dominant role during the first few years of a child’s life but, as the child progresses into school, peer influences start to emerge.

However, play with friends demands co-operation and negotiation. Dunn (1993) in her study of five and seven year olds, observed that children who had a high degree of

involvement with their mothers were more likely to use compromise and negotiation in their arguments with friends, compared with children who did not experience such high levels of maternal warmth. Developmentally, therefore, children who are socially withdrawn, excessively shy or aggressive, socially isolated or rejected might be 'at risk', according to Rubin and Lollis (1988).

The social fabric of peer groups can reinforce aggressive antisocial behaviours. Peers inadvertently intensify the aggressive child's use of threats and physical force to achieve personal goals, by backing down and allowing them to succeed (Coie *et al* 1991).

However, even though aggressive children may meet with negative consequences, from their peers, they continue to function in ways that elicit peer disapproval, because they lack the ability to compare themselves accurately with other children and subsequently misperceive their own degree of acceptance within their peer group (Coie & Jacobs 1993). Peers, also may choose to withhold negative feedback from aggressive-rejected children out of fear of retaliation (Coie *et al* 1991).

Preventative intervention programmes need to focus on the following:

- Parent training that addresses the pattern of co-ercive interchanges and enhances healthy interaction between parent and child.
- Child training which should be designed to control anger and improve social-problem solving.
- Teacher training which should attend to consistent reinforcement of desired behaviours while discouraging maladaptive behaviours.

Teachers who have received appropriate training may be able to convey this through classroom discussions, which allow children to express their feelings about coercive behaviour in a non-judgmental way, and lead them into thinking of ways they can as a group discourage this kind of behaviour (Coie & Jacobs 1993). This could be combined with private discussions between teacher and specific children.

This form of intervention is more likely to be successful with a child displaying proactive aggression, due to the fact that the underlying problems are likely to be more straightforward and will probably respond to consistent reinforcement of non-aggressive behaviours and consistent consequences of aggressive antisocial behaviour.

A child exhibiting reactive aggression is more likely to be lacking in close interpersonal relationships with significant others, such as parent/s and may need a figure who is able to provide a secure attachment for the child. The important factor therefore, is the early identification of a child's situation, because as a child enters puberty, the peer influences become much stronger.

As the child, who has developed a problem behaviour becomes older, the peer group becomes a principal influence in the maintenance of deviant behaviour, especially if the young person does not have a strong family bond. A number of studies have highlighted the strong influence of deviant peer associations in adolescent delinquency (Coie & Jacobs 1993; Cairns *et al* 1989; Dishon *et al* 1991). Findings from Coie *et al* (1992) indicated that deviant children do not associate with each other merely because they are rejected by everyone else, but rather because they frequently live in the same neighbourhood and affiliation with deviant peers directly contributes to higher status and makes adolescents more likable within their particular social context.

For this particular group of young people, intervention must be targeted on the peer network. Costanzo (1992) suggests resocialization of social identity which focuses on the attitudes and behaviours of the main opinion leaders within the group. Rather than allow deviant peer group leaders to reside solely in their ability to defy conventional authority and violate the rules of society, provide them instead with opportunities to associate with attractive youth culture idols, publicly, where they endorse non-violent and non-risk taking behaviour. However, this shift in values would have to be supported by ongoing opportunities for personal success, requiring access to economic resources, such as meaningful and productive employment and training opportunities that fit the interests and skills of the identified peer leaders, in order to prevent a feeling of patronization and give encouragement for them to take an active role in resocialising the lives of their peer cohorts. The goal must be to provide inner city

youth with non-delinquent alternatives to personal success and autonomy (Coie & Jacobs 1993).

5.4.10 School

During the last ten years, since the introduction of *Tomorrow's Schools*, which abolished zoning, there has been a greater polarization between the more wealthy and poorer schools within New Zealand.

This policy was introduced by David Lange, (Labour Party Prime Minister of New Zealand), during 1988. He claimed this scheme would provide *'more immediate delivery of resources, more parental and community involvement and greater teacher responsibility'* (New Zealand Herald 29 August 1998).

This policy has however, had severe detrimental effects on schools and families in the lower socio-economic sector of society, because:

1. The best schools, (rather than the parents), choose who they will enroll. Research by Ladd and Fiske (1998) found that 86% of Auckland's secondary schools at the top of the socio-economic scale had enrollment schemes, compared with 28% of schools in the lower socio-economic sector (New Zealand Herald 29 August 1998). This has impacted upon the service delivery of the poorer schools who are struggling and unable to provide the same equal opportunities for their pupils as the top schools, due to the fact funding is linked to student numbers and these schools suffered the greatest loss of students, after zoning was removed.
2. Schools who cater for the lower socio-economic groups are unable to improve, because many of the children are from unemployed families, who are unable to afford school fees and are less likely to be able to provide educational expertise or incentive for their children.
3. This disadvantage impacts heavily upon Maori children. According to figures recorded in the New Zealand Herald 29 August (1998), almost 40% of Maori leave school with no qualifications and more than 40% of Maori children are

suspended or expelled from school due to problem behaviour. In school, antisocial behaviour interferes with learning, due to the disruptive nature of behaviours and also high risk children are likely to be at schools where there is a high density of other children with similar problems. *“The failing, disliked and antisocial child is ultimately left with few social settings that provide any form of reinforcement”* (Coie & Jacobs 1993) *“This, in turn makes teaching more difficult and, for inexperienced or highly stressed teachers, can lead to re-enactment of the coercive and inconsistent home situation”* (Bierman et al 1992).

During pre and primary school years, children may merely be observed as troublesome or difficult to manage, with little consideration being given that these behaviours may manifest into more serious problems. Therefore, for a preventative intervention programme, it would be important for pre and primary schools to obtain appropriate staff training and adopt a behavioural management policy, which consistently reinforces positive behaviour and discourages maladaptive behaviour. It would be important to discuss the programme with parents, in order to encourage the same procedures in the home environment.

Some children would be better prepared to respond to these efforts than others. Coie and Jacobs (1993) suggest training young children to delay immediate gratification. *“In essence, conduct disordered children tend to opt for immediate gratification in the form of acquiring a desired toy, pushing in to the front of the line, or trying other methods in which to get their own way.”* These children should be provided with the skills necessary to visualize, plan and maintain long term patterns of goal directed behaviour. Interventions should be designed to teach self regulatory cognition's and restructuring techniques in a step by step format. This should be reinforced with an explicit emphasis on the social consequences of maladaptive behaviour.

These programmes should be a policy which is effective in every school, in order to address the many children who move from school to school, frequently a problem for 'at risk' children.

Placing social workers in primary schools, especially in high risk areas, would provide an additional resource for early detection of problem behaviour and intervention services for families and children. Up to 40% of children rejected by their peers are aggressive, and children who are aggressive and rejected have been shown to be at highest risk to develop antisocial behaviour in adolescence (Coie, Underwood, Lochman, 1991). A quote from a Principal July 1995, involved with Social Work in Schools Programme: North Shore Pilot. "*There are a number of cases emerging which need professional attention... But these cases are not yet of sufficient gravity to approach outside agencies*" (Belgrave & Brown 1996:31).

5.5 Changes in Social Work Delivery

Over the years there has been a great deal of research completed and literature written about the origins of conduct disordered children and the risk factors contributing to antisocial behaviour. These risk factors can be broken down into two main sections:

1. High Risk Parent/s:

- Historical Factors such as the personal genetic make-up of the parent. Their childhood upbringing, such as poor attachment with their parents, unresolved child abuse, poor impulse control, absence of available family/whanau/social support, and poor utilization of support when made available.
- Environmental Factors such as poverty, early childbirth, poor health, ignorance of child development and child care necessities, isolation, poor education, abusive relationships and inadequate housing.
- Behavioural and emotional factors such as undetected post-natal depression. Negative attitudes toward their children such as overt rejection, harsh discipline, denial of pregnancy, failure to respond to child's needs and more focused on personal needs.

2. High Risk Child:

- Genetic make up of the child.
- Child is a product of a difficult pregnancy, perhaps resulting in neurological impairment or prolonged separation due to illness, feeding difficulties, problems in pacifying and settling the child and failure to thrive. These factors impinge upon the feelings of adequacy as a parent and the self-esteem and confidence of both parent and child.

Some of the outlined high risk environmental factors associated with antisocial behaviour are connected with poverty. Parents who are suffering from these multiple stressors are further disadvantaged by the current neo-liberalist views, which uphold individual choice and responsibility and argue against state provision of welfare. Many of these families, because they have no choice, seek assistance and support from CYPFS, but the disintegration of resources and restriction in funding, coupled with the increase in child abuse notifications, has meant many of these referrals, concerning hardship and an inability to cope, are not attended to.

The New Zealand Herald 27 June (1998), outlined some alarming figures, publicizing the increase in reported child abuse cases to CYPFS. *"In the two weeks from June 6 - 19, 1998, Auckland social workers received 199 new abuse cases to investigate, 22 more than for the same period last year"*. Overall it was estimated that more than 20 notifications of child abuse were reported per day, however, it was ascertained that these were only the tip of the iceberg, representing only the children known to the State's child protection services.

The last decade has seen profound social, political and economic changes in New Zealand. The Public Finance Act, State Sector Act and Employment Contracts Act have strongly impacted upon the way in which the public sector is organized. Organizationally, the Department of Social Welfare and CYPFS experienced a number of reviews and restructurings, which impinged significantly on social work

practice. Consequently, there has been a move away from the more traditional “psychosocial assessments” which detailed the above risk factors and enabled the social worker to ascertain the risks and needs of the child/ren or young people and their family. This was a planned and proactive approach which aimed to resource and empower the family in order to secure the safety of the child and prevent further referrals.

Current social work practice is crisis and incident focused and reactive, where cases only receive attention when they get serious enough. This output driven mentality has resulted in expediency, due to pressure placed on social workers to construct their assessments around the existing provision of resources rather than the actual needs of the child and family (Cheyne *et al* 1997). It, therefore comes as no surprise that up to 45% of CYPFS notifications have become re-notifications (Robertson & Maxwell 1996). Each time a child is re-notified, there is a real danger that the abuse or overall situation will be more severe, the problem more entrenched and the long term damage more profound.

An analysis of child death inquiries portrays a forlorn picture. Similar patterns of practice and organizational failure exist across most of these reviews, such as lack of clarity about the statutory role; poor or absent supervision; breakdown in communications between workers, sites and interagency; inadequate recording and knowledge base; an incident ‘quick fix’ focus with a failure to gather information, assess, plan or recognize abusive patterns.

This was the context for the genesis of the Risk Management, Strengthening Families (inter-agency collaboration) and Family Start Projects, which have been recently introduced into CYPFS.

5.5.1 Risk Management introduced in 1996

The programme adopted by CYPFS was based on the Manitoba Risk Estimation System (MRES) (Sigurson & Reid 1996). This instrument is constructed to estimate:

1. The vulnerability of the child and assesses whether there is an adequate protector, and ascertains the child’s ability to protect him/herself from access by perpetrator.

2. The likelihood that abuse or neglect will recur, addressing aspects of severity, frequency, type of abuse/neglect, and previous history.
3. The type and quality of family interaction, parenting knowledge and skills, attitudes to discipline and attachment and perception of the child, characteristics of family such as violence, mental health problems, stress, substance abuse, family's relationship with the community, social isolation, family support and type of reference groups.

This tool is designed to assess risk, beyond the presenting problem, by examining patterns of abuse and neglect and the structures of beliefs and attitudes underpinning the adult behaviour which contributes to and maintains abusive or neglectful circumstances. Each item is rated numerically and a level of risk assigned from the total score. The aim therefore of MRES is therefore to determine the intervention necessary to improve the situation for the child or young person and produce consistent and effective approaches based on best practice, in order to assist and guide the clinical decision making of CYPFS staff.

MRES is based on a responsibility model, focusing primarily on the contribution to risk of parents/caregivers and the vulnerability of the child. It does not link this factor in with an ecological model in that the only mention of the social and contextual issues is in regards to the family's reference group and geographic isolation. Thus the focus for risk reduction is mainly on adult behaviour and attitudes.

This risk assessment instrument is a checklist tool, however, its focus is on the indication of risk rather than causation and need. Initially the MRES overlooked cultural diversity and has since been adapted to assess the risk of Maori and Pacific families. Consequently, the limitations are inherent in its inability to address specific cultural needs, due to the fact that a disproportionate number of children at risk are tamariki Maori and Pacific children, who are predominantly represented in the lower socioeconomic sectors of our society. According to the Ministry of Health (1998:67) "*compared with non-Maori children, tamariki are 83% more likely to die before reaching 15 years of age*". Fergusson *et al* (1990) from his studies found that, children in around 5 percent of New Zealand families (about 25,000 families) are

estimated to be at high risk, with children in another 45 percent of families at some risk, given further adverse circumstances.

MRES is obviously attractive to CYPFS, given the high number of referrals, because it is an instrument that claims to predict substantiation and recurrence of abuse, thereby determining a high or low risk category, a priority response system (hence the low priority given to children and young people presenting with problem behaviour) and effective deployment of staff in the areas of greatest urgency. According to Wald and Woolverton (1990) the use of risk-assessment tools can lead to more efficient utilization of resources, but they will not enable agencies to provide adequate intervention if caseloads are excessive or treatment programmes limited. Wald and Woolverton (1990) considered it ethically wrong for administrators to adopt risk-assessment procedures in lieu of pushing the political system for more resources. They believed that politicians must be made to bear the consequences of their unwillingness to adequately fund the child protection system.

MRES is a useful tool for facilitating consultation between social worker and supervisor, because it should be able to standardise a benchmark for determining risks within a family which is helpful when seeking guidance on appropriate intervention, and social work practice, especially in the quest for knowledge and understanding. However, it does not resolve all the issues in child protection and its effectiveness can be influenced by relying on a numerical score to provide a practice decision, which has the potential to negate professional clinical responsibility. Furthermore, this tool does not address the emotional risks in children who are displaying antisocial behaviour (in fact these notifications may not be seen as a priority), and it does not account for the cultural, social or financial needs of families. Because of these factors and many others connected with resourcing, MRES has never been fully implemented in the wider Auckland area.

5.5.2 Strengthening Families introduced in 1997

Strengthening Families (an interagency collaboration) is overseen by the Ministers of Health, Education, and Social Services, Work and Income. Its strategy operates on several levels. At the heart is the local coordination initiative whereby local management groups are pushing forward with the case management model to increase

the level of service targeted at the most at risk. Secondly, policy makers and funders are constantly scrutinizing existing programmes and services to see how they might be adapted or changed to provide better forms of remedial intervention, early intervention and prevention. A third stream of work is aimed at improving family and parental responsibility. This work is linked with the possibility of a Code of Family and Social Responsibility. (DSW Strengthening Families for Well-being 1998:4).

This approach was designed for improved case management under the premise that children and young people from multi-problem families would benefit from improvements in the inter-agency co-ordination of services among welfare, education and health. The objective is to identify a lead agency, in cases where there are two or more agencies involved, who will take responsibility for managing the case. There are concerns, however, that this strategy has been established to focus on changes in organizational structures which do not increase costs but instead identify overlaps rather than the gaps in service delivery.

“This argument is based on the belief that the relatively low cost of improving services co-ordination among these systems will ensure that each child receives the most appropriate services, regardless of which system has first contact with the child. It is assumed that more appropriate services will result in better outcomes for the children” (Glisson & Hemmelgarn 1998:402).

Stevenson (1989) has noted five major barriers to collaboration:

1. Different organizational structures, systems, cultures, values.
2. Communication barriers: what seems essential for one professional to share, may seem a breach of confidentiality to another.
3. Differences in status and perceived power. At its most acute, the statutory responsibility of Social Services for the protection of abused children is at odds with its lower status and less certain identity when compared, for instance, with other groups on whom it is dependent to carry out those responsibilities, such as doctors and lawyers.
4. Conflicting professional and organizational priorities.

5. Extent to which collaboration is perceived as mutually beneficial. The fact that Government policy requires agencies to collaborate is no guarantee that they will do so.

These barriers outlined by Stevenson are currently very apparent, especially with Mental Health Services, who are extremely under-resourced and are unable to address the needs of children and young people with severe antisocial behaviour, due to severe budgetary cut-backs which have increased the strains on inter-agency collaboration. Hence these families are frequently left with limited support and access to therapeutic / treatment programmes.

“Reforming legislation in health, education and social services has resulted in extensive decentralization, and the creation of internal markets and competition which have fundamentally altered the relationships between those who purchase services and those delivering them. Rationalization of services, competitive tendering for service contracts and the market ethos have all increased the competition for resources between agencies, and made it more difficult to work co-operatively simply on the basis of shared concerns and values” (Morrison 1998:5).

While inter-agency services co-ordination appears to be a logical and obvious way of addressing multiple needs of those individuals most at risk, evaluations of service co-ordination efforts have been unsuccessful in documenting any major benefits (Hoagwood 1997).

According to Glisson and Hemmelgarn (1998) there has been almost no empirical research on the contribution of organizational climate to human services effectiveness and none that examines the link between climate and the outcomes of human services that focus on improving individual psychosocial functioning.

“Front line staff are powerfully affected by agency cultures. If staff lack a basic sense of trust and confidence in their own agency, their ability to work empathetically and skillfully with dysfunctional family dynamics will be impaired. Thus the front line of partnership, where workers seek to engage with families, can become an

interaction between two parties neither of whom feel understood, valued, respected, prepared, or supported” (Morrison, 1998:15).

“Agencies with higher levels of job satisfaction, fairness, role clarity, cooperation and personalisation and lower levels of role overload, conflict and emotional exhaustion are more likely to support caseworkers’ efforts to accomplish these objectives. In short, positive climates reflect work environments that complement and encourage the type of service provider activities that lead to success” (Glisson & Hemmegarn 1998:416).

According to Glisson and Hemmelgarn (1998) and Morrison (1998); improved service quality does not translate into significantly more positive outcomes, because process orientated approaches emphasize pre-programmed activities that limit employee discretion and responsiveness to unexpected problems and opportunities. In comparison, results-orientated approaches focus employee attention on the desired outcomes and require employee flexibility and discretion in the development of individualized approaches to reaching those outcomes. Therefore intra-agency and inter-agency processes have a significant influence on the capacity for individual practitioners to work effectively in partnerships with families, coupled with a potential for agency systems to behave irrationally and dangerously.

According to Morrison (1998:21) some of the key factors required for positive outcomes are:

1. Good planning based on analysis of risks and needs, combined with identifying family strengths and needs as well as risks and problems.
2. The most important condition for success is the quality of the relationship between a child’s family and the professionals. Sensitivity to the first emotional reaction during a child protection inquiry is key.
3. Maximizing the involvement of families in decision-making processes.
4. Early allocation of workers.

5. Provision of both preventative and post-abuse services, for without preventative services, a system is seen as identifying and labeling problems but unable to resolve them. This requires planning and targeting services which provide effective management information systems, identify the nature and extent of needs, the location of services and monitors outcomes of service provision.
6. Staff care. If collaboration is in part designed to share anxiety, then it follows that staff care should be a proper concern, not just at an individual agency level, but also at an inter-agency level. Without this, staff will not be able to go on day after day listening and responding to the pain, disruption, grief, loss and violence that is child abuse. Their partnerships with clients will be partial engagements focused on following procedures, rapid turn over and personal survival, whilst avoiding the emotional realities and meaning for the children and families, with whom they work.
7. Structures are necessary to: clarify local roles, develop trust, share anxieties, provide resolutions for conflict, and identify resources and needs. Too often, without these networks, negative experiences of the formal structures, such as, case conferences go uncorrected, undermining future co-operation.
8. Philosophy of intervention is necessary to develop a shared value base and clarify the aims of collaborative intervention. In a climate of rapid change attention to values and rationale is easily lost. Neither legislation nor inter-agency procedures can work if they are interpreted differently by divergent groups according to their value system about child abuse. The Government must provide both the mandate and framework for collaboration, for without this some agencies will continue to opt out.

However, in spite of the conceptual critiques of services co-ordination and the limited empirical evidence to date supporting the value of co-ordination, most of the recent literature continues to argue for the benefits of inter-agency co-ordination in the social service sector generally and in the mental health sector in particular (Alter & Hage 1993; Glisson 1994; Goldman *et al* 1992; Provan & Millard 1995).

5.5.3 Family Start: (introduced October 1998)

Family Start is the first national initiative to be rolled out under the Strengthening Families banner. Prototypes will be developed in West Auckland, Whangarei and Rotorua over the next five years. Christchurch's "Early Start" programme will also be part of the extended programme.

The new service will identify high risk families at the time of childbirth and provide a family worker to assist where social and family circumstances may put at risk good health, education and welfare outcomes for children. A family worker will undertake a thorough needs assessment, provide support to the family, teach parenting skills and link families with services as required, so they can develop the skills needed to take responsibility for helping themselves and their families. (DSW Strengthening Families for Well-being 1998:4).

The programme is voluntary. Potential participants will be referred to the programme by health professionals. It is expected that the programme will cover about 15% of families with new born infants. The Health Funding Agency (HFA), Community Funding Agency (CFA) and Early Childhood Development are working together to develop contracts with providers (DSW Strengthening Families for Well-being 1998:4).

The "Family Start" initiative has not yet begun and very few CYPFS staff have been briefed about the basic nature of the programme. It will, however, be an extremely useful scheme, if it is able to assess the real needs of young families, in order to gain appropriate resources, support and effective interventions. However, there is an underlying concern from staff that its main function will be assisting new parents to come to terms with *'their reality'*. Therefore, offering services around parenting skills and budgeting, will not address the miseries of poverty, inadequate housing, and poor employment conditions.

5.6 Summary

CYPFS social workers are currently working in a climate where they receive little respect from clients and the general public, which in turn influences their view of their employer. The literature indicates that this atmosphere makes it difficult for a social worker to be creative or innovative, when they are subjected to criticism, rather than praise and their every effort is undervalued by CYPFS, clients and society.

The factors underpinning these attitudes are directly related to Government policy and CYPFS guidelines, requiring social workers to fulfill the agency's function, rather than focus on client needs and social justice. These include:

1. Prioritizing cases at the time of the initial referral. There is always a danger in this practice, because the notifier may have minimized the facts, which results in the case assigned a low priority status, when in fact there may be more serious issues, or the notifier maximizing the problem, in order to obtain an immediate response.
2. Estimation of risk. Assessment is invariably influenced by resource constraints. Determination of risk, therefore, frequently overlooks the wider social problems contributing to the problems within the family and empowerment has been replaced by individualizing the problem and focusing on the degree of dependency upon the system.

Currently CYPFS social workers are restricted to interventions which are consistent with the outputs purchased by the government under the Public Finance Act. This has resulted in a social work practice which is fiscally driven, rather than effective practice which is driven by client needs. The next chapter examines the findings from this study and assesses the outcomes for families who have had children exhibiting problem behaviour, under the present public sector reforms.

Chapter Six

The Study

6.1 Introduction

This study examines the relationship of CYPFS intervention in the lives of children and young people who presented with problem behaviour, at Waitakere Care and Protection Site Office West Auckland, between 1990 - 1995, and the long term outcomes for these children and young people, over a maximum of a seven year and minimum of a two year span, from the time of referral through to 1997. This study identifies key risk factors and the level of intervention CYPFS has undertaken to address this problem area. It also determines the magnitude of the problem, common themes and patterns related to outcomes for families, children and young people.

This is an exploratory study, designed to formulate the following hypothesis.

Early detection of severe problem behaviour in children, coupled with appropriate intervention will, in a majority of situations, prevent antisocial behaviour patterns from becoming firmly established during the adolescent years, by which time positive change is either extremely difficult or impossible.

This section explains the methods used, the type of research design, the reasons why an exploratory study was undertaken, sampling, sources and procedures for collecting the data, data analysis and examines the overall findings.

6.2 Method

6.2.1 Research Design

The level of knowledge accumulated in the assessment of outcomes for children and young people with problem behaviour is extremely limited because, for the most part, government services have been evaluated against their own terms of reference or benchmark. This is currently the situation with CYPFS, where the main measure is on whether the agency is meeting its 'output targets'. This study is focused on the outcomes for children, young people and families, rather than on the outcomes for CYPFS. It therefore pays particular attention to the cases which were referred and re-referred for problem behaviour, in order to ascertain common themes.

New Zealand, has not had a history of extensive research or evaluation, into the impact of its policies on the general population of the country. Due to these factors and because there is no certainty between the correlation of the independent (interventions) and dependent (outcomes) variables, it is considered appropriate to use an exploratory research design.

The purpose of an exploratory study is to uncover generalizations, determine the magnitude of the problem, ascertain the variables, yield new insights and develop a hypothesis which can be tested. Because there are no previous studies in this field, within CYPFS, this is an exploratory study, which aims to achieve the following (Sarantakos 1993:114):

- **Feasibility** - this will determine whether this study is warranted, worthwhile or feasible.
- **Familiarization** - which will assist in ascertaining the social context of the issue, with details about relationships, values, standards and factors related to this research topic, its theoretical framework and methods.
- **New ideas** - during this process new ideas, views and opinions may be generated, which will help in the construction of an effective research design.
- **Formulation of the hypotheses** - in this context, an explorative study will assist in determining the correlation between variables and their significance.

- **Operationalisation** - an exploratory study can help to operationalise the concepts and variables, by explaining their structure and identifying indicators.

Content analysis was the method used for analysing and classifying the files and data. This method was used because it was unobtrusive, the most economical and time efficient data collection method of obtaining the units of analysis and categories from the retrospective case records, used in this study, and transforming the material into quantitative data. The disadvantages of this method will be discussed in the limitations of this study.

6.3 Procedures

6.3.1 Ethics

Ethical issues were addressed through the Human Ethics Committee Massey University, Palmerston North and CYPFS Ethics Committee National Office, Wellington.

In all aspects of social research the following principles should be adhered to :

- Respect for all who participate
- Research methods should be appropriate to the values, beliefs of cultural and ethnic groups involved in the research.
- There should be benefits for the various groups which are involved in the research. If there are conflict of interests it is important for these to be resolved.
- The research should have integrity, be independent and should provide reliable and accurate information.

6.3.2 Confidentiality

This study did not involve any personal contact with clients or participants, however, it did require the perusal and examination of certain case files, to which I had legitimate access, due to my current position within CYPFS.

The case records which were accessed for the purpose of this study, were entered onto a spreadsheet and given a corresponding anonymous number, case details did not include names and were only used to gain the following information :

- ethnicity
- age
- gender
- type of problem
- level of intervention
- outcomes
- number of notifications

At no stage was any personal details about the client, family etc. recorded.

Confidentiality was carefully maintained and the data has been presented by way of units of analysis and categories. The aims and objectives of this study were discussed with work colleagues, in order to eliminate any suspicions about concerns over practice issues.

However, it was anticipated that possible conflicts of interest may arise, if obvious concerns about practice issues emerged. However, these did not occur, but it was felt these could have been addressed in one of the following ways, appropriate to the emerging problem.

- If the case was current and the worker presently involved. A sensitive approach would be made to the worker, clearly outlining the observations, possibly including his/her Supervisor.
- If the cases were closed, and recurrent practice issues appeared to be emerging, a suggestion would be made to the Site Manager about appropriate training programmes, for all workers, in relevant fields of practice, however, this never occurred.

6.4 Data Collection

6.4.1 Sample

The retrospective case records used for this research were accessed through the CYPFS computerised Social Work information system (SWis), which produced a client ID number and category type for each client referred to CYPFS. For the purpose of this study, clients referred to CYPFS between 1990 - 1995, under the category of problem behaviour, were accessed. The information gathered has only been obtained from the computer entries, because of limited time, paper-based files, were not accessed. Each case was coded, independent of client ID numbers, in order to categorise and ensure that confidentiality was carefully maintained.

The files of 536 retrospective case records were accessed. However, 179 of these were unable to be categorised for the purposes of the research because they were entered as miscellaneous. A further 51 cases had insufficient information. As a result 306 cases were analysed. Data, on ethnicity, age, gender, type of problem, family background, number of referrals, offending patterns, number of FGCs and actions taken to investigate and intervene, were coded and entered on a computer spreadsheet.

This analysis was then transformed into quantitative data and compared with existing literature on conduct behaviour problems, for the purpose of (a) linking effects and causes, (b) identifying risk factors, (c) highlighting protective and resilience factors (d) exploring effective preventative interventions and (e) identifying areas for further research.

6.4.2 Changes in CYPFS categories

One factor, to do with categories, which impinged on this study is the change in criteria and categories for referrals to CYPFS which took place during 1994.

Categories prior to 1994

Alleged abuse

*Problem behaviour

*Leaving home

*Relationship difficulties

Categories from 1994 onwards

Physical/sexual abuse-family

Physical/sexual abuse-non-family

Care concerns / emotional abuse

Children/young people with a

Detrimental environment	problem behaviour
Adult violence	
Custody enquiries	
Individual adults with personal problems	
Housing difficulties	
Material or financial assistance	

During the period from 1990 -1995, most CYPFS site offices within Auckland, had rostered duty intake workers and this frequently resulted in inconsistent information gathering and categorisation of notifications. As a consequence, children and young people who were perceived as having problem behaviour prior to 1994, could have been placed in one of the three categories, marked with an asterisk above, depending on the immediate complaint. These included: problem behaviour or child, young person leaving home or relationship difficulties (which referred to either parent/child or between parents). For this study it was decided to focus on problem behaviour as it was hoped this category would capture majority of the cases, however, it must be acknowledged that there could be a number of cases overlooked due to this factor. Another problem which emerged was due all categories prior to 1994, marked with an asterisk above, being condensed into one category (child/young person with a problem behaviour) from 1994 onwards, this therefore precluded an accurate, year by year comparison to ascertain whether there had been an increase or decrease in problem behaviour notifications, in relation to CYPFS change in threshold levels and priority classification of risk, in response to the increased number of intakes and shrinking resources.

6.5 Data Analysis

The case records used for this study, came from a computerised print-out of all the problem behaviour referrals made to Waitakere CYPFS between 1990-1995. Each case was then accessed through the CYPFS computerised SWis, coded, entered onto a spreadsheet and analysed for the following:

Units of analysis

- number of cases, including year of initial referral
- gender
- outcome to be measured. The judgement of this was very difficult, because in many cases this was not fully recorded, making this task difficult without a follow-up current assessment of the family. However the criteria used was from recorded information and an assumption that the situation had been resolved if it had been indicated by the social worker or if there had been no further referrals for at least three years. A case was considered unresolved, if the re-referrals numbered three or more, or there was an indication of ongoing recidivism or if three or more FGCs had been held and / or ongoing concerns with limited family involvement.

Categories and reasons examining these:

- **ethnicity** is necessary for determining the cultural component in order to ascertain if an over representation of certain cultures is evident and to use strategies, in further research, which will accommodate cultural differences in expectations, norms and behaviours. Researchers must either develop preventative models that apply to multiple groups or evaluate which interventions are successful with particular groups. (Bierman *et al* 1992).
- **age at time of initial referral** in order to determine if the age onset of problem behaviour has a link with outcome. The age referred to in this study is obtained by subtracting the client date of birth away from the first recorded computer entry, however, this may be inaccurate because if a child or young person was referred to CYPFS prior to the introduction of SWis, this information therefore, may be held elsewhere on a paper based file.
- **family and social situation** this section refers to recorded incidence of family violence; multi-problem families; lone, two or extended family environment; step-parents; child abuse; substance abuse, in order to ascertain if there findings which correlate with other extensive studies highlighted in the review of the literature. However, this may not offer a true reflection because the level of social work documentation during the introduction of the computers was inconsistent and frequently very poor, due to the new concept computerised recording, lack of

experience with computers and a reluctance to move from a paper based filing system.

- **category of behaviour** such as minor problems with behaviour, adolescent related problem behaviour, severe antisocial behaviour, severe antisocial behaviour accompanied by recidivism, recidivism, youth justice involvement.
- **number of FGCs** in order to determine the effectiveness and timeliness of an FGC.
- **level of social work intervention** in order to ascertain if this has any relevance to outcome. However, a true reflection was unlikely, because of the problems outlined previously under family and social situation.
- **placements** to ascertain if a kinship placement was able to be made or an out-of-family placement was required, in order to obtain approximate costs incurred by CYPFS for out-family placements. A list of placements (including costs), used by children and young people from this study, has been outlined in Appendix A.

6.6 Findings

6.6.1 The findings for the total sample

Gender

The entire sample had a recorded gender which consisted of 189 males and 117 females. This is summarised in Table 1.

Males	189	61.8%
Female	117	38.2%
TOTAL	306	100%

Table 1. Total sample illustrating the differences in gender.

This table indicates that nearly two thirds of the sample consisted of males

Ages

The ages identified in this study were from the first documented referral to CYPFS for each case sample, recorded on the computerised social work information system

(SWis). The ages ranged from 10 months through to 17½ years. The ages were determined by deducting each persons date of birth from the date of the very first recorded entry. Of the 306 cases 303 had their date of birth recorded.

The ages were broken down into the following groupings, in order to capture the approximate age range for early childhood (0-2), pre-school (3-5), middle school (6-8), pre-adolescence (9-11), early adolescence (12-14), adolescence (15-17) and older adolescence (17½). These findings are summarised in Table 2.

The overall average age for first referral to CYPFS was 12.5 years with the average age for males being 12.2 years and 12.8 years for females, indicating a similarity between both genders. Comparisons are summarised in Figure 1.

Age	Total Sample <i>n</i> = 306		Males <i>n</i> = 189		Females <i>n</i> = 117	
0 - 2	3	1.0%	2	1.1%	1	0.85%
3 - 5	19	6.2%	12	6.4%	7	6.0%
6 - 8	22	7.2%	17	9.0%	5	4.3%
9 - 11	42	13.7%	29	15.3%	13	11.1%
12 - 14	129	42.2%	81	42.9%	48	41.0%
15 - 17	86	28.1%	46	24.3%	40	34.2%
17½	2	0.6%	1	0.5%	1	0.85%
Unknown	3	1.0%	1	0.5%	1	1.7%
TOTAL	306	100%	189	100%	117	100%

Table 2. Age breakdown for first referral to CYPFS, in total sample and differences between male and females.

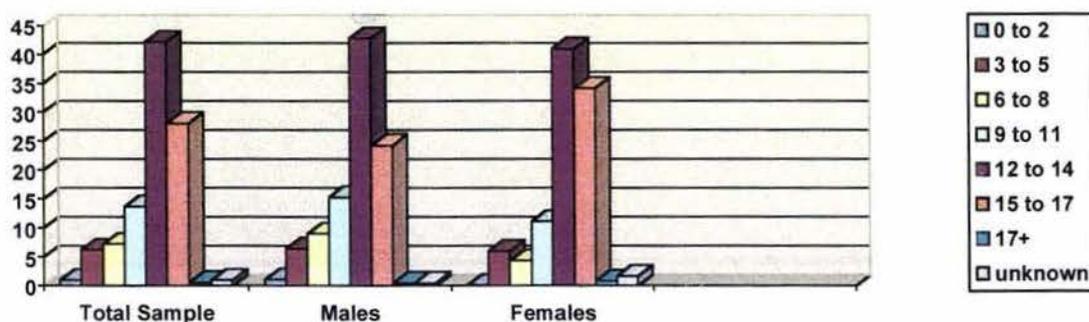


Figure 1. Comparison, in percentages among the age of first referrals, for the total sample, males and females.

The overall average age of first referral between male and female is very similar to the average age for the total sample. However, there are some distinct differences between male and females in certain age groups. The referral rate for males between the ages of 6 - 8 is twice as high as the females (males = 9% and females = 4.3%) and it is also higher in the 9 -11 age group (males = 15.3% and females 11.1%). Conversely the percentage of females in the 15 - 17 age group is higher than males (females = 34.2% and males = 24.3%). Within the other remaining age categories 0 - 2, 3 - 5, 12 - 14, 17½ and unknown, there are no distinct gender differences in the referral rates.

Ethnicity

Out of the 306 cases, 294 had a recorded ethnicity, 14 of which were categorised under 'other' because there was no defined category for their particular ethnicity. The cases which have been defined as unknown is because there was no entry in the ethnicity section.

The following table illustrates the ethnicity proportions for the entire sample and compares the percentages with the national CYPFS notifications from 1990 -1994 and the ethnicity breakdown for Waitakere City, West Auckland obtained from the 1996 census. Please note there is no entry under Asian for the national CYPFS percentages nor Maori/European for the Waitakere City figures, due to being unable to obtain them at the time of the request.

Ethnicity	Present Study		National CYPFS	Waitakere City
	<i>n</i>	%	%	%
European	146	47.7%	48.1%	68.0%
Maori	90	29.4%	30.9%	13.7%
PacificIsland	29	9.5%	7.2%	11.0%
Other	14	4.6%	4.2%	0.5%
Asian	2	0.7%		6.8%
Maori/European	13	4.2%	9.6%	
Unknown	12	3.9%		
TOTAL	306	100%	100%	100%

Table 3. Ethnicity for overall sample, showing a comparison with the national CYPFS and Waitakere City percentages.

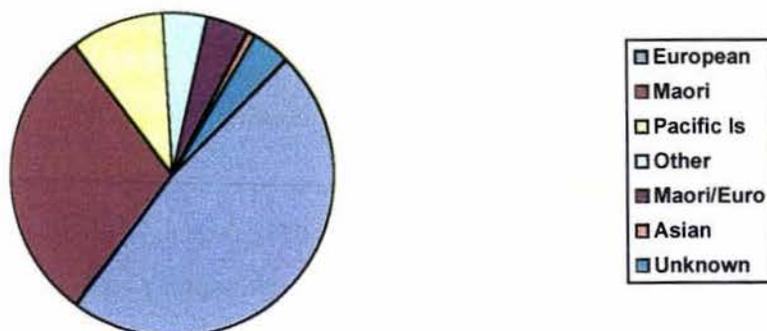


Figure 2 a. Ethnicity proportions for total sample of present study.

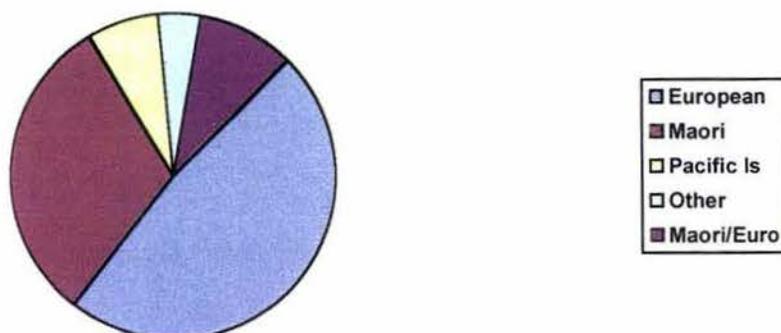


Figure 2 b. Ethnicity proportions from national CYPFS percentages 1990-1994.

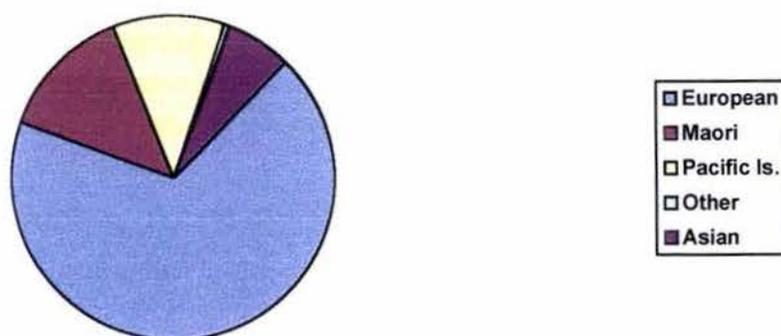


Figure 2 c. Ethnicity for Waitakere City from 1996 Census.

The percentages for Maori from the present study (29.4%) are consistent with CYPFS national percentages (30.6%) from 1990 -1994, emphasising an over

representation of Maori compared with a Maori population of only 13.7% within the sample area of West Auckland.

These same nation-wide trends are also prominent within other aspects that are related to high risk families for CD, such as:

- Education: In 1996 39% Maori and 27% of Pacific Island students, left school with no qualification, compared with 14% of students from all other ethnic groups.
- Unemployment: Maori, Pacific people and young adults, have much higher rates of unemployment than the general population.
- Health: The relatively poor health status of Maori results from a number of factors, but it is mostly due to poorer socio-economic circumstances, than non-Maori.

(The Social, Cultural and Economic Determinants of Health in N.Z.: Action to improve Health. National Health Committee June 1998: 26 -30).

Ethnicity and Gender

Below is a comparative table, assessing the differences between male and female and comparing these percentages with the overall sample.

Ethnicity	Males	%	Females	%	% Total Sample
	<i>n</i>		<i>n</i>		
European	98	51.8%	48	41.0%	47.7%
Maori	52	27.5%	39	33.3%	29.4%
Pacific Island	20	10.6%	8	6.8%	9.5%
Maori/European	10	5.3%	3	2.6%	4.2%
Asian	0	0%	2	1.7%	0.7%
Other	4	2.1%	10	8.6%	4.6%
Unknown	5	2.7%	7	6.0%	3.9%
TOTAL	189	100%	117	100%	100%

Table 4. Ethnicity and gender compared with the total sample.

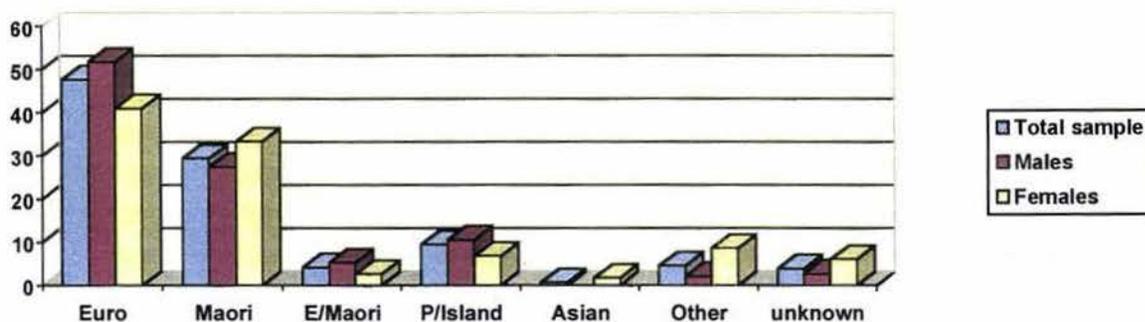


Figure 3. Graph comparing ethnicity with gender.

Table 4 and Figure 3 shows a higher proportion of European males and Maori females, and there is also a higher proportion of females within the 'other' category compared to the average total.

Family Situation

Of the 306 cases, 260 had a record of the parental status, as to whether it was a lone or two parent family, adoptive parents or one biological and one step-parent.

Parental status	<i>n</i>	%
Lone parent families	178	58.2%
Two biological parents	58	19.0%
One biological parent / one Step-parent	13	4.2%
Adoptive parents	11	3.6%
Unknown	46	15.0%
TOTAL	306	100%

Table 5. Parental status within families

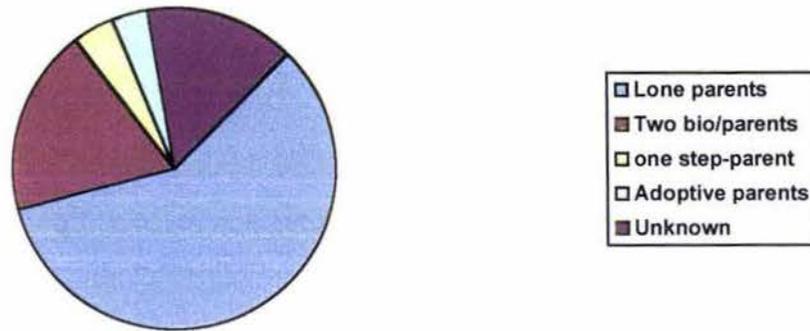


Figure 4. Parental status within families

Table 5 and Figure 4 show that a high percentage of children and young people from this study came from lone parent families. However it is difficult to ascertain the accuracy of this finding because 15% of the sample had an unrecorded entry regarding parental status therefore, if all of the ‘unknowns’ were from two parent families there would not be a distinct difference between the lone and two parent categories.

Categories of behaviour

Each case examined for this study tended to fall into broad categories of behaviour. A common theme for most cases was minimal truanting, parental conflict, drug and alcohol experimentation. Because of this common themes such as these were not broken into categories. Instead, categorised behaviours on the basis of their intensity, seriousness and duration. The broad categories were as follows:

1. Severe antisocial behaviour. This was established from the recorded history, social work assessments, psychological assessments which had diagnosed the child or young person (YP) as severe CD, expulsion from schools, level of aggression, lighting fires, cruelty to animals, drug alcohol abuse, youth justice involvement, ADHD, and out of control behaviour.
2. Severe antisocial behaviour accompanied by ongoing recidivism. One or two youth justice referrals did not determine recidivism, but rather, measurement was based on continual offending, which was unresolved by 17 years old and/or referred to the District Court.
3. Recidivist offending only, including armed robbery, murder and attempted murder. In this category there was no recorded history of previous severe antisocial

problems. However, this category may have emerged because details of previous antisocial behaviours had not been recorded on SWis but, instead noted elsewhere on a paper file.

4. Involvement with Youth Justice, but not recidivism. Adolescents who had had one or two referrals to Youth Justice with no indication of recidivism, and had no other history of problem behaviour.
5. One off, adolescent /peer related behaviours, such as parental conflict, disruption in school (with no history of previous concern), there was no Youth Justice involvement for this group. The age of this group was 12 - 17½ years.
6. Pre-adolescent, one off referrals for problem behaviour. The age range for this group was 0 -11 years.

Category	<i>n</i>	%
Severe antisocial behaviour	52	17%
Severe antisocial behaviour accompanied by recidivism	35	11.4%
Recidivist offending only	15	4.9%
Youth Justice, without recidivism.	50	16.3%
Age/peer related behaviours	118	38.6%
Pre-adolescent, one off referrals for problem behaviour	36	11.8%
TOTAL	306	100%

Table 6. Behaviour Categories

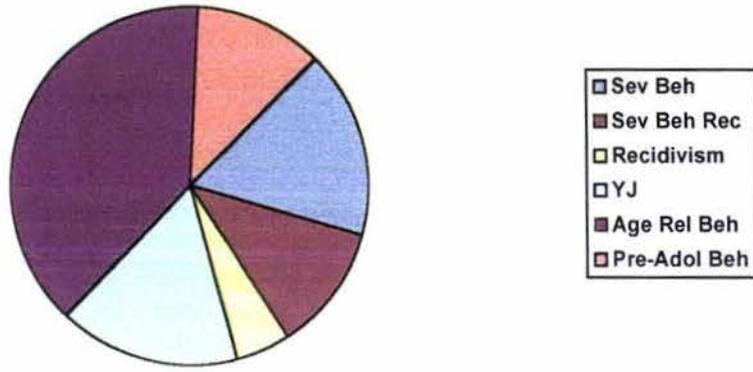


Figure 5. Behaviour Categories

Category of Behaviour	Males	%	Females	%
Severe Antisocial Behaviour	36	19.1%	16	13.7%
Severe antisocial behaviour accompanied by recidivism	29	15.3%	6	5.1%
Recidivist offending only	14	7.4%	1	0.9%
Youth Justice, without recidivism	30	15.9%	20	17.1%
Adolescent/peer related behaviours	58	30.7%	60	51.3%
Pre-adolescent, one off, referrals for problem behaviour.	22	11.6%	14	11.9%
TOTAL	189	100%	117	100%

Table 7. Gender differences for behaviour categories

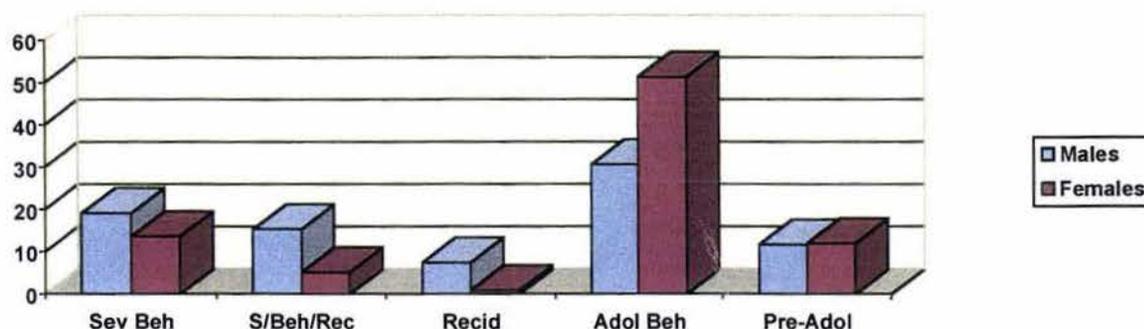


Figure 6. Gender differences for behaviour categories

Table 7 and Figure 6 show marked differences between male and female for severe antisocial behaviour accompanied by recidivism and recidivism only. These two categories have a higher proportion of males compared to females, it must be noted that the female sample size in the recidivist only category is one, however there is an overall suggestion from these findings that females are less likely to feature as recidivists. Conversely the percentage of females in the adolescent / peer related group is distinctly higher than the males from this group.

6.6.2 Findings from each behaviour category

Each behaviour category is examined, in order to ascertain the following details: parental status, ethnicity, number of referrals and FGCs, level of social work intervention, family dynamics, age of first referral, placements, degree of family support and outcome. For the purposes of this study multi-problem families, domestic/family violence and family support were determined by:

Multi-problem families: were classified as such if they had two or more of the following:

- transient life style (three or more changes of address within a year);
- poor parental child rearing;
- parental substance abuse;
- enmeshment is where boundaries become blurred, due to poorly differentiated roles between parent/caregiver and child, for example "*children may act like parents and parental control may be ineffective*" (Goldenberg and Goldenberg 1985:67). In a study completed by Minuchin *et al* (1967), it was found that the extremes of enmeshment or

disengagement characterized family interaction of poor disadvantaged, unstable families, where there were delinquent children;

- poverty;
- child neglect, failure to thrive, left home alone;
- child abuse and violence.

Family violence: was classified, when this had been documented in the absence of any other family problems. This, however, may not be an accurate reflection due to the problems noted earlier in regards to social work recording.

Family support: was determined by the level of commitment displayed by either the immediate or extended family to support their son or daughter and acknowledge that the 'problem' was a family responsibility, rather than solely identifying the child or young person as the 'problem'.

Severe antisocial behaviour

Out of the 52 cases within this category, 51 had a recorded parental status, one female had no recorded parental status.

- Single Parent Families: 37 single parents, two cases recorded conflict with previous step- parents. There were 27 males and 10 females represented in this sample.
- Two Parent Families, totalled 14 which included 10 biological parents, 2 adoptive parent families and 2 step-families. There were 9 males, 1 of whom was adopted and 2 from step- parent families, and 5 females, 1 of whom was adopted, represented in this sample.
- Ethnicity had 51 listed out of 52

Ethnicity	n	%	Males n=36		Females n=16		% Total Sample
European	30	57.7%	23	63.9%	7	43.7%	47.7%
Maori	15	28.8%	9	25.0%	6	37.5%	29.4%
Pacific Island	3	5.8%	2	5.5%	1	6.3%	9.5%
Maori/Euro	2	3.9%	1	2.8%	1	6.3%	4.2%
Asian	1	1.9%			1	6.3%	0.7%
Unknown	1	1.9%	1	2.8%			3.9%
TOTAL	52	100%	36	100%	16	100%	

Table 8. Ethnicity and gender for severe antisocial behaviour category compared with percentage of total sample.

- Referrals, FGC's and social work intervention. Of the 52 cases, there were on average 3.2 referrals for each case and 0.61 FGC's.
1. Cases where there appeared to be a resolution: Seventeen or (32.7%) of the fifty two cases appeared to have been resolved, through good social work intervention, appropriate referrals to outside agencies and/or good family/whanau support. Four of these families were involved in an FGC and on average these families were referred 2.58 times before an intervention. Average age of initial referral for this group was 9.7 years.
 2. Cases which are still ongoing: Of the 52 cases 14 or (26.9%) are still ongoing. On average these families were referred 3.9 times before they received an intervention and 5 of these families have been involved in 1 or more FGCs. Average age of initial referral for this group was 8.1 years
 3. Cases which appeared unresolved: The remaining 21 or (40.38%) of the cases, appeared to be unresolved, because they had been closed with no indication of a successful outcome or there were continuing unresolved presenting problems until the age of 17 years.. On average, these children/YP were referred 3.3 times and 12 of these families were involved in 1 or more FGC. Average age of initial referral for this group was 10.9 years.

- Child abuse (sexual, emotional and physical), family violence, poor parenting, attachment/bonding problems, ADHD, drug/alcohol abuse, mental health problems, PTSD and suicides, multi-problem families, were among the problems and outcomes identified in this group. As summarised in Table 14 child abuse (23%), family violence (17.3%) and multi problem families (17.3%) featured quite highly within this behaviour group.
- The average age for the first referral in this group was 9.8 years, which was slightly lower than the other categories (summarised in Table 15) and was distinctly lower than the average for the total sample which was 12.5 years, excepting the pre-adolescent group. The average for males was 1.75 years younger than the average female age for this group.
- Out of family placements, 15 or 28.8% were recorded for this group, 3 of which were short-term and the remaining 12 were long-term costly placements, some have been recently placed with Youth Horizons Trust, costing around \$400 - \$500 per night. There were 4 or 7.7% recorded placements made within the wider family.
- Family support was reported to be evident and effective in 2 or 3.8% of the cases within this category.

Severe antisocial behaviour accompanied by recidivism:

- Out of the 35 cases within this category 34 had a recorded parental status, one male did not have a recorded parental status. Single parent families: 24 or 70.6% out of the recorded 34 were single parent families. There were 21 males and 3 females represented in this sample.
- Two parent families: 10 or 29.4%, 3 of which had a history of family violence, 3 were adoptive parents and 1 was a combination of biological and step-parent.

There were 7 males, 3 of whom had adoptive parents and 1 from a step-parent family, and 3 females represented in this sample.

Ethnicity: 34 out of the 35 had an identified ethnicity, 1 male had no recorded ethnicity

Ethnicity	N	Percentage	Males n=29		Females n=6	
European	16	45.7%	15	51.7%	1	16.7%
Maori	12	34.3%	9	31.0%	3	50.0%
Pacific Island	3	8.6%	2	6.9%	1	16.7%
Maori/Euro	3	8.6%	2	6.9%	1	16.7%
Unknown	1	2.8%	1	3.5%		
TOTAL	35	100%	29	100%	6	100%

Table 9. Ethnicity and gender for severe antisocial behaviour accompanied by recidivism.

- Referrals, FGCs and social work intervention. Of the 35 cases there were on average 5 referrals for each case and 2.8 FGC's.
1. Cases where there appeared to be a resolution: There were no recorded resolutions for any of the children or young people from within this category.
 2. Cases which are still ongoing: Of the 35 cases 5 or 14.3% are currently ongoing. . On average these families were referred 4.2 times before they received an intervention and all of these families have been involved in one or more FGC. Average age of initial referral for this group was 9.2 years.
 3. Cases which appeared unresolved: The remaining 30 or 85.7% of the cases appeared unresolved as most were referred to district court or closed at age 17. On average these YP were referred 5.5 times and were involved in one or more FGCs. Average age of initial referral for this group was 11.6 years.
- All of the single parent families were multi-problem families, who were unable to cope. Both family violence (22.9%) and multi problem families (20%) featured among the highest, for this group, as summarised in Table 14. The common themes recorded were, family violence, alcohol/drug abuse, transient life-styles, poverty,

and poor parental child rearing combined with enmeshed boundaries. Antisocial/offending behaviour: Severe drug/alcohol abuse, continual truancy and related crimes, arson suicide, attempted murder and murder, were among the behaviours documented for the children and YP within this group.

- The overall average age for the first referral was 11 years, which was lower than the average of 12.5 for the total sample. The average for males in this group was nearly 2 years younger than the females, as summarised in Table 15.
- Out of family placements, 15 or 42.8 % were recorded for this group, 1 short-term placement and the remaining 14 were long term and many were involved in Weymouth NRU (Northern Residential Unit) costing around \$400 -\$500 per night, or recently placed in Youth Horizons Trust, similar costs to NRU. There were no recorded family placements.
- Family support, there was no recorded evidence of family support for this behaviour category.

Whether the causal links for these behaviours are established due to biological factors or in tandem with environmental components, the fact remains they exist. The question must be asked, if early intervention had occurred for the above families, could the above problems have been prevented?

Recidivist Offending

There were 15 cases in this category, the findings were as follows:

- Single parent families: Out of the 15 families, 14 had an entry about the number of parents within the family, for one male there was no record of parental status. There were 9 or 64.3% single parent families, 9 males were represented in this sample
- Two parent families totaled 5 or 35.7% , family violence was recorded in 2 or 40% of these cases, 4 males and 1 female was represented in this sample.

- Ethnicity was entered on all instances

Ethnicity	<i>n</i>	Percentage	Males <i>n</i> =14	Female <i>n</i> =1
European	6	40%	6 42.9%	
Maori	7	46.7%	6 42.9%	1 100%
Pacific Island	2	13.3%	2 14.2%	
TOTAL	15	100%	14 100%	1 100%

Table 10. Ethnicity and gender for recidivist offenders.

This group consisted of mainly males, with similar findings in the previous group, suggesting that females do not go on to become recidivist offenders. The female sample size is very small for both the severe antisocial behaviour accompanied by recidivism and recidivist only groups, therefore further comparable studies with the Youth Justice figures would be required, in order to verify these findings. However, these findings are consistent with Zoccolillo (1993) who found that females are less likely to manifest criminal behaviour, section 4.3.3.

- Referrals, FGCs and social work intervention. Of the 15 cases there was, on average, 3.8 referrals for each case and 2.6 FGC's.
- Cases where there appeared to be a resolution, two of the cases appeared to have a successful outcome, after the third referral, where in both situations the YP had been placed in a successful out of family placement. The remaining cases had been closed at age 17, without an apparent resolution or referred on to the district court.
- Child abuse (sexual, emotional and physical), family violence, drug alcohol abuse, continual offending and many out of family placements, were among the problems identified within this group. The sample size was very small for this group, however family violence, multi problem families and substance abuse problems with the YP, featured in 13.3% of the cases, as summarised in Table 14.

- The average age of the first referral for this group was 13, above the average age for the total sample, however, this may not be very accurate due to the fact that clients within this group may have had previous referrals noted on their paper based files, but not recorded on SWis.
- Out of Family Placements: 5 or 33% of clients for this group required long term out of family placements, such as Northern Residential Unit (NRU Weymouth), Youth Horizons Trust and various Community Funded placements resulting in huge financial costs for CYPFS. There were no recorded placements made within the family.
- Family support, there was no recorded evidence of family support for this behaviour category.

Youth Justice referrals (without recidivism):

There were 50 cases in this category. Of the 50 cases, 46 had a record of the parental status, there were 4 males with no recorded parental status.

- Single parent families totaled 27 or 58.7%. There were 12 males and 15 females represented in this sample.
- Two parent families totaled 19 or 41.3%. Included in this group were 7 step-parent families and 1 adoptive family. There were 14 males, 3 of which were from step-parent families and 5 females, 4 of which were from step-parent families and 1 adopted family, represented in this sample.
- Ethnicity: Of this sample of 50, 48 had a documented ethnicity

Ethnicity	N		Males n=30		Females n=20	
European	22	44%	15	50.0%	7	35%
Maori	17	34%	8	26.7%	9	45%
Maori/European	4	8%	4	13.3%	0	
Pacific Island	2	4%	2	6.7%	0	
Other	3	6%	0		3	15%
Unknown	2	4%	1	3.3%	1	5%
TOTAL	50	100%	30	100%	20	100%

Table 11. Ethnicity and gender for YJ (without recidivism).

- Referrals, FGCs and social work intervention For the 50 YJ cases there was on average 2.2 referrals and 0.64 FGCs.
1. Cases where there appeared to be a resolution: totaled 26 or 52%, of these cases, there were 27 FGCs and 77% of these seemed to have a successful outcome. Overall 52% (n=26) of the cases had only one referral, 24% (n=6) of which had a (recorded) social work intervention. at the time of the first referral, and appeared to have a successful outcome, and the other 20, had insufficient recorded data but appeared to have resolved themselves. Of the remaining 24 cases 11 or 22% appeared to have received social work intervention after the second or third referral with an apparent resolution.
 2. Cases which were still ongoing or appeared unresolved: 6 or 12% appeared unresolved and were closed at age 17, 1 case was ongoing, 1 committed suicide and the remaining 5 had insufficient recorded data.
- The common themes identified within this group were peer influence and relationship difficulties with parents, especially apparent among the adolescent females which had recorded conflicts with either step-parents or a partner/s of their biological parent. Documented family violence, drug/alcohol problems and poor parenting featured in 9 or 18% of the cases within this category. Family violence, multi-problem families featured in 6% of the families and child abuse 2% within

this group and 8% of the YP were involved in substance abuse as summarised in Table 14.

The average age of the initial referral was 14.25 years, nearly 2 years older than the average age for the total sample, suggesting the older the YP is at the time of being referred to YJ the less likely they are to become a recidivist offender. . This group and the adolescent peer related category were the two largest groups, suggesting a consistency with the findings of Moffit (1993), who completed a literature review and found that antisocial behaviour continues with age but its frequency increases drastically during adolescents, as discussed in section 2.6.

- Out of Family Placements: Of the 50 cases 9 or 18% of the clients required a long term out of family placement mainly with Youthlink and/or an alternative community funded placement and 2 or 4% short-term placements . There were 3 or 6% recorded placements made with wider family.
- Family support was reported to be evident and effective in 6 or 12% of the cases within this behaviour category, suggesting this could be a protective factor against ongoing offending.

Adolescent / Peer Related behaviours:

There were 118 in this category. Of the 118 cases, only 89 had a documentation of the parental status. There were 15 males and 14 females without a recorded parental status.

- Lone or single parent families totaled 59 or 66.3%. There were 32 males and 27 females represented in this sample.
- Two parent families totaled 30 or 33.7%. There were 11 males and 19 females represented in this sample.
- Ethnicity: Ethnicity was recorded in 114 of this section.

Ethnicity	<i>N</i>	Percentage	Males <i>n</i> =58		Females <i>n</i> =60	
European	55	48.2%	29	50%	26	43.3%
Maori	32	28.1%	15	25.9%	17	28.3%
Maori/Euro	3	2.6%	2	3.45%	1	1.7%
Pacific Island	14	12.3%	6	10.3%	8	13.3%
Asian	1	0.9%			1	1.7%
Other	9	7.9%	4	6.9%	5	8.3%
Unknown	4	3.4%	2	3.45%	2	3.3%
TOTAL	118	100%	58	100%	60	100%

Table 12. Ethnicity and gender for the adolescent/peer related behaviours.

Males totaled 58 or 49% and females 60 or 51% of the sample. This was the only group where females presented a higher representation than the males.

- Referrals, FGCs and social work intervention. Of the 118 cases, there were on average 1.3 referrals for each case and 0.06 FGCs . The average age for this section was, overall, much higher than the other groups and there was infinitesimal recorded social work intervention, as a consequence it is possible this group would have received minimal or perhaps no intervention, due to the low priority assigned to adolescent referrals (50% were 15+ years old at the time of the initial referral). This could also account for the lack of documented data on each of these cases. It was, therefore, very difficult to ascertain the outcome, due to lack of information and the fact that any ongoing problems would most likely be immediately directed to an outside agency. The main problems recorded for this group, were relationship and parental difficulties, with family violence featuring in 6 or 5% of the cases. Social work intervention was recorded in 26 or 22% of these intakes and appeared to have a successful outcome. A referral to another agency (without a recorded social work assessment) occurred in 6 or 5% of the cases and the other remaining 68% of the cases from this section, appeared to have had only one referral without any assessment, intervention or follow-up.

- Age was recorded in 115 of the 118 cases and the average age was 14.7 years, over 2 years older than the overall average age for the total sample, suggesting the older a YP is at time of the first referral the less likely they are to be involved with Youth Justice.
- Out of family placements: 12 or 10.2% were placed in an out-of-family-placement, most of which were short term and 4 or 3.4% were placed with wider family.
- Family support was recorded in 20 or 16.9% of the cases from this group, suggesting this could be protective factor against youth offending.

Pre-adolescent Referral for problem Behaviour

The number in this category totaled 36. Of the 36 cases, 28 had a documented record of the parental status

- Parental status: There were 24 or 85.7% single parent families. There were 14 males and 10 females within this sample.
- Two parent families There were 4 or 14.3% two parent families within this group. There were 3 males and 1 female within this sample.
- Ethnicity: Of the 36 cases, 30 had a recorded ethnicity.

Ethnicity	Number	Percentage	Males <i>n</i> =22		Females <i>n</i> =14	
European	16	44.4%	10	45.5%	6	42.9%
Maori	7	19.4%	4	18.2%	3	21.4%
Maori/Euro	1	2.8%	1	4.5%		
Pacific Island	5	13.9%	5	22.7%		
Other	1	2.8%			1	7.1%
Unknown	6	16.7%	2	9.1%	4	28.6%
TOTAL	36	100%	22	100%	14	100%

Table 13. Ethnicity and gender for the pre-adolescent group

This group was included in the sample because they were entered in under 'problem behaviour'. However, it is suspected that they were incorrectly categorised, because most were referred at a time when the parents had just recently separated, as indicated by the 85.7% of single parents for this sample. It therefore appeared that at the time of the CYPFS notification the child was emotionally unsettled, but soon recovered.

- Age, number of referrals and FGCs: The average age for this group was 7.4 years and average number of referrals and FGCs were 1.4 and 0.08 respectively. Immediate social work intervention featured in 13 or 36% of these cases and there appeared to be a successful outcome for all 13 of these cases. The main problems and outcomes recorded for this group were:
 - Custody disputes which had a short term affect on the behaviour of the child, featured in 3 or 8.3%
 - Family violence in 3 or 8.3%
 - An initial referral to Marinoto Child and Family Unit was noted in 6 or 16.6%, with apparent success.
 - Out-of-family-placement was documented in 3 or 8.3% of the cases
 - Placements within family was documented in 1 or 2.7% of the cases
 - Ongoing CYPFS intervention was evident in 3 or 8.3% of this sample
 - Good family / whanau support was reported in 5 or 13.8% of the cases and indicated a strong commitment to resolve their present situation.
 - The remaining cases had insufficient information, however, there were no further referrals, perhaps indicating the situation had resolved itself.

6.6.3 Summary of Findings

The following tables summarise the overall findings from this study.

	Family Violence	Multi- problem Families	Child Abuse	Drug/ Alcohol problems	Sexual Offenders	Suicide
Antisocial Behaviour <i>n</i> = 52	9 or 17.3%	9 or 17.3%	12 or 23%	4 or 7.7%	2 or 3.8%	3 or 5.8%
Antisocial Behaviour + Recidivism <i>n</i> = 35	8 or 22.9%	7 or 20%	1 or 2.9%	1 or 2.9%	1 or 2.9%	2 or 5.7%
Recidivism <i>n</i> = 15	2 or 13.3%	2 or 13.3%	1 or 6.6%	2 or 13.3%		
Youth Justice without recidivism <i>n</i> = 50	3 or 6%	3 or 6%	1 or 2%	4 or 8%	1 or 2%	1 or 2%
Adolescent/ Peer Related <i>n</i> = 118	7 or 5.9%	2 or 1.7%	5 or 4.2%	1 or 0.8%	3 or 2.5%	
Pre-adolescent <i>n</i> = 36	2 or 5.5%		2 or 5.5%			
TOTAL <i>n</i> = 306	31 or 10.1%	23 or 7.5%	22 or 7.2%	12 or 3.9%	7 or 2.3%	6 or 1.9%

Table 14. Summary of documented adverse family situations for total sample, comparing all behaviour categories.

Table 14 shows that in the first three behaviour categories, there was a larger number of recorded incidence of child abuse, family violence and families with multiple problems, than in the remaining three three categories, resulting in poorer outcomes for the children and young people with severe antisocial and recidivist behaviour. These findings appear to be consistent with findings by Murray, 1993; Koziol & Stout 1994; Scharwz & Perry 1994; and Perry & Pate outlined in section 3.4. The findings from this study also suggest that multiple factors add to childhood vulnerability and poorer outcomes, consistent with Rutter (1991) in section 4.3.3. and Karen (1994); Offord (1982); and McDowell (1995) in section 5.3.

Behaviour Category	Average age	Average age Male	Average age Female
Severe antisocial behaviour <i>n</i> = 52	9.8 years	9 years	10.75 years
Severe antisocial behaviour accompanied by recidivism <i>n</i> = 35	11 years	10.9 years	12.75 years
Recidivism only <i>n</i> = 15	13 years	13 years	15 years
Youth Justice, without recidivism <i>n</i> = 50	14.25 years	14.3 years	14.15 years
Age/peer related behaviours <i>n</i> = 118	14.7 years	14.6 years	14.75 years
Pre-adolescent, one off referrals for problem behaviour <i>n</i> = 36	7.3 years	7.6 years	7 years

Table 15. Summary of documented age of first referral for all behaviour categories

In Table 15 it is apparent that overall, males were younger at the time of the first referral and suggests that the younger the age of onset of problem behaviour, the poorer the outcome, consistent with the findings of Moffitt (1990), Eron (1990), Church (1994) and Berkowitz (1993) in section 5.2 and 5.3. However, the average age for recidivist offenders was 6 months older than the average overall age for the total study, suggesting intervention is less likely to be effective as outlined in section 5.1.

	Family Violence	Multi- problem Families	Child Abuse	Drug/ Alcohol problems	Sexual Offenders	Suicide
Lone Parent <i>n</i> = 178	18 or 10.1%	20 or 11.2%	16 or 9%	8 or 4.5%	3 or 1.7%	4 or 2.2%
Two Parent <i>n</i> = 58	11 or 19%	2 or 3.4%	5 or 8.6%	3 or 5.1%	4 or 6.9%	2 or 3.4%
Biological Parent + S/Parent <i>n</i> = 13	2 or 15.4%			1 or 7.7%		
Unknown <i>n</i> = 46		1 or 2.2%	1 or 2.2%			
TOTAL <i>n</i> = 277	31 or 11.2%	23 or 8.3%	22 or 7.9%	12 or 4.3%	7 or 2.5%	6 or 2.2%

Table 16. Summary of parental status in relation to adverse family situations

Table 16 shows that there were no recorded incidents of adoptive parents being a multi-problem family or involved in family violence or child abuse. Table 16, however, shows that lone parents have quite a high incidence of multiple problems, family violence and child abuse which suggests there could be a link with poverty, and minimal support, which are considered to be major contributors to insensitive or abusive parenting and negative child outcomes as outlined in section 4.2. Table 16 also shows a higher incidence of domestic violence within two parent families, the suggested reasons for this are discussed in chapter 7.

	Family Violence	Multi- problem Families	Child Abuse	Drug/ Alcohol problems	Sexual Offenders	Suicide
European <i>n</i> = 146	10 or 6.8%	17 or 11.6%	8 or 5.5%	7 or 4.8%	4 or 2.7%	2 or 1.4%
Maori <i>n</i> = 90	17 or 18.9%	4 or 4.4%	6 or 6.7%	3 or 3.3%	3 or 3.3%	4 or 4.4%
Maori/ European <i>n</i> = 13			3 or 23%	1 or 7.7%		
Pacific Island <i>n</i> = 29	3 or 10.3%	1 or 3.4%	4 or 13.8%			
Asian <i>n</i> = 2	1 or 50%					
Unknown <i>n</i> = 12		1 or 8.3%	1 or 8.3%	1 or 8.3%		
TOTAL <i>n</i> = 292	31 or 10.6%	23 or 7.9%	22 or 7.5%	12 or 4.1%	7 or 2.4%	6 or 2%

Table 17. Summary of ethnicity in relation to adverse family situations

Table 17 shows a higher percentage of family violence within the Maori and Pacific Island cultures, except Asian, the findings of which are distorted by the small sample. Conversely, the findings show there is a higher percentage of European families who have multiple problems.

The following graph summarises the number of referrals and FGCs for each behaviour category.

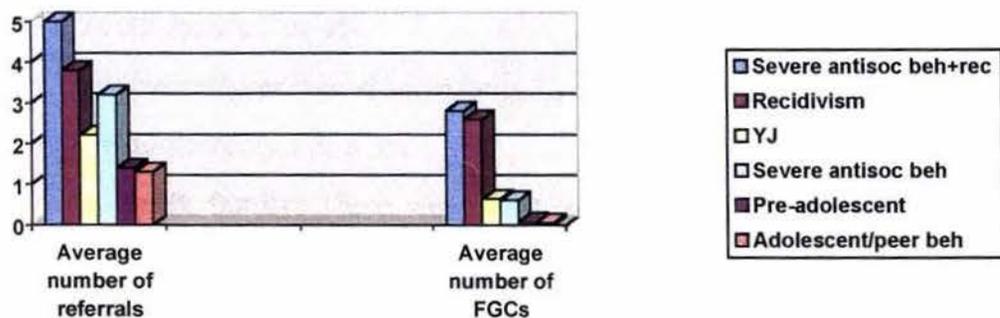


Figure 7. The average number of referrals and the average number of FGCs recorded

for each behaviour category.

Figure 7 does not show any correlation between the number of referrals and the number of FGCs, as demonstrated by the severe antisocial behaviour category, however, it does show a correlation between the number of FGCs and the degree of youth offending, suggesting that FGCs are used frequently by Youth Justice for diversion purposes, but rarely within Care and Protection when a child or young person is presenting with problem behaviour in the absence of child abuse.

Out of family placements, placements within family and family support

Summary of the overall placement types utilized in this study are as follows:

- **Long term placements:** These were for periods of six months or longer. For the overall study there were 40 or 13 % of the young people requiring long term placements which were recorded. All of these were from:
 - Severe anti-social behaviour 12 or 23%
 - Severe anti-social behaviour accompanied by recidivism 14 or 40%
 - Recidivism only 5 or 33.3%
 - Youth Justice (without recidivism) 9 or 18%
- **Short term placements:** These were for periods not exceeding 56 days, however, it was recorded that the same child or young person was sometimes placed 2 or 3 times throughout the year, an approximate number of children or young people requiring short term placements for the overall study was 21 or 6.8% and these were:
 - Severe anti-social behaviour 3 or 5.8%
 - Severe anti-social behaviour accompanied by recidivism 1 or 2.8%
 - Youth Justice 2 or 4%
 - Adolescent/peer related behaviours 12 or 10.2%
 - Pre-adolescents 3 or 8.3%
- **Placements made with family:** These were short or long term placements made where a young person was placed with a family or whanau member within the wider family. Overall this was only indicated in 13 or 4.2% of the cases.
 - Severe anti-social behaviour 4 or 7.7%

- Severe anti-social behaviour accompanied by recidivism 1 or 2.8%
 - Youth Justice (without recidivism) 3 or 6%
 - Adolescent/peer related behaviours 4 or 3.4%
 - Pre-adolescent 1 or 2.7%
- **Family Support not requiring placements:** Good family support indicating a commitment for positive change, through counselling or therapy was recorded in 33 or 10.8% of the cases.
 - Severe anti-social behaviour 2 or 3.8%
 - Youth Justice (without recidivism) 6 or 12%
 - Adolescent/peer related behaviours 20 or 16.9%
 - Pre-adolescent 5 or 13.8%

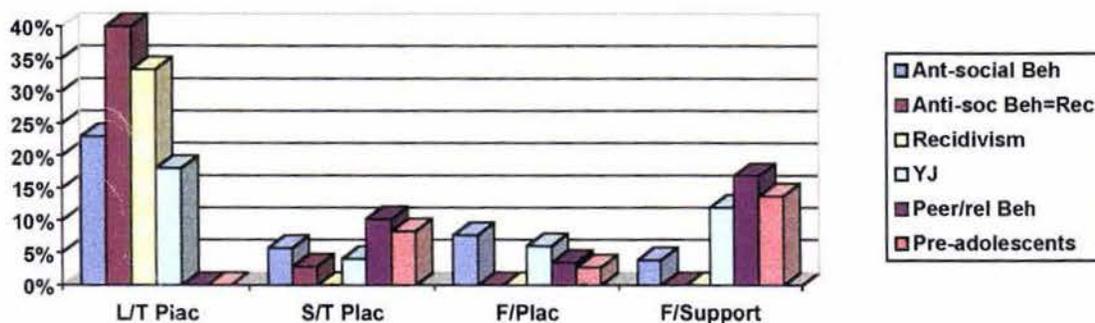


Figure 8. Type of placements utilized by each behaviour category

Code: (L/T Plac) Long Term placement; (S/T Plac) Short Term placement; (F/Plac) Placement made within family; (F/Support) Good supportive family not requiring a placement.

Figure 8 shows that the severe antisocial and recidivist behaviour categories have less family support and a greater need for long term placements, which suggests that family support assists in mitigating risk and providing resilience as discussed in section 4.4. The costs associated with long term placements is discussed in chapter 7.

6.7 Summary

This has been a feasible study, because it has been cost efficient and has highlighted common themes such as gender, ethnic proportions and risk factors such as family violence, multi-problem families and child abuse which appear to be associated with antisocial behaviour. The overall findings from this study have shown that about 33% of the sample presented with severe antisocial behaviour, thereby indicating the size of the problem. However, the findings were unable to demonstrate definite causal links among the variables, but did obtain an assessment of certain indicators, such as age, gender, ethnicity, number of referrals to CYPFS, level of intervention and family situation, which suggested a correlation with outcome. The importance of identifying these risk factors, indicates the need for further research, in order to ascertain effective intervention and treatment.

Chapter Seven

Discussion

The hypothesis for this study is: “Early detection of severe behaviour problems in children, coupled with appropriate intervention will, in a majority of situations, prevent anti-social behaviour patterns from becoming firmly established during the adolescent years, by which time positive change is either extremely difficult or impossible”. This is an exploratory study, using the research method of content analysis, which has attempted to explore the symptoms, causes and treatment of anti-social behaviour. The findings from this study suggests that antisocial behaviour appears to be associated with family violence, poverty, unemployment, ineffective parenting and general economic hardship. Current studies consider the cause to be linked to a combination of genetic, psychological, family and wider social and environmental factors.

7.1 Age of initial referral and early onset of problem behaviour

The literature suggests that conduct disorder commonly begins in early to middle childhood. (Loeber, Lahey & Thomas 1991) While 50% of the cases tend not to become evident until adolescence, there is a strong indication that antisocial personality disorder rarely begins without warning signs in early childhood. (Patterson 1982, Robins 1966).

Children most at risk come from families marked by a combination of factors that include insecure attachments (Karen 1994; Ainsworth 1989; Greenberg *et al* 1993) marital discord, (Offord 1982; Rutter & Giller 1983), posttraumatic stress disorder PTSD in early childhood (Perry 1996), socioeconomic stress (Offord *et al* 1986), criminal or psychopathological parental traits (West & Farrington 1973), punitive and inconsistent discipline methods (Campbell *et al* 1986, Patterson 1982), and child maltreatment which conveys messages of how negatively they are valued (McDowell 1995).

The findings from this study suggest a consistency with this literature, because it was able to demonstrate distinct differences between the first three behaviour categories and the last three, as shown in Tables 14 and 15, chapter 6. It can be seen that the age of initial referral for males with severe antisocial behaviour was much younger. Family adversity, such as family violence, multi-problem families and child abuse was evident in 50% of the first three behaviour categories identified which were severe anti-social behaviour, anti-social behaviour accompanied by recidivism and recidivist offenders, whereas family adversity was only recorded in 12.25% of the other three behaviour categories. However, it must be acknowledged that this study has been unable to determine the age of onset as this would require further research by interviewing the families involved, in order to gain further insights from retrospective family reports. This in turn would increase the validity of this research.

However, from Figure 1:114, the referral rate for males was twice as high as females for the 6 to 8 year olds and also higher in the 9 to 11 age group until early adolescence 12 – 14 age group, when both male and females were referred at similar rates, and then 15 – 17 age group, the percentage of females was considerably higher than the males. These findings, as shown in Figure 6:122, are similar to the Dunedin Study, which found that 11 and 13 year old young males continued to be twice as likely as young females, to have a disorder such as inattention-hyperactivity, anxiety and conduct disorders which were the most common problems at 11 years of age. However, the gender imbalance started to reverse after 13 years and by 15 years of age, young females in the study were more likely than boys to have a mental health disorder (McGee *et al* 1992). These findings were supported by Fergusson *et al* (1993) who found that by age 15, young females outnumbered boys in virtually all diagnostic groups, especially depression and anxiety. The main exceptions were inattention, conduct disorder and social phobia, where young males continued to be disproportionately represented. The reasons for this are unclear, Karen (1994), however reported that securely attached boys were no more assertive, or aggressive than secure girls, but he reported that insecurely attached (avoidant) boys were extremely aggressive. Insecurely attached (avoidant) females were less aggressive and were more inclined to cope with their anxiety by behaving in socially approved ways and internalised their feelings more by blaming themselves and becoming depressed.

This study is entirely consistent with the findings of Moffitt (1993) who found that problem behaviour continues with age but its frequency increases drastically during adolescence, as seen in Figure 1, and highlighted in the youth justice and adolescent/peer related behaviour categories, terming the behaviour to be “*adolescent limited*”, but there is a small group of children and young people, whose antisocial behaviour continues and is “*life course persistent*”, the causal factors for this group can be determined from their early childhood experiences. The majority of young people (55%) within this study fell into the adolescent limited behaviour category, while 16.3% were recidivist offenders and 17% presented with ongoing antisocial behaviour, however, because this study will not be tracking these young people into adulthood, it is difficult to ascertain if these latter groups will continue into the life-course persistent category.

Moffitt (1990) also looked at how ADD (Attention Deficit Disorder) relates to juvenile delinquency. In her study of N.Z. children aged 3 – 15, she found that delinquent boys who were also ADD fared the worst in family adversity, verbal intelligence, reading and their antisocial behaviour began before school age and persisted into adolescence. She predicted that this group were more likely to continue their criminal behaviour past the adolescent period.

7.2 Ethnicity

There was an over-representation of Maori within this sample, 29.4% compared with a Maori population of only 13.7% in Waitakere, West Auckland community. It has been noted on page 131 of this study, that these same trends are consistent with education, unemployment and health. There were a disproportionate number of Maori who were recidivist offenders 46.7% Maori compared with 40% European, this study is consistent with the findings of Maxwell and Morris (1993) who found the recidivist offenders were more likely to be Maori. The representation of Maori females, overall was much higher than Maori males and certainly much higher in relation to Europeans than the males, as highlighted in Table 4:117, and Maori females had the highest

percentage representation in the youth justice (without recidivism) group. The reason as to why Maori females (ahead of Maori males and other females in general), are more vulnerable as they enter adolescence is unclear, for this study it may be indicative of the recording system during the early 1990s, where workers tended to classify non-Europeans as Maori. Further research is required in order to ascertain if this has continued to be the trend within CYPFS.

7.3 Social work intervention

It was difficult to determine the level of social work intervention with any degree of accuracy, because of the following:

- there was no access to paper based files
- inconsistent and limited case note recording
- official case notes were not intended for research purposes.

However, it was relatively easy to judge the referral and re-referral rate, because most of the additional notifications were electronically entered under a new output, but it was less easy to ascertain if social work intervention had occurred between the opening of a new (investigation and assessment) output and its closure, when there were no electronically recorded case-notes entered under the output. It was therefore concluded, for the purpose of this study, that the absence of case notes, indicated limited or no social work input.

7.3.1 Re-referral rate and number of FGCs:

The average re-referral rate and number of FGCs for each behaviour category was (commencing from the highest):

1. Severe antisocial behaviour accompanied by recidivism, on average recorded 5 referrals and 2.8 FGCs for each case.
2. Recidivist offenders, on average recorded 3.8 referrals and 2.6 FGCs for each case.
3. Severe antisocial behaviour, on average recorded 3.2 referrals and 0.61 FGCs for each case.
4. Youth justice (without recidivism) on average recorded 2.2 referrals and 0.64

FGCs for each case.

5. Pre-adolescent group, on average recorded 1.4 referrals and 0.08 FGCs for each case. Immediate social work intervention featured in 36% of the cases with an apparent good outcome.
6. Adolescent / Peer related behaviours, on average recorded 1.3 referrals and 0.06 FGCs for each case.

These findings are summarised in Figure 7:138. It clearly shows a correlation between the number of FGCs and the degree of youth offending, as young people who were known to care and protection but not youth justice received very few FGCs in comparison. The purpose of FGCs within care and protection is to ensure the safety of the child or young person consequently, because problem behaviour is not frequently deemed a safety issue, an FGC is very rarely considered necessary. The purpose of FGCs within the youth justice system, is to provide a forum which is deemed to be more effective than the court proceedings, because it allows the wider family/whanau, the victim and the community a more direct say in the process of dealing with the young offender. The aim is to prevent further offending, by addressing retribution procedures and any underlying family / personal problems which may be contributing to the offending. However, within this study, there was little evidence that the FGCs prevented further offending, which resulted in ongoing referrals. The findings from this research found that:

1. FGCs were overall, poorly attended by wider family. This was measured by the documentation entered on SWis regarding the number of family members attending a particular FGC. The reasons of which were unclear, but could have been due to the fact they were not informed, lack of funding prevented them from attending or an unwillingness from families to become involved.
2. Plans which were formulated at the FGC were frequently not followed through with or evaluated, through a review process, in order to determine their effectiveness.
3. There were a high percentage of Maori within the three groups where offending

behaviour was a feature. There were 34.3% Maori for the severe antisocial behaviour accompanied by recidivism group, 46.7% for recidivist offenders and 34% for youth justice, as highlighted in Tables 9, 10, and 11. Any genuine attempt to reduce youth crime must start with the realisation that changes are also needed to the economic and social structures of our society, including the criminal justice system, in order to enhance, empower, strengthen and promote family / whanau life. The success of the CYP&F Act 1989 and traditional Maori practice shows that a system of restorative justice offers much more to whanau and society than does a punitive and retributive one. However, there did not appear to be any indication of a commitment to this type of practice.

4. The findings of this study showed that a large FGC, attended by many family/whanau members, only occurred when the offending pattern had already become well established, rather than at the time of the first FGC. Further research is required in this area and comparisons made with cases where a large and comprehensive FGC was held initially, in order to determine whether a better outcome is achieved.
5. Ongoing funding cuts have undermined the FGC process. Maxwell (1994), found the resources available for FGCs have been diminished by a factor of nearly four since the first year of operation. This in turn has impacted upon all the underlying principles of the CYP&F Act 1989 and most of all it has failed its obligations which were promised to whanau, hapu and iwi, for our Maori children.

There is a need for further ongoing research around the implementation and process of FGCs. One way of assessing and evaluating the effectiveness of the FGC process, would be to use a randomised sample and a control group for children and young people from high-risk families, who presented with problem behaviour under care and protection, before any evidence of offending behaviour. The randomised sample would receive a timely intervention, involving an FGC, consisting of as many family/whanau members as possible, where as the control group would receive an intervention consistent with current practice. These cases would require an assessment three to four years later in order to evaluate the outcome.

7.3.2 Identified risk factors and family adversity

The findings from this study as shown in Table 14:135, shows that family adversity such as family violence, families with multiple problems and child abuse featured in 77 or 24.8% of the total sample.

Family violence: featured in 31 cases and the overall trend from this study, showed that children and young people, who were exposed to and/or were victims of family/domestic violence presented with more severe problem behaviour and/or recidivism. In fact, recorded documentation relating to family violence, was three times higher in the severe antisocial and/or recidivism categories, than in the other 3 behavioural categories.

Witnessing family violence may be as traumatic to children as being direct victims of abuse. Both result in similar psychological and developmental effects and many studies demonstrated that violence observed by children increases the risk that they will react violently later in life. (Wright *et al* 1997; Zuckerman *et al* 1995; Hughes 1988; Egeland *et al* 1988; Perry 1996).

Overall, the impact of violence on children's lives, is potentially very damaging, frequently resulting in behavioural and emotional problems (Shepherd 1995).

The following statistics indicate the scale of family violence in New Zealand:

- 40% of all homicides between 1988 and 1993 resulted from domestic disputes and a further 4% from child abuse, according to Police statistics;
- 12 children were victims of homicide at the hands of their parents or step-parents during 1994;
- in 1994/5 the Department of Social Welfare dealt with 24,290 child protection notifications;
- 8,763 women and their 12,130 children sought assistance from women's refuge in the 12 month period from July 1994 to June 1995;
- in 1994/5 there were 9,959 reports of male assault against females made to the

police an increase of 17.5% over the previous year. Overseas estimates suggest that only 10% of all domestic violence is ever reported to the police (DSW Family Violence Unit 1996:4).

This study is consistent with the research on the detrimental effects family violence has on children. James (1994) highlights that babies, toddlers and pre-schoolers are potentially extremely vulnerable to harm caused through domestic violence due to their limited cognitive ability and resource for adaptation and confirms that children from domestic violence family backgrounds have significantly more behavioural problems and lower social competence than children from non-violent backgrounds.

Children who witness their mother being abused by their father or mother's partner frequently experience PTSD the symptoms of which include, re-experiencing the trauma (nightmares, intrusive thoughts/images, flashbacks), fear, anxiety, tension and hypervigilance, irritability and outbursts of anger and aggression, and efforts to avoid being reminded of the abuse (Perry 1996). These children frequently have a greater risk of behaviour problems, such as aggression with peers, non-compliance with adults, destructive behaviour and conflict with the law (Hughes 1988).

The findings on family/domestic violence, from this study, are far from conclusive, due to the limited detail recorded in the case notes on the overall family situation. However, it is worth noting the distinctive differences between the high incidence of family/domestic violence within Maori and Pacific Island families compared to European families. (**NB** No comment will be made about the Asian families, due to the small sample size, except to say, ethnic minority groups are not well represented or supported within the New Zealand community, especially refugees, who have problems with resettlement, housing, language, health, coping with loss and grief, employment and gender equality).

Addressing these issues within CYPFS has been a very long process, in fact it has never really gone beyond the concept of "cultural sensitivity". Prior to the introduction of the CYP&F Act 1989, there was a ground swell of "cultural awareness" where the issues of disempowerment, discrimination for Maori were being

discussed and challenged. Then during the 1990s CYPFS moved into the “cultural sensitivity stage”, where workers were sensitive to the appropriate greetings and involvement of wider whanau in the decision making process for their children and young people who were referred to CYPFS. However, it has remained in this phase and has never moved on to the ultimate of “cultural safety” which addresses the power dynamics within New Zealand society and the total recognition that Maori are the tangata whenua and all Governments have an obligation to relate to Maori in the spirit of true partnership and adequate resourcing, under the rights guaranteed in the Treaty of Waitangi.

In the context of family violence it must be acknowledged that:

- Maori women and their children are the most at risk group
- Recognising the link between the colonisation of Maori people and family violence
- Maori self-determination in seeking their own solutions.
- Tauwiwi acknowledging that individual cultural and institutional racism which is inherent in New Zealand, supports family violence perpetrated against Maori women and their children (DSW: An interagency response to Family Violence: 1996).

Incidents of family violence were recorded in 11.25% of lone parent families and 18.3% of two parent families including step-parents. Since there was a higher incidence of family/domestic violence within two parent families, the evidence may suggest that women stay in violent relationships because there are too many obstacles which prevent them from leaving a violent partner, particularly when there are children.

Women are often rendered powerless because they are made feel guilty for breaking up the family and they are made to feel responsible for the violence. This ideology combined with an inadequate income or housing, means many women feel a failure if they acknowledge their situation and seek help.

It is important for women to be educated to break their cycle of silence as evidence indicates that children whose mothers cope especially well, leave the violent

relationship and have strong social supports will fare better than children who continue to remain in an unprotected hostile environment (Jaffe, Wolfe, Wilson 1990).

Multiple problem families: this study found an over representation of lone parent families who had multiple problems, as shown in Table 16:137, this is not surprising given that economic hardship is unquestionably linked with multi-problem families. The overall trend, showed that children and young people, who came from multi-problem families presented with more severe problem behaviour and/or recidivism. In fact, recorded documentation relating to multi-problem families, was seven times higher in the severe antisocial and/or recidivism categories, than as in the other 3 behavioural categories.

Multi problem families are usually associated with many components which are commonly linked with social and economic disadvantage. These underlying risk factors which have a cumulative effect include:

- prolonged low income
- long term unemployment
- poor housing and poor isolated neighbourhoods
- transient, mobile lifestyles
- drug alcohol abuse
- family breakdown, unsupported parents
- low educational attainment
- ineffective and inconsistent parenting, poor bonding and attachment
- psychiatric illness (Kazdin 1995; Dumas & Wahler 1983; Patterson *et al* 1991; Goleman 1996, as outlined in section 4.3.3)

Children in around 5 percent of New Zealand families (about 25,000 families) are estimated to be at high risk, with children in another 45 percent of families at some risk, given further adverse circumstances (Fergusson *et al* 1990). It was found that these children were at higher risk of substance abuse, youth suicide, teenage pregnancies and delinquency.

There have been many studies which have reported that exposure to family change and parental separation during childhood is associated with increased risks of adolescent problem behaviour (Fergusson *et al* 1993; Henry *et al* 1993; Rodgers and Pryor 1998).

Research findings for children from single parent and step-families suggest a number of ways in which they do not fare as well as those from intact families. Studies demonstrated that adolescents in particular, were more likely than adolescents from two parent families, to be engaged in antisocial and criminal activities. (Henry *et al.*, 1993).

A recent study by Rodgers and Pryor (1998) on children from separated families found that these children had a higher probability of:

- being in poverty and poor housing
- being poorer when they are adults
- behavioural problems, including bedwetting, withdrawn behaviour, aggression, delinquency and other antisocial behaviour, due to family conflict before, during and after separation
- performing less well in school
- leaving home and school when young
- becoming sexually active, pregnant or a parent at an early age
- depressive symptoms, high levels of smoking, drinking and drug use during adolescence and adulthood
- multiple changes in family structure increase the probability of poor outcomes.

In this study, however, the results were not quite so conclusive for single parent families. For multi-problem families the connection with lone parents is consistent with the above literature, but with family violence, the children and young people fared worse in the two parent families, which suggests, the association is with adverse family backgrounds rather than lone or separated families.

Coleman and Ganong (1990) and Fergusson *et al* (1993) found that parental separation in the absence of other social and contextual factors, is unlikely to be an event that

increases risks of adolescent psychopathology markedly. According to Fergusson *et al* (1993), these considerations suggest there may be considerable value in reducing the emphasis on parental separation as a cause of adolescent psychopathology and replacing this emphasis with a more general perspective involving social and contextual factors including family social background, parental substance abuse, parental values and parental conflicts that may give rise to increased risk of psychopathology in adolescents.

A few recent, process-focused studies provide direct evidence that an increase in harsh, punitive, and inconsistent discipline, parental hostility and parent-child conflict in response to elevated levels of psychological distress in parents is one of the pathways by which poverty adversely and indirectly affects children's socio-emotional functioning (McLoyd, 1995).

Further research, within CYPFS, would be necessary in order to determine the cause and effect of economic hardship on outcomes for children and young people, because this has implications for further generations, given the increase in economic hardship within New Zealand.

Child Abuse: Overall there were 22 documented incidents of child abuse (8 sexual, 5 physical, and 9 emotional abuse cases), representing 7.2% of the entire study. The reason these cases were recorded under the 'problem behaviour' category was because the child or young person first presented with behavioural indicators, before a disclosure of child abuse was made. This sample, therefore is not an accurate representation of the child abuse cases reported to CYPFS, which nationally is estimated to be 20 per day (New Zealand Herald 27 June, 1998).

Children and young people who have been victims of abuse are, according to Fergusson *et al* (1997), three times more likely than non-abused children to engage in violent behaviour, criminal offending, attempted suicide and experience anxiety disorders, during adolescence, if they have been physically abused or maltreated. If they had been sexually abused Fergusson *et al* (1996) found that victims had higher rates of major depression, anxiety disorder, conduct disorder, substance abuse, suicidal

behaviours and psychiatric disorders, than non-abused young people.

This study appears to be consistent with these findings (Table 14:135), as 14 out of the 22 children or young people who were reported to be victims of child abuse were categorised as having severe antisocial behaviour and/ or recidivism. However, this sample is too small for these results to be considered conclusive and further research would be required to assess the outcomes for children and young people who were referred to CYPFS under the categories of child abuse and neglect.

However, it is worth noting here, that all children and young people who have been subjected to sexual and physical abuse, neglect, insecure parental attachment, and family violence, have all been exposed to a form of emotional abuse and yet this is the most consistently overlooked area of concern within CYPFS. The main reason for this is because children and young people find it difficult to acknowledge and describe their emotional experiences and usually there are no physical signs other than behavioural indicators to alert professionals to the possibility of emotional abuse.

It is important, therefore, for professionals to understand and identify the risk factors associated with all forms of abuse. Fergusson *et al* (1997) have identified a wide range of factors associated with children being at increased risk of child abuse, highlighting the importance of social and family determinants, such as:

- single parent families
- children of young mothers
- children who experience more than two changes of parents or parent figures, up to age 15.
- high levels of parental conflict
- parents who have a history of criminal offending and substance abuse problems
- economically disadvantaged families
- experience childhood adversity and disadvantage (eg. low level of pre-school education, low participation in preventative health care)
- exposed to childhood sexual abuse
- poor parental attachment

- frequent or severe physical punishments.

Other detrimental findings for the children and young people within this sample were:

Drug and Alcohol Abuse: Most adolescents at some stage of their development, experiment with drugs and alcohol. This study indicated that the most common concerns were relating to relationship difficulties between parent and adolescent, especially over the confrontation of drug and alcohol use. However, this study only focused on the drug and alcohol use which was documented as dysfunctional and hazardous to the young person concerned, which represented 3.9% of the overall study. The greatest association with severe drug and alcohol use was among the recidivists (13.3%) and the severe anti-social behaviour group (7.7%). All of these young people had a recorded entry indicating they had engaged in drug and alcohol abuse before age 15. This is consistent with the literature which suggests that *“childhood conduct disorder is a major forerunner to problems with adolescent alcohol and drug use”* (McDowell and Ziginskis 1994:48). This is also supported by Fergusson *et al* (1993) who found that young people involved in the Christchurch study with a history of major conduct problems were 2.8 times more likely to use cannabis before they were 15 years old than children with no history of conduct disorder.

Sexual Offenders: In the cases covered by this study, there were 7 documented sexual offenders, which was an unexpected finding, it was worth noting because of the similarities with other studies. They were all male, representing 3.7% of the males within this study, their average age was 13.8 years. This age is consistent with other research (Ryan 1996; Svensson 1998), where the average age of young sexual offenders was found to be about 14 years. However, this sample is not a true reflection of adolescent sexual offenders, because most notifications of this nature would be categorised under abuse. This therefore is just the tip of the iceberg, which is of concern due to the lack of preventive programmes available within New Zealand.

Suicide: More than 150 young people within New Zealand commit suicide each year,

one of the highest rates among the Western countries. In New Zealand, suicide is the second most common form of death for young people, however, much of the support for these young people is provided by professionals who have not had the opportunity to undergo extensive training in mental health (McDowell & Ziginskas 1994). A recent Auckland study found that 19% of young people had considered taking their own lives and 8% said they had made at least one suicide attempt (Coggan *et al* 1995).

Hollis (1995) found from his studies, that while there is good evidence to support a strong relationship between depression and suicidal behaviour, interpretation of this relationship is complicated by the issue of comorbidity. He therefore discovered:

1. **Depression and conduct symptoms:** The depression-specific analyses showed that conduct symptoms are most strongly associated with the risk of suicidal behaviour in non-depressed cases, that is when conduct symptoms occur together with depression, the risk of suicidal behaviour tends to be reduced, this was also found by Harrington *et al* (1994).
2. **Family Relationship Disturbance:** Hollis (1995), confirmed the association between disturbed family relationships and suicidal behaviour which had been reported in previous studies by Adams *et al* (1994). The possible reasons for this link may be due to lack of family support and poor parent/child relationships, coupled with family discord/violence, resulting in limited opportunities of developing a secure inner-self and/or learning social problem solving skills.
3. **Gender, Depression and Suicidal Behaviour:** Hollis found no gender difference in the risk of suicidal behaviour within a depressed sample. However, this is less clear among non-depressed adolescents. Data published by the World health Organisation (WHO) in 1994, illustrates New Zealand had the highest rate of male youth suicide (15-24 years) amongst the 16 compared countries, while the female rate for the same age group was third highest. Young men are many times more likely to die by suicide (excluding vehicle accidents which are unknown), than young women and this may be a reflection of the methods they use. However, it

has been noted from CYPFS death reviews of young people known to the service, that an increasing number of young women are resorting to similar methods such as hanging and that numbers of young Maori female suicides have increased (DSW 1997).

This study reflects these associations and findings. There were six recorded deaths by suicide, representing 1.9% of the overall study. However, 5 or 83% were from the Severe antisocial behaviour /recidivism groups. There were two females who were both Maori and four males two of whom were Maori

Maori	4	4.4% of entire study
European	2	1.4% of entire study
Males	4	2.1% of entire study
Females	2	1.7% of entire study
Maori females	2	5.1% of entire study
Maori males	2	3.8% of entire study
Euro males	2	2.0% of entire study

The findings from this study regarding suicide rates for Maori females and males are consistent with the national trends. However, the sample of suicide rates within this study were not anticipated outcomes and are very small, with no clear indications of cause and effect, due to insufficient detail and recorded information. Further research is required in this area in order to determine the cause and ascertain the risk factors which are contributing to these figures. One explanation to the rapid increase in suicide rates within New Zealand over the past ten years could be connected to the increased poverty and hardship and limited resources within social welfare and mental health services.

Holinger *et al* (1994) studied a number of economic variables (e.g. unemployment) and related them to Offer Self Image Questionnaire (OSIQ) in thousands of adolescents in 9 of 10 countries, Australia, Bangladesh, Hungary, Israel, Italy, Japan (no figures provided for younger age group), Taiwan, Turkey, United States of America, and West Germany. He discovered:

- The gross national product of countries showed positive correlations with

the emotional tone and social relationship scales.

- Per-capita income correlated positively with the body and self image and sexual attitude scales.
- Educational expenditure per-capita showed significant correlations with the social relationships and psychopathology scales. (i.e. the higher the educational expenditure the lower the reported problems).

These results support (Brenner's 1979) work and suggests that in a variety of countries, economic variables are associated not only with mortality but also with a wide range of psychopathology and adolescents' 'feelings about themselves'. This would require further investigation, and research, however, it is an area of real concern requiring more training and resources within the mental health sector.

7.3.3 Level of social work intervention

As a whole, care and protection social workers have been reluctant to accept difficult adolescents because:

1. Most care and protection social workers within CYPFS have large case loads mainly consisting of children who are vulnerable and have been abused. Adolescents and children with problem behaviour are assessed as being less vulnerable, therefore receive a low priority.
2. If a young person is involved with youth justice, responsibility for the care and social issues relating to the young person is often seen as the 'role of the other', resulting in issues being left unattended.
3. Difficult young people are very time consuming due to the nature of their behaviour, running away, constantly trying to find new placements. In general there are a lack of appropriate resources. Most foster families are unhappy about taking in children and young people with challenging behaviours because of the potential risks to other children and limited access to appropriate training and supports. If a child or young person is deemed to have a psychiatric disorder there is often a difficulty in engaging mental health services due to under-resourcing.
4. Overall children and young people with challenging behaviours are not viewed as a safety issue this is mainly because most of the training for social workers, within

CYPFS, focuses on risk factors and indicators of child abuse, with very limited training on the importance of parent/child attachment/bonding, the effects of trauma on the developing brain, or on the assessment of risk and protective factors associated with anti-social behaviour. The current risk estimation assessment, which CYPFS is using, tends to centre on the immediate safety of the child or young person and the prioritization of cases. This type of assessment precludes cases where there is high risk of maltreatment but no physical manifestation or admission of abuse, nor does it assess the long term effects of insecure parent / child attachments.

Data taken from the findings outlined in chapter 6 of this study show that a recorded social work intervention which included a comprehensive family assessment, a clear identification of the issues, a plan of action and a follow-up review, occurred in 45 or 14.7% of the total sample, at the time of the first referral and in 30 or 9.8% of the cases, at the time of the second or third notification. There appeared to be a good outcome and resolution for these 75 cases, measured by the fact there were no further notifications.

Conversely cases which did not receive a social work intervention until the fourth or fifth notification, by which time it seemed likely the problem had intensified, totalled 70 or 22.9% of the total sample. Overall the outcomes for these cases were poor, measured by ongoing aggressive antisocial behaviour, truancy, continual running away and change of placements, parents unable to cope and ongoing recidivism.

Of the 306 cases 19 or 6.2% of the total sample were still ongoing, most of which had been referred about three times prior to an intervention from a social worker. The remaining 142 or 46.4% of the total sample, had only one referral and appeared resolved without an apparent social work intervention. Overall there was insufficient recorded information for this group and the age of most of these cases fell into the 14 to 17 year old category.

Because there are many unrecorded independent variables which are associated with outcome such as the protective factors within a family, it is difficult to say with

certainty that an early and timely intervention prevented ongoing problems and conversely there is no way of accounting whether an early intervention would have been effective in the cases where there were major ongoing problems. However, there is a suggestion that early intervention did effect a good outcome and there is compelling evidence within the literature, suggesting that treatment is found to be more advantageous and beneficial to families than no treatment at all (Kazdin 1997).

The literature also indicates that aggressive antisocial behaviour crystallises at approximately 8 or 9 years of age, therefore, interventions aiming to reduce this type of behaviour, should focus on “at risk” children before this developmental period and preventative intervention and programmes need to focus on the characteristics known to increase the risk of CD such as family discord, violence, insecure attachments and coercive parent-child interactions (Church 1994; Offord 1989; Ainsworth 1989; Perry 1996).

It is worth noting a distinct finding from this study, that young people whose first referral was at age 14½ - 17 were less at risk of developing further ongoing antisocial problems, consistent with the findings of Moffit (1993).

7.3.4 Prevention

This study appears to be consistent with the substantiated findings of Moffitt (1993), Farrington (1991), Karen (1994), McCord (1991), Tremblay *et al* (1994) and Eron (1990), that entrenched disruptive behaviour patterns during the early childhood years are more likely to increase the risk for later antisocial behaviours.

This study also seems to support the literature, that children most ‘at risk’ come from families marked by a combination of biological, family, social and contextual factors, as outlined in Chapter 5 of this study under identification of ‘at risk’ children.

According to Sanders and Markie-Dadds (1995) the prevalence of conduct disorder has increased over recent years, making it one of the most frequent diagnoses in the mental health services for children. However, many programmes and interventions have been unsuccessful in the treatment of severe antisocial behaviour, mainly because

social service agencies have only responded or families have only sought assistance, when the child's problem behaviour has become severe and long standing (Kazdin 1987). Other obstacles precluding successful intervention include high levels of attrition and failure to sustain treatment gains, particularly in families characterised by marital discord, parental depression, poverty and lack of social support (Kazdin 1997). As a result, the long term personal, family and social costs have been substantial.

The success of preventative programmes, therefore, depends on identifying risk factors early in a child's life, risks which have been clearly identified in Chapter 5 of this study.

According to Offord and Bennett (1994), primary and secondary prevention for conduct disorder and antisocial behaviour must begin in very early childhood and continue through adolescence and beyond. *"It is unlikely that a time limited intervention offered at one point in a child's life will permanently eliminate existing undesirable behaviours and/or protect against subsequent developmental or life stresses that occur after the intervention has ended"* (Offord & Bennett, 1994:1076).

Many early intervention programmes show promise, but the most promising to date is multisystemic therapy (outlined in detail in chapter 5). The multisystemic approach is based on an ecological concept that a child is embedded in a number of systems including, immediate family, extended family, peers, school, neighbourhood and wider community and society. Consequently, this form of treatment, can be viewed as a package of interventions that are constructed with children and their families.

A multisystemic approach combined with the new CYPFS Family Start Programme designed to identify early risk indicators, and ongoing longitudinal research that tests well defined causal pathways in relation to well defined outcomes may, in fact, prevent severe antisocial behaviours from occurring.

7.4 Placements and family support

As highlighted on page 156 of this study, there were a total of 74 or 24.2% children and young people who required a placement outside the immediate family. 40 of these were long term placements and 29 of these were placements in NRU Northern Residential Unit or Youth Horizon Trust at an approximate cost of \$400 or more a day or \$146,000.00 a year per young person. This estimated cost, however does not take into account the cost of the hours of social work investment required in these cases or the social, family and community costs, especially associated with the crimes committed by these young people. The remaining 11 requiring long term residential care were placed in community funded placements costing around \$140 per night or about \$51,000 per year per person. The overall costs per year for 40 young people would be approximately \$5 million for residential services only. It is anticipated that this could be a conservative figure, because placement details were only recorded on 74 or 24.2% of the cases, including short-term and family placements.

Of the 74 recorded placements, 40 or 54% were long term costly placements, 21 or 28.4% were short term placements and 13 or 17.6 % were placements with wider family. These figures cannot be considered conclusive, but they do highlight the problems in the monetarists economic policy which seeks to reduce public expenditure on the premise that surplus capital will be freed up, enabling families to take responsibility for their children. As previously discussed, at the time of and prior to the introduction of the CYP&F Act 1989, the Department of Social Welfare set about closing residential institutions and family homes. Policy makers implied that with the closing of many Department of Social Welfare Institutions, the projected savings would be invested in community-based care and family resourcing in order to promote the policy of minimal state intervention and the concept that all children should be supported at home or in the community. However, within a year of the introduction of the CYP&F Act 1989, Government reduced welfare benefits to single parent families as well as the unemployment benefit by 20 percent, while at the same time promoting user pays for health care and education. The situation now is that families are left to take the responsibilities without any of the resources that would have been provided in full if a young person was in a Department of Social Welfare Institution.

It has now become a reality that many families with difficult children are unable to provide the necessary care required and the community, due to limited funds, is unable to provide the intensive multi-level programmes required to address effectively the severe anti-social behaviour problems being displayed by many children and young people. The fact is, it costs a great deal to empower families to care for children with challenging behaviours. Knapp (1985), from the University of Kent in England found that community care options are likely to be cheaper and more effective for the less difficult children, however, policy makers must take account of the way that service options become more expensive if they are to be effective with the most difficult children. As a result, the costs of not providing specialist child and family services escalate into the longer-term cost equations that appear in our national budget for institutional beds in mental hospitals or prisons. Child and family policies formulated with a preoccupation for accountancy costs and short-term solutions all too easily result in longer term problems and costs which exceed our wildest expectations (Fulcher 1991).

Minimal state intervention and funding starvation has been a national problem throughout the social services in New Zealand over recent years. This is especially so within CYPFS, which has had a huge impact upon service delivery, in particular, the implementation of the basic principles of the CYP&F Act 1989, which advocates that extended family/whanau networks should be, empowered, resourced and supported to look after their own children and make decisions affecting their futures. This process is usually facilitated through a FGC, a process deemed to have a positive outcome and assist families to care for their own children. However, ongoing funding cuts have undermined this process, Maxwell (1994) found the resources available to FGC's have been diminished by a factor of nearly four since the first year of operation, this in turn has impacted upon all the underlying principles of the CYP&F Act 1989, and most of all it has failed in the obligations which were promised to whanau, hapu and iwi for our Maori children. This study appears to reflect these factors, especially in the first three behaviour categories (n=102), where family placements and family support only featured in 5 or 4.9% and 2 or 1.9% cases respectively.

7.5 Limitations

There were many variables and obstacles which impinged upon this study and highlighted areas for further ongoing research. Limitations of this study were as follows:

1. Sample size. The initial sample was 536, however 179 of these cases were invalid because they were entered under 'problem behaviour miscellaneous', which meant these cases could not be categorised. A further 51 had insufficient information, as a result the sample size was reduced to 306. With such a larger proportion excluded from the study, this may have lead to problems around bias.
2. It was difficult to classify a benchmark for the success of interventions due to the limited information recorded on the CYPFS social work computerised system (SWis). Although, re-referred cases were examined closely in order to determine common themes, it was not possible, without accessing the client's paper-based file, or directly discussing with the client or social worker involved, to ascertain the accuracy of this information. Ongoing research, therefore, would require, at least, access to previous paper-based files.
3. There was a major problem in obtaining data regarding the overall family situation such as, family violence, the age of the parents, parental status, family/whanau support and other factors including drug/alcohol, sexual, physical or emotional abuse, because there was no consistent level of recording. The level of social work documentation, during the early 1990s was very poor, mainly due to the new concept of computerised recording and most social workers at that time had limited keyboard skills, were not computer literate and demonstrated a definite reluctance to move from a paper-based filing and recording system. Ongoing research may benefit from access to paper-based files, although inconsistent documentation might continue to be a problem.
4. Determining age of initial referral and onset of problem behaviour was considered a major problem. The review of the literature concluded that a

great majority of children who are at risk through behaviour problems are considered to be at risk prior to entering school and can be identified from the age of 4 or 5 years onward. This aspect was difficult to establish because many of the cases which were transferred on to the computer system during 1990 did not record the date of the first referral to DSW or the age of onset of the problem behaviour. Consequently the age of onset identified in this study is conceivably inaccurate and would benefit greatly by accessing the previous paper based files. The age, referred to in this study is obtained by subtracting the client date of birth away from the first recorded computer entry.

5. The method of content analysis used in this study is purely descriptive and is a useful technique for these purposes, but it cannot establish causal relationships among variables. This study, therefore, did not attempt to address causal links between variables, as this was not possible because of the method used and the problems outlined above.
6. Category changes as outlined in chapter 6. From 1990 - 1997, there have been various changes in the categories for notifications, old categories have been phased out and new ones introduced. During the period from 1990 - 1995, most CYPFS site offices within Auckland, had rostered duty intake workers and this frequently resulted in inconsistent information gathering and categorisation of notifications. As a consequence, children and young people who were perceived as having problem behaviour, could have been placed in one of three categories, depending on the immediate complaint. These included: problem behaviour or child, young person leaving home or relationship difficulties (which referred to either parent/child or between parents). For this study it was decided to focus on problem behaviour as it was hoped this category would capture majority of the cases. However, it must be acknowledged that there could be a number of cases overlooked due to this factor. The category variation and changes have also precluded, a year by year comparison to ascertain whether there has been an increase or decrease in 'problem behaviour' notifications, in connection with

changes in CYPFS threshold levels and classification of priority, in response to increased number of intakes and shrinking resources.

7. This study did not combine the official computerised case records, with retrospective family reports, because of time and financial constraints and issues relating to confidentiality and the process of tracking the family. This, however, decreased the validity of the research because retrospective family reports would have assisted in confirming the accuracy of the findings in relation to intervention and outcome.

7.6 Conclusion

Overall this study has highlighted the social costs and the environmental, psychological, family and genetic factors associated with antisocial behaviour. It has also illustrated the need for further ongoing research, specifically in the area of identifying the needs of families, particularly the empowerment needs of Maori, and prevention and early intervention programmes for children who are at risk of developing conduct disorder. This study, has not been able to conclusively demonstrate a direct correlation between early intervention and the mitigation of antisocial behaviour because of the limitations outlined above. However, the findings do suggest that families who received a timely intervention appeared to fare better than families who received little or no immediate intervention. A review of the literature strongly suggests that the only effective way of preventing the development of conduct disorder is by early intervention which identifies the risk and protective factors, followed by appropriate treatment, which could include a process such as a FGC, in order to inform the entire family about the issues, establish the need for change, offer resources and review the progress. The main aversive family situations impinging on antisocial behaviour identified in this study were families who had multiple problems, experienced family violence and child abuse. Poverty also appeared to be a contributing factor, thereby highlighting a need to minimise economic hardship and promote strong caring relationships between parent and child, family and community and the *“far-reaching value of an ecological intervention model of parent*

education and support, and developmental and behavioural remediation of the very young maltreated child" (Moore *et al* 1998:14).

7.7 Recommendations

1. Education: In conjunction with the current education programmes organized by CYPFS, education programmes should be introduced, during ante-natal classes for prospective parents, about the importance of secure attachments and bonding between parent/s and child and about the detrimental effects family violence and other extreme traumatic events, has on the developing brain.
2. Family Start, a new initiative by CYPFS outlined in chapter 5. The staff involved in supporting 'at risk' children and families, should be fully trained in identifying the risk indicators associated with the development of behaviour and have the skills required to empower and process positive change within the family setting.
3. Preventative Intervention: CYPFS needs to acknowledge the importance of early preventative intervention and make provisions for increasing the resources for social workers especially in the area of training on the identification of risk and protective factors and effective levels of intervention. Research into treatment has shown the importance of targeting specific interventions for specific problems, in an ordered sequence where there are multiple problems. Action could include both direct intervention work, behavioural work, parent-skill classes, as well as material aid and other supportive services designed to alleviate stress and poverty. It might include individual or family work to improve relationships and attachment. Thus it can be seen how this general model of change can accommodate a range of different interventions as long as the intervention is matched to where the client is up to (Morrison 1996).
4. A thorough family assessment designed to identify the above factors followed by the FGC process or an extended family group meeting should be a required practice, for 'problem behaviour' notifications. This would provide a process to inform and educate the entire family/whanau of the effects detrimental environments have upon children. It would empower, assist and resource family/whanau to make decisions

regarding effective changes and it would provide a process which could review progress and hopefully prevent ongoing behaviour problems.

5. **Social Workers in Schools:** Consideration needs to be made for placing social workers in primary rather than secondary schools. The Dunedin and Christchurch longitudinal health and development studies have each tracked the age-specific prevalence of mental health disorders in samples of nearly 1000 born in the 1970s. Their studies have brought many insights toward determining the risk indicators which are likely to predict future anti-social behaviour. Moffitt and Harrington (1996), from the Dunedin study, found that 5 year old boys with hyperactivity, low IQ scores and delayed motor development were more likely than five year old boys without these features to go onto engage in anti-social behaviours, including crime, later in childhood and adolescence. By placing social workers in primary schools, early detection followed by a comprehensive family assessment, in order to determine risk and protective factors within the family and advise on an appropriate intervention.
6. **Consultation with Maori:** Consultation with the following iwi : Te Whanau O Waipareira, Ngati Whatua, Tainui, Te Aupouri and Ngapuhi around the Auckland area needs to occur, so as to share the information and findings from this study, in order for informed decisions to be made by Maori as to how they may wish to target their resources and advise policy makers on future funding requirements for their Maori children or tamariki.
7. **Ongoing Research:** The strong support for the link between childhood delinquency and future criminal activities implies that there is a need for thorough, up-to-date longitudinal studies among New Zealand offenders, in order to gain more insights into the nature and motives of their offending. Reports of anti-social behaviour should be collected from multiple sources, (not only from high risk lower socio-economic families, but also from the affluent sectors of our society), and should be assessed repeatedly from childhood to adolescents, in order to determine the factors which remain constant and assess the factors which may be less stable or predictive across time. It is unfortunate that many of the studies on antisocial behaviour are concentrated during the adolescent period, when antisocial behaviour is at its peak. This may not give an accurate picture of the future deviants of our society. In

order to understand adolescence, one must also understand the pre and post adolescent period (Moffitt, 1993).

8. **Alternative Placements:** Supporting and empowering families to care for their own children must remain the ultimate priority, however, it was found by the Paediatric Society of New Zealand (1992) during the Ministerial Review of the CYP&F Act 1989, that there are a few children, often young males between the ages of 8 - 13, who exhibit extremely difficult behaviour. The Society believed that many families are not prepared or able to cope with such behaviour and in these circumstances small community based, alternative, stable and therapeutic placements are needed. The Paediatric Society believed that it is only under these circumstances that any effective psychological work can be done with these children. Currently, finding suitable programmes and placements for this group is a problem and because of this, the most comprehensive plan inevitably breaks down, resulting in failed placements and continual moves causing ongoing disruption and instability, for the young person.

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Appendix A

- **Some One Cares:** Short to medium term care for males 13 - 17 years
- **Te Hou Ora:** Short to medium term care for females 12 - 17 years.
- **Te Whanau O Waipareira:** Provides family homes for males and females 0 - 17 years. Available additional services consist of whanau health and social services, medical clinic, dentist, adolescent education, drug and alcohol rehabilitation programmes, nutritionist and dietitian, training and employment services.
- **Barnados:** Family Action Services provide short-term foster-care for children and young people in crisis situations.
- **Kauri Trust Youth Services:** Short to long term residential care for males 12 - 17 with challenging behaviour.
- **West Auckland Family Services:** Caters for young children and provides short-term respite foster care, counseling and child management training.
- **Glenburn Centre:** Presbyterian Social Services. Provides residential and weekday school, behavioural and social skills programme, for boys and girls aged 6 -12 for about 6 to 12 weeks.
- **Youthlink Family Trust:** Provides a three stage residential, educational and counseling programme for adolescent males and females 11 - 16 years for an average period of five months.
- **Pacific Island Women's Health Project:** Provides residential care, counseling for sexual abuse and domestic violence for Pacific Island females 0 -17 and males 0- 11.

- **Stoddart House:** Anglican Trust for Women and Children. Provides a residential home and school for boys aged 7 -12 years, with a focus on behaviour modification, family therapy and family rehabilitation. The usual length of stay is two school terms.
- **Arohanui Christian Trust:** Provides family homes for males and females 12 - 17 years old, short to medium term care.
- **Dingwall Trust:** Provides short and long term residential care, social work support, boarding school, holiday programmes, counseling and therapy, for children and adolescents.
- **Odyssey House:** Provides an adolescent residential treatment programme designed for 13 - 17 year old males and females who have serious difficulties with substance abuse.
- **Open Home Foundation:** Provides short, medium and long term alternative families for children and young people, unlikely to live with their own parents or within their extended family.

The cost of these placements range from \$45.00 to \$ 140.00 per night. The more expensive residential placements accessed for clients in this study were:

- **Northern Residential Unit,** which is funded by CYPFS National Office in Wellington. This unit is mainly used by YJ and provides a secure unit for the more challenging adolescents.
- **Youth Horizons Programme:** is funded by CYPFS National and Auckland Area Offices. This service is designed to help young people between the ages of 11 and 15 who exhibit behaviour which challenges parents and teachers. It provides a four step programme for a minimum period of two years.

1. Step one or entry level lasts for about 4 months, under intensive supervision.
2. Step two lasts for about 8 to 12 months and provides a structured environment with specific personal goals.
3. Step three, lasts up to 18 months and integrates the young person into community schools and training programmes, while living in a well supervised family home.
4. Step four, the young person is re-integrated back with their family and a supportive programme is provided for the young person and the parents for 3 to 24 months

These two residential programmes cost from \$400 to \$600 per night.