

Evidence  
Based Practices for  
Conduct Disorder in  
Children and Adolescents

PROJECT LAUNCH MAY 31ST 2001

CHILDREN'S MENTAL HEALTH ONTARIO

Children's Mental Health Ontario gratefully acknowledges  
the financial support of the  
Ontario Ministry of Community and Social Services  
in the development of these materials.

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May, 2001

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# **Evidence Based Practices for Children and Adolescents with Conduct Disorder**

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## **INTRODUCTION**

This document represents the work to date of Children's Mental Health Ontario in identifying Evidence Based Practices for Children and Adolescents with Conduct Disorder. The goal of this project has been to produce up-to-date information and practical tools that would assist children's mental health professionals in their daily work with this challenging population.

This project has taken an important first step towards promoting Evidence Based Practice in the field of children's mental health in Ontario. The process has been guided by a group of dedicated, knowledgeable and creative individuals who formed the Steering Committee:

Claire Fainer, East Metro Youth Services (Chair)  
Doug Brown, Peel Children's Centre  
Karen Engel, Yorktown Child & Family Centre  
Greg Lubimiv, The Phoenix Centre for Children and Families  
Cherry Murray, Crossroads Children's Centre  
Dan Pare, Youth Services Bureau of Ottawa-Carlton  
Alex Thomson, Lynwood Hall Child and Family Centre  
Sheila Weinstock, Children's Mental Health Ontario  
Sally Wills, Child and Youth Wellness Centre of Leeds & Grenville

A very important part of this work has been to ensure that a bridge was built between research and practice. The success of this bridge building would not have been possible without the reality-based wisdom and experience of the Expert Panel and Focus Groups drawn from across Ontario. Please see Appendix 1 for a list of participants.

The Research Director, Dr. Arnold Love, and project consultants Debbie Garbe and Dr. Linda Baker, have played a major role in the development of the materials that have been produced, as well as those that are still being created. Their expertise in research and clinical practice has been critical to this work.

This project was made possible through the vision and sponsorship of the Ministry of Community and Social Services. The Ministry's support is acknowledged with gratitude.

Joanne Johnston  
Project Manager

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# SECTION 1

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Children and Adolescents with Conduct Disorder:

## **Summary of Findings**

from the Literature and Clinical Consultation in Ontario

# Children and Adolescents with Conduct Disorder: Findings from the Literature and Clinical Consultation in Ontario

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## SUMMARY

Conduct disorder (CD) is characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. Conduct disorder can be extremely challenging for parents, teachers, and mental health professionals. Clinical experience at children's mental health centres in Ontario indicates that children with early-onset conduct disorder consume the most resources and they are the most expensive clients to serve. Early identification, accurate assessment, and effective treatment are essential to reduce the burden of suffering caused by conduct disorder for children, families, and society.

### EPIDEMIOLOGY

The prevalence of conduct disorder is estimated at between 1.5% and 3.4% of the general child and adolescent population. Although only 3% to 5% of all youth with conduct disorder have onset before adolescence, these young people appear to consume the most resources in the mental health system and to be responsible for at least half of the illegal offenses committed by juveniles.

CD appears from 3 to 5 times more often in boys than girls, but the gap between boys and girls closes at adolescence. By mid-adolescence, girls surpass boys in the onset of conduct disorders. Boys more likely to exhibit aggressive behaviour and girls to commit covert offenses and prostitution, but gender differences in type of behaviour tend to disappear in the youth who are the most severely disturbed.

### CLINICAL CHARACTERISTICS

Conduct disorder involves a pattern of disturbed behaviour that causes significant impairment in social, academic, or occupational functioning. Conduct-disordered behaviours include aggression to people and animals, deliberate destruction of property (including fire-setting), stealing and lying, and truancy from school. Research shows that there are different profiles for conduct disorder based on age of onset and severity.

In **childhood-onset conduct disorder**, a combination of biological and psychosocial factors appear to interact to cause the disorder. Disruptive behaviours emerge early in childhood, usually as negative, hostile, and defiant behaviour characteristic of oppositional defiant disorder (ODD). As the child grows, there usually is an escalation to behaviours more characteristic of conduct disorder, especially lying, fighting, and stealing. These children are more likely to have attention-deficit disorder/hyperactivity disorder (ADHD), learning disabilities, and poor academic achievement. In terms of developmental progression, ADHD tends to be followed by ODD and then by conduct disorder. Children with childhood-onset conduct disorder tend to be mostly male and incidence is not strongly related to socioeconomic class or ethnic group.

In **adolescent-onset conduct disorder**, sociocultural factors, such as the influences of poverty and peer groups, appear to be largely responsible for the resulting behaviours. Youth with adolescent-onset conduct disorder usually do not have serious problems before adolescence.

During the preschool and school-age years, they tend not to show oppositional behaviour or social, academic, or community problems. Oppositional and illegal behaviour begins during adolescence and tend to take place in a group environment. Whereas childhood-onset CD involves mostly boys, girls are also involved in the adolescent-onset group. Adolescent-onset CD is likely to involve urban, poor, and minority youth. They do not have the severe learning problems, developmental disabilities, neuropsychiatric problems, or family history of antisocial behaviour demonstrated by youth with childhood-onset CD. The problem behaviours demonstrate less aggression, especially aggression aimed at others, and they tend to stop as the youth mature into adulthood.

In general, children with childhood-onset conduct disorder may be distinguished from adolescent-onset by their long history of aggression and antisocial acts such as fighting at school, truancy, stealing, early substance abuse, being taken into care, and placement breakdowns. Overall, the prognosis is good for youth with adolescent-onset CD, but less favorable for those with childhood-onset type of conduct disorder. This situation makes early identification and treatment of childhood-onset CD extremely important.

## **RISK FACTORS AND PROTECTIVE FACTORS**

Research suggests that there is a gradual accumulation of risks and interaction among risk factors that lead to CD, balanced by a parallel accumulation of protective factors. Overall, the greater the number of risk factors and earlier they appear, the higher the risk for serious conduct.

Risk factors for CD include early age of onset (pre-school and early school years), conduct problems that occur in multiple settings (home, school), frequency and intensity of conduct problems, diversity of conduct problems and covert problems (lying, firesetting, stealing) at younger ages, and family and parent characteristics. Children with conduct disorder tend to come from large, low-income, urban families led by single mothers. Fathers of conduct disordered children have a greater incidence of antisocial personality disorder and substance abuse, and they are often absent from the home. The mothers of CD children have high rates of depression, antisocial personality disorder, substance abuse and somatization disorders. Parents of children with conduct disorder tend to use corporal punishment coupled with a high rate of neglect and physical abuse.

Protective factors include higher levels of intelligence, good social skills, relaxed temperament, positive work habits in school, areas of competence outside school, and a positive relationship with an adult. Given the strong association of environmental and family factors in CD, some children and youth may adopt CD traits as a protective strategy. It is important, therefore, that clinicians consider the socioeconomic context when assessing the presence of CD.

## **ASSESSMENT**

A diagnosis of conduct disorder is made when DSM-IV-TR target symptoms are present or reported in the child's history, and other disorders have been eliminated. Target symptoms include aggressive behaviour, deliberate destruction of property, deceitfulness and theft, and serious violations of society's rules (e.g., truancy). It is important to know that DSM-IV-TR does not consider one specific criterion alone necessary for diagnosis and that any combination of three or more criteria are sufficient. The number of conduct problems and the harm they cause to others determine the severity of CD.

Since CD is a complex mental health problem affecting multiple domains of functioning and showing a high rate of comorbidity with other disorders, suspicion of CD requires a comprehensive assessment. Assessment information should be obtained from multiple sources, including the child, family, school, peers, and community. Information from these sources will help the clinician determine whether the child has conduct disorder, identify the type of conduct disorder (childhood- or adolescent-onset), determine if a psychiatric or medical problem is causing the disorder, and detect if there is an additional comorbid disorder.

## **DISORDERS COMORBID WITH CONDUCT DISORDER**

Between half and three-quarters of children who have conduct disorder also have ADHD at the same time (comorbid disorder). About half of the children with CD also have an internalizing disorder such as depression or anxiety disorder. Children with CD and comorbid depression are at higher risk of suicide than children with depression alone. They also are more likely to harm themselves without intending suicide. As many as 90% of drug abusing young offenders have CD.

## **TREATMENT**

Research and practice consensus indicates that successful treatment must address multiple domains in a coordinated manner over a period of time. Outpatient treatment of CD usually involves the child/youth, family, school and peer group. Some milder forms of CD, however, require minor intervention, usually **training for the child** (social skills, problem solving) and **training for the parents** (behaviour management, parenting skills) and **consultation to schools**. Moderate and severe CD often involve comorbid disorders that require treatment. Chronic CD, which is usually childhood-onset type, requires early intervention, extensive treatment in multiple domains and long-term follow-up.

**Pharmacotherapy** alone is not sufficient to treat conduct disorder. Although some psychiatric medications are used to treat CD youth with a comorbid disorder (e.g., antidepressants for mood and anxiety disorders, stimulants for ADHD), there is an absence of adequate efficacy studies in this area.

There is research evidence to support the effectiveness of **Cognitive Behavioural Therapy** for treating youth with CD, especially **Problem-Solving Skills Training**. These forms of therapy help to control antisocial behaviours and strengthen prosocial functioning. Although cognitive behavioural interventions and skills training appear helpful in the short-term, especially for older children and adolescents, their long-term efficacy has not been established.

**Family intervention** is an essential component for treating conduct disorder. For younger children, the family often is the primary target for intervention and a useful support for adolescent treatment, if the family is present and willing to participate. Before beginning interventions, children's mental health professionals may need to **collaborate with other systems** to ensure that there is a safe home environment, adequate housing and resources to meet basic needs, and parents' psychiatric or substance abuse issues are addressed. The overall approach for working with families is to identify and build upon the parent(s) strengths through **parent counselling, parent education, family therapy, and parent management training** programs. There are numerous studies that demonstrate the effectiveness of these programs for improving parenting skills and helping parents manage child behaviour effectively without the use of physical punishment. There also is evidence that **multi-systemic therapy** is an effective intervention for CD youth that may be delivered in family and community settings.



Children and adolescents with conduct disorder usually show poor academic achievement and may be disliked by their teachers and classmates. Faced with frustration and exclusion, the child or youth may resort to bullying and antisocial behaviour and associate with other students who are in a similar situation. Children with CD may be treated effectively in **day treatment programs**, but good follow-up and transition planning is necessary if treatment gains are to be maintained in regular classrooms. Two common school-based treatment approaches for CD children that have research support are **contingency management** and the use of **token economies** to reinforce positive behaviour and reduce negative behaviours. During the last 10 years, a number of school-based programs have been developed to address conduct problems, including **anger management, conflict resolution, social problem solving, and social skill training**. Only a few of these programs have empirical support for their ability to change problem behaviours or to maintain changes after the program ends.

Adolescent-onset CD is often associated with membership in a group of antisocial youth. To avoid conduct-disordered behavior, **peer intervention** may be necessary to remove the youth from an antisocial group and help them to develop a new peer group. Several evidence-based peer group intervention programs have proven effective. There also has been research support for **multi-systemic therapy** that treats conduct-disordered adolescents (including serious and violent offenders) in their social settings while combining family and community interventions.

## **TREATMENT SETTINGS**

Treatment of CD usually takes place in outpatient and community settings, although **residential treatment** may be indicated by severe family dysfunction, marked noncompliance, or persistent involvement with a deviant peer group. Many children with severe CD have been rejected by their families and have experienced a high level of placement breakdowns. These children are very difficult to manage outside of a residential treatment program. Although the effectiveness of different types of residential treatment have not been thoroughly tested, **treatment foster care** appears to be the preferred residential treatment option for children under 12 who commit moderate to severe offenses and require out-of-home placements. CD youth who are sexual perpetrators may need placement in a **specialized sex offenders program**.

Research supports the use of **home-based or community-based multi-systemic therapy** as an alternative to emergency psychiatric hospitalization or residential care in reducing the symptoms of youth with severe CD problems. Multisystemic therapy involves changing the multiple systems that affect the child's behaviour, including the child, family, school, peers and community. This form of therapy also appears to be effective for CD youth who have substance abuse problems. Criteria for CD usually do not justify **hospitalization** unless there are symptoms of substance abuse, self-destructive or suicidal behaviour, or homicidal or aggressive behaviour that warrant the concurrent diagnosis of ADHD, intermittent explosive disorder, mood disorder, bipolar disorder, or substance abuse disorder.

## **ADDITIONAL RESOURCES:**

See the CMHO website at <http://www.cmho.org> for the full paper "Children and Adolescents with Conduct Disorder: Findings from the Literature and Clinical Consultation in Ontario" and for links to other helpful resources regarding conduct disorder.

## SECTION 2

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Children and Adolescents with Conduct Disorder:

### **Findings**

from the Literature and Clinical Consultation in Ontario

# Children and Adolescents with Conduct Disorder: Findings from the Literature and Clinical Consultation in Ontario

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# **Children and Adolescents with Conduct Disorder: Findings from the Literature and Clinical Consultation in Ontario**

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## **1. INTRODUCTION**

Conduct disorder (CD) is characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. Conduct disorder can be extremely challenging for parents, teachers, and mental health professionals. CD also exacts a high cost in terms of personal loss for children, families, and society (Gureje and others, 1994). For example, although children with early-onset CD compose only 3% to 5% of all youth with conduct disorder, they appear to be responsible for at least half of the illegal offenses committed by juveniles. Since other disorders often occur at the same time with CD (that is, comorbid disorders such as attention-deficit disorder, substance abuse, depression), CD is difficult to treat and contributes to a high rate of treatment failures. Clinical experience in children's mental health centres in Ontario indicates that children with early-onset CD consume the most resources and they are the most expensive clients to serve.

Since their problem behaviours often first bring them into contact with the juvenile justice and education systems, children with CD often do not receive the mental health services they need in a timely manner. Furthermore, conduct disorder is one of the most difficult disorders to treat because it is complex and requires carefully designed and coordinated treatment interventions aimed at multiple areas of functioning. Considerable resources are required to properly assess and implement an effective treatment plan for children with CD, especially in Young Offender settings. Only in recent years have reliable data become available about the extent of the disorder, factors that contribute to risk and resilience, and effective treatment strategies.

## **2. METHODOLOGY**

This paper aims to draw together current research for the treatment of conduct disorder in children and adolescents based on both empirical evidence and systematic clinical experience. This information is directed towards child and adolescent mental health professionals in Ontario and is not intended to be prescriptive, but rather to present clinicians with a broad template to guide their practice.

The overall Project was guided by a Steering Committee of highly-experienced

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Executive Directors and clinicians from Children's Mental Health Ontario's member centres. The research process began with a series of computer-assisted and hand searches of databases, journals, and published and unpublished reports from Ontario and other jurisdictions to identify information about conduct disorder based on both empirical research and systematic clinical evidence. This strategy was adopted to address the known disparity between clinical practice and efficacy studies (Seligman, 1995).

Then the Draft Findings were presented for validation and feedback to a Panel of Experts in conduct disorder. Individual interviews also were conducted with experts in the field. Next the Draft Findings were shared with children's mental health professionals in a series of Regional Focus Groups. Participants in the Regional Focus Groups validated the data, identified gaps requiring additional research, made recommendations for changes, and identified children's mental health centres in Ontario that were implementing the specific types of evidence-based programs reported in the Draft Findings. Then the Draft Findings were revised and presented to the Steering Committee for approval. To facilitate the transfer of knowledge, the information in the Findings guided the development of a number of tools that could be used by children's mental health professionals in the assessment and treatment of conduct disorder.

### **3. EPIDEMIOLOGY**

The prevalence of conduct disorder is estimated at between 1.5% and 3.4% of the general child and adolescent population (Bartol & Bartol, 1989; Feehan and others, 1993). The onset of conduct disorder tends to peak in late childhood and early adolescence (Loeber and others, 1993b). About 40% of children and adolescents with CD eventually develop antisocial personality disorder.

Overall, conduct disorder appears more often in boys than girls, with a rate of 6% to 10% for males and 2% to 9% for females (APA, 1994). These rates vary by age range and type of conduct disorder. Epidemiological studies estimate the male-female ratio between about 3:1 and 5:1 (Boyle and others, 1992). Although more boys are affected at all ages, the gap between boys and girls closes at adolescence and, by mid-adolescence, girls surpass boys in the onset of conduct disorders (Offord, 1987). There has been much less research regarding CD in girls (Loeber & Keenan, 1994) although some studies are now appearing. Gender differences in the expression of CD become more obvious at adolescence, with boys more likely to exhibit aggressive behaviour and girls to commit covert offenses and prostitution. However, these gender differences in type of behaviour tend to disappear in the youth who are the most severely disturbed. In recent years, there has been an increase in the number of very aggressive girls

admitted to Young Offender facilities in Ontario. Many of these girls have serious abuse and neglect issues that create a very complex clinical picture and risks to society for future parenting in the next generation.

Between 50% and 75% of children who have conduct disorder have comorbid attention-deficit disorder/hyperactivity disorder (ADHD). About half of the children with CD also have an internalizing disorder such as depression or anxiety disorder. Children with CD and comorbid depression are at higher risk of suicide than children with depression alone; and they are more likely to harm themselves without intending suicide. As many as 90% of drug abusing young offenders have CD. Children with CD often show a significant history of the following (Bock & Goode, 1996; Carey & DiLalla; Plomin, 1994):

- Specific developmental disorders
- Lower scores on intelligence tests
- Head and facial injuries
- Soft neurological signs
- Psychomotor seizures
- Febrile seizures
- Nonspecific EEG abnormalities
- Vague psychotic symptoms (paranoia, thought disorder, grandiose thoughts)

The families of children and adolescents with conduct disorder also have important differences when they are compared with other families (Frick and others, 1992, 1993; Plomin, 1994). Children with conduct disorder tend to come from large, low-income, urban families led by single mothers. Fathers of conduct disordered children have a greater incidence of antisocial personality disorder and substance abuse, and they are often absent from the home. The mothers of CD children have high rates of depression, antisocial personality disorder, substance abuse and somatization disorders. Parents of children with conduct disorder tend to use corporal punishment coupled with a high rate of neglect and physical abuse (Luntz & Widom, 1994; Patterson and others, 1989, 1992). The parents of children with conduct disorder and comorbid ADHD have a greater history of violence, trouble with the law, arrests and imprisonment, when compared with the parents of children who have conduct disorder alone.

Adoption and twin studies suggest a family and/or genetic link to conduct disorder (Carey & DiLalla, 1994), although research by Offord (1990) and others has called this conclusion into question. Given the strong association of environmental and family factors, some children and youth may adopt CD traits as a protective strategy -- it is important that clinicians consider the socio-economic context when assessing the presence of CD.

## **4. ASSESSMENT**

Since CD is a complex mental health problem affecting multiple domains of functioning and showing a high rate of comorbidity with other disorders, suspicion of CD requires a comprehensive assessment that encompasses the child, family, school, peers, and community (Waddell and others, 1999). It is especially important that clinicians distinguish between early onset and adolescent onset CD. Although a thorough assessment may place a strain on limited children's mental health resources, it is a good investment in time, money, and clinical resources in the long run. Without a comprehensive assessment of CD it is extremely difficult to offer effective treatment.

The child and parent(s) should be interviewed separately and together. Family members, school, social welfare, probation and other relevant persons should also be interviewed. The purpose of the assessment (e.g., forensic, clinical management, or treatment) should be made clear to all concerned (Benton-Hardy & Steiner, 1997).

### **4.1 Parent Interview**

From the parent(s) obtain the following information:

- Specific conduct problems observed by the parent(s)
- Whether parents have observed sibling violence, abuse of family pets, and cruelty to animals outside of family (these factors are associated with more serious CD and chronic CD)
- Age of onset of conduct problems
- History of symptoms, starting with the mother's pregnancy
- Problems during pregnancy, especially alcohol/drug use, infections, and complications
- Difficulties during infancy, including temperament
- Behaviour during the preschool years, especially oppositional and/or aggressive behaviour, attention and impulse control (ADHD symptoms), attachment problems involving parent or caregiver (to detect possible comorbid separation anxiety disorder, parental depression and substance abuse)
- Context in which the child exhibits the problem behaviour (alone or in a group)
- Specific events associated with the onset of the behaviour problems, including injury or illness
- Corporal punishment of the child (history of severe corporal punishment appears in backgrounds of children with CD and amplifies severity)
- Medical history with special attention to central nervous system problems

- Physical and sexual abuse history (as victim and/or perpetrator)
- School history, especially behaviour problems at school, specific learning problems, relationship with peers, special education services received, and how the school has responded to any behaviour problems (e.g., suspended or expelled child)
- Legal history, especially involvement with legal system, charges pending, convictions, disposition (especially removal from home or community), probation status
- Family history, including detailed history of parents' psychiatric problems and history of substance abuse, antisocial behaviour problems (violence, physical or sexual abuse, imprisonment), ADHD or major psychiatric illness in parents and sibs
- Treatment history of child, including specific types of medication, types of treatment that have and have not been helpful, and history of hospitalizations, adoptions and placements in foster care and out-of-family care
- Parents' perception of the child's strengths and weaknesses
- Family coping style, resources (financial, social), parenting skills, problem solving skills, interaction between parent(s) and child, and conflict resolution skills

## 4.2 Child Interview

If the child is an adolescent, the interview may precede the parent interview. Obtain the following information from the child or adolescent alone:

- Conduct or review the findings of the physical examination, looking especially for soft neurological signs, suggesting nonspecific CNS dysfunction, signs of organic impairment such as fetal alcohol syndrome, signs of abuse or self-injury
- During the examination, assess the child's ability to hear and understand language, restlessness and distractibility, oppositional behaviour, recognize negative emotions and anger
- Cognitive functioning
- Child's assessment of his or her strengths and weaknesses
- Presence of psychiatric symptoms
- Specific questions about changes in mood, with special attention for signs of depression or anxiety disorder and level of self-esteem
- Specific questions about peer relationships
- Evidence of self-injury, suicidal and homicidal thoughts and behaviour
- Specific questions about sexual or physical abuse, sexual behaviour and promiscuity



- Specific questions about actions that would get the child in trouble with his or her parents or with the police
- Specific questions about substance abuse

Usually additional lab tests are not needed for a child with disruptive behaviour (e.g., EEG, chromosomal). For the moderately to severely disturbed child, additional tests may be helpful to confirm the presence or absence of a major mental illness, hearing/auditory processing problem, ADHD, or learning disability. Additional tests may help assess the child's strengths and weaknesses

### **4.3 School Information**

From teachers, obtain the following information:

- Academic performance
- Behaviour problems at school
- School response to behaviour problems at school
- Developmental delays, speech and language problems
- Specific learning problems (high concurrence with CD)
- Relationship with peers
- Teacher's perception of the child's strengths and weaknesses

To obtain more objective information from teachers, it is often useful to have the teacher complete a simple behaviour questionnaire, such as Child Behavior Checklist (Teacher Form) or the Conners Teacher Rating Scale, before the interview.

### **4.4 Probation Information**

If the juvenile justice system is involved, obtain the following information from the probation officer:

- Confirmation of the child's legal history, especially involvement with legal system, charges pending, probation status
- Specific information about child and family from probation officer's perspective
- Probation officer's perception of the child's strengths and weaknesses

### **4.5 Risk Factors and Protective Factors**

Research suggests that there is a gradual accumulation of risks and interaction among risk factors that lead to conduct disorder, balanced by a parallel accumulation of protective factors (Loeber and others, 1993a). Epidemiological

research has been supported by prospective studies (Raine and others, 1994) that show CD is produced by a combination of factors. Overall, the greater the number of risk factors and earlier they appear, the higher the risk for serious conduct disorder (McCord & Tremblay, 1992).

Risk factors for CD include early age of onset (pre-school and early school years), conduct problems that occur in multiple settings (home, school), frequency and intensity of conduct problems, diversity of conduct problems and covert problems (lying, firesetting, stealing) at younger ages, and family and parent characteristics. Details of risk factors associated with age of onset may be found in Sections 4.8 and 4.9.

Protective factors appear to interact with risk factors to lower the cumulative impact of conduct disorders. Research by Naomi Rae-Grant and others (1989) have identified factors that offer protection against conduct-disordered behaviours in the face of risk. These protective factors include higher levels of intelligence, good social skills, relaxed temperament, positive work habits in school, areas of competence outside school, and a positive relationship with an adult.

#### **4.6 Making a Diagnosis of Conduct Disorder**

The assessments obtained from the above sources will help the clinician determine whether the child has conduct disorder, the type of conduct disorder (childhood- or adolescent-onset), whether a psychiatric or medical problem is causing the disorder, and whether there is an additional comorbid disorder.

A diagnosis of conduct disorder is made when DSM-IV-TR (APA, 2000) target symptoms are present or reported in the history, and other disorders have been eliminated. It is important to know that DSM-IV-TR does not consider one specific criterion alone necessary for diagnosis and that any combination of three or more criteria are sufficient (that is, CD is a polythetic diagnostic category).

Since research shows that there are different profiles for conduct disorder based on age of onset and severity (Lahey and others, 1994), DSM-IV-TR criteria allow for distinguishing between childhood-onset and adolescent-onset conduct disorder and for conduct problems that are mild, moderate, and severe.

#### **4.7 DSM-IV Criteria**

The DSM-IV-TR identifies conduct disorder when three (or more) of the following criteria are manifest in the past 12 months, with at least one criterion present in the past 6 months:

- 1) Aggression to people and animals  
Often bullies, threatens, or intimidates others; initiates physical fights; has used a weapon that can cause serious physical harm to others; has been physically cruel to people or animals; has stolen while confronting a victim; has forced someone into sexual activity
- 2) Destruction of property  
Deliberately set a fire with the intention of causing serious damage or deliberately destroyed others property by other means
- 3) Deceitfulness or theft  
Broke into someone else's home, building or car; often lies to obtain goods or favours or to avoid obligations; stole items of considerable value without confronting a victim
- 4) Serious violations of rules  
Stays out at night despite parental objections, beginning before age 13; ran away from home overnight at least twice (or once without returning for a lengthy period of time); often truant from school, beginning before age 13

The disturbance in behaviour must cause clinically significant impairment in social, academic, or occupational functioning and, if the youth is 18 years of age or older, the criteria for Antisocial Personality Disorder are not met.

Childhood-onset type of CD is identified by the onset of at least one criterion prior to 10 years of age and adolescent-onset type by the absence of any criteria for conduct disorder prior to 10 years of age.

Conduct disorder is classified as "mild" if there are few conduct problems beyond those required to make the diagnosis and if the problems cause only minor harm to others. It is classified as "severe" if there are many conduct problems beyond those required to make the diagnosis or if the conduct problems cause considerable harm to others. Conduct disorder is considered "moderate" if the number of conduct problems and effect on others is intermediate between "mild" and "severe".

The major difference in DSM-IV-TR criteria for childhood-onset and adolescent onset conduct disorder is that at least one criterion must be present before age 10 for a diagnosis of childhood-onset type and all criteria must be absent for adolescent-onset type. In terms of developmental paths and treatment implications, however, there are striking differences between the two types of conduct disorder.

## 4.8 Childhood-Onset Conduct Disorder

Children with childhood-onset conduct disorder tend to be mostly male and incidence is not strongly related to socioeconomic class or ethnic group. They tend to be more aggressive than the adolescent-onset youth. By age 18, the majority of youth with childhood-onset conduct disorder meet the criteria for antisocial personality disorders and often they are imprisoned. As noted in the introduction, although the childhood-onset CD group comprise only 3% to 5% of youth with conduct disorder, they are believed to account for at least half of the offenses committed by young offenders.

In childhood-onset conduct disorder, a combination of biological and psychosocial factors appear to interact to cause the disorder. Disruptive behaviours emerge early in childhood, usually as negative, hostile, and defiant behaviour characteristic of oppositional defiant disorder. As the child grows, there usually is an escalation to behaviours more characteristic of conduct disorder, especially lying, fighting, and stealing. These children are more likely to have ADHD, learning disabilities, and poor academic achievement. A consistent finding in the research is that children with ADHD are likely to have persistent conduct problems that extend into adulthood (Mannuzza and others, 1990). In terms of developmental progression, ADHD tends to be followed by oppositional defiant disorder (ODD) and then by conduct disorder. The association between ADHD and CD is especially strong for boys, although girls show a higher risk than boys to develop CD if they have ADHD (Loeber & Keenan, 1994). The addition of substance abuse to ADHD and CD is predictive of violent behaviour for boys. Consequently, early treatment for ADHD, ODD and substance abuse is key element in the treatment of CD.

Children with conduct disorder also may show other forms of neuropsychiatric and neurobiological differences, such as low CSF serotonin levels and abnormal dopamine  $\beta$ -hydroxylase (DBH), lending support to the idea that childhood-onset CD is more constitutional and neurobiologic in origin than adolescent-onset conduct disorder. As these children grow older, their offenses tend to become increasingly severe (e.g., break-and-enter, stealing valuable goods, forced sex). They have a high incidence of substance abuse, erratic employment and marriage histories, and physical abuse of their spouses or partners and children.

In general, children with childhood-onset conduct disorder may be distinguished from adolescent-onset by their long history of aggression and antisocial acts such as fighting at school, truancy, stealing, early substance abuse, being taken into care, and placement breakdowns.

## 4.9 Adolescent-Onset Conduct Disorder

Youth with adolescent-onset conduct disorder present a different clinical profile. In adolescent-onset conduct disorder, it appears that sociocultural factors such as the influence of poverty and peer groups are largely responsible for the resulting behaviours. Youth with adolescent-onset conduct disorder usually do not have serious problems before adolescence. During the preschool and school-age years, they tend not to show oppositional behaviour or social, academic, or community problems. This finding is so persistent that the DSM-IV-TR criteria for adolescent-onset CD demands the absence of any criteria characteristic of CD before age 10. Oppositional and illegal behaviour begins during adolescence and tend to take place in a group environment. Whereas childhood-onset CD involves mostly boys, girls are involved in the adolescent-onset group. Adolescent-onset CD is likely to involve urban, poor, and minority youth. They do not have the severe learning problems, developmental disabilities, neuropsychiatric problems, or family history of antisocial behaviour demonstrated by youth with childhood-onset CD. The problem behaviours demonstrate less aggression, especially aggression aimed at others, and they tend to stop as the youth mature into adulthood. Anxiety disorder can be comorbid with conduct disorder, especially in adolescent girls. Overall, the prognosis is good for youth with adolescent-onset CD, but poor for those with childhood-onset type of conduct disorder.

## 5. DIFFERENTIAL DIAGNOSIS

Several types of disorders have manifestations that are similar to conduct disorder. A child or adolescent who is manic may engage in dangerous and disruptive behaviour. There will be other behaviours not typical of conduct disorder, however, such as pressured speech, flight of ideas, and a decreased need for sleep that serves to distinguish CD from manic behaviour. For differential diagnosis, therefore, it is always desirable to include a psychiatric assessment when CD is suspected, although psychiatric and/or psychological resources may be difficult to obtain in some systems, such as the Young Offenders system.

Conduct disorder may appear in a child, but most often in an adolescent, who is depressed. The youth may feel irritable, inadequate, isolated, and alone. He or she may begin identifying with nonconforming teens. A depressed adolescent may be defiant to parents and other persons in authority, and behaviour may include truancy and failure, use of alcohol or illegal drugs, sexual activity, and the appearance of delinquent behaviours. Unlike the conduct-disordered youth, however, the depressed youth usually shows a change in mood that comes before the disruptive behaviour. As the youth's mood improves, the deviant behaviour diminishes. Youth with conduct disorder often are depressed too, but the problem behaviour precedes the change in mood and the youth's actions do not

change greatly with the treatment of the mood disorder. Boys are more affected by comorbidity of depression with conduct disorder before puberty and girls afterwards. With comorbid depression the conduct disorder usually precedes the depression. The presence of depression comorbid with conduct disorder raises the risk of suicidal behaviour.

A child may exhibit conduct-disordered behaviour in response to a stressful event such as starting school, conflict between parents, and physical or sexual abuse. Usually the onset of the behaviour is associated with the stressful event and diminishes as the situation improves. Adolescents may show CD behaviour in response to a recent stressful event or from a recent association with a peer group of troubled youth. If the problem behaviour is isolated and if the youth's level of functioning was good before the behaviour occurred, then conduct symptoms are most likely secondary to another disorder such as adjustment disorder, post-traumatic stress disorder or depression.

Disruptive behaviour can be associated with an anxiety disorder but it should dissipate with treatment of the anxiety disorder. Problem behaviour also may be a symptom of a serious psychiatric disorder, such as psychosis. The child's assessment should identify a history of hallucinations, delusions, or a thought disorder. Disruptive behaviour may result from an organic personality disorder in children with a congenital or acquired injury to the central nervous system, such as fetal alcohol syndrome, head injury, or encephalopathy. Aggressive outbursts also may indicate psychomotor seizures. In such cases, the aggression is generalized and not aimed at a specific person. There also may be other symptoms of a seizure disorder, such as aura, confusion, and EEG changes.

Children with CD often have below-average intelligence, as measured by verbal IQ. They often achieve poorly in school, especially in reading and other verbal skills. Assessment may indicate that CD is comorbid with learning or communication disorders in some children.

In short, although a number of disorders show symptoms similar to conduct disorder and they can be comorbid with CD, usually the persistent pattern of violating societal norms, antisocial behaviour and a history of problems with the law help to distinguish conduct disorder.

## **6. TREATMENT**

Research and practice consensus indicates that successful treatment must address multiple domains in a coordinated manner over a period of time. Outpatient treatment of CD usually involves the child/youth, family, school and peer group. Some milder forms of CD, however, require minor intervention,

usually training for the child (social skills, problem solving) and training for the parents (behaviour management, parenting skills) and consultation to schools.

Moderate and severe CD often involves comorbid disorders that require treatment (e.g., ADHD, developmental disabilities, substance abuse disorder, anxiety disorder, mood disorders). Chronic CD, which is usually childhood-onset type, requires early intervention, extensive treatment in multiple domains and long-term follow-up (Offord & Bennett, 1994).

Since conduct disorder involves mostly externalizing symptoms, there is a preference for social learning interventions that provide structure in the life of a child, rather than psychopharmacological or intrapsychic approaches alone. Research indicates that therapy for CD should involve a multimodal continuum of interventions that is delivered with enough frequency and long enough to produce the desired treatment outcomes. There is little research support for single-session or brief interventions or for "shock" approaches such as boot camps, psychiatric hospitalization, medication trials, or a brief course of cognitive-behavioral therapy (Cowles and others, 1995; Kazdin, 1989; Mendel, 1995; Short, 1993; Webster-Stratton, 1993)

## **6.1 Pharmacotherapy**

Pharmacotherapy alone is not sufficient to treat conduct disorder. Although some psychiatric medications are used to treat CD youth who have a comorbid disorder (e.g., antidepressants for mood and anxiety disorders, stimulants for ADHD), this treatment is recommended only on the basis of clinical experience, since there is an absence of adequate efficacy studies to support their use (Lavin & Rifkin, 1993; Ritchers and others, 1995). The strongest evidence is in support for the use of stimulants to treat comorbid ADHD symptoms (American Academy of Child & Adolescent Psychiatry, 1997). Although neuroleptics have been shown to reduce aggression in CD children, side-effects may outweigh their benefits, especially for longer-term use.

## **6.2 Treatment for the Child or Adolescent**

Choice of treatment for the child or adolescent depends on age, type and severity of conduct disorder, strengths, interaction and processing style, and ability to engage in treatment. The main evidence-based individual therapy with conduct disordered youth is cognitive behavioural therapy (CBT), especially Problem-Solving Skills Training (PSST) developed by Spivak and Shure (1974, 1976, 1978). This form of therapy targets both antisocial behaviours and prosocial functioning. It helps suppress undesirable behaviours and create structure in a child's life that provides the security to build positive relationships as therapy

progresses. PSST helps the child manage the cognitive deficiencies are believed to contribute to antisocial behaviour by improving communication skills, problem-solving skills, impulse control, and anger management (Kazdin, 1995; Tremblay and others, 1991). Assessment is important, since CBT may not work with a child who has neurological or processing problems. Although cognitive behavioural interventions and skills training appear helpful in the short-term, especially for older children, their long-term efficacy has not been established.

Although the literature generally does not support the effectiveness of individual psychodynamic therapy with CD children, several studies indicate that an explorative approach (Fonagy & Target, 1994) or an attachment-based approach (Moretti and others, 1994) may be useful for some CD children. If for no other reason, explorative approaches are employed to establish a therapeutic relationship that will effectively engage the child or adolescent in therapy. Likewise, psychosocial interventions alone have shown only modest effects for children with CD (Lipsey, 1992).

Recommended treatment for the child or adolescent includes:

- Cognitive-behavioural therapy
- Problem-Solving Skill Training

### **6.3 Family Intervention**

Family intervention is an essential component for treating conduct disorder. For younger children, the family often is the primary target for intervention. Before family intervention can begin, however, the following conditions that affect the basic safety of the child should be met:

- Appropriate housing for the family
- Adequate resources to meet basic needs
- Parent with a psychiatric or substance abuse disorder is receiving treatment for the problem
- Home is safe -- potential problems of domestic and child abuse have been identified and addressed
- Adequate supervision for all children in the home

To meet these conditions, children's mental health professionals may first need to work in collaboration with other systems, such as child welfare, social assistance, and addiction and adult mental health services.

The overall approach for working with families is to identify and build upon the



parent(s) strengths. There are two primary strategies for family intervention: 1) parent education about the cycle of events that leads to problem conduct behaviours, and 2) parent management training (PMT) to improve parenting skills and to manage child behaviour effectively without the use of physical punishment. Numerous studies support the effectiveness of parenting skills training and training for the child to improve child behaviour, positive peer relationships, academic achievement, and reduce aversive interactions with authority figures (McCord and others, 1994; Mendel, 1995; Patterson and others, 1989; Wells, 1995).

Evidence-based parent training programs for children with CD or at risk for CD include:

- COPE (Cunningham and others, 1995)
- Incredible Years (Webster-Stratton, 1989; Webster-Stratton and others, 1994)
- Parenting Wisely (Kacir & Gordon, 1999)
- Defiant Children (Barkley, 1997)
- SNAP Parent Training (Day & Hrynkiw-Augimeri, 1996)

A recent review of the outcomes studies of PMT shows that these gains have been maintained for 1 to 3 years after treatment (Kazdin, 1997). Since parenting skills training depends heavily on parent participation, it is not useful for multiproblem families in which parents cannot participate consistently.

Recent well-designed experimental studies support the efficacy of prenatal and early childhood interventions (such as home visits) to reduce behavioural problems and antisocial behaviour and criminal activity in children born to poor families (Olds and others, 1998).

Recommended family intervention includes:

- Parent counselling that enhances parental strengths
- Parent training to establish consistent behaviour management
- Family therapy
- Treatment of substance abuse and other problems of parents/family members

There is evidence that multi-systemic therapy (MST) is an effective intervention for CD youth that may be delivered in family and community settings (Henggeler and others, 1998, 1990).

## 6.4 School Intervention

Children and adolescents with conduct disorder often see school as a place of frustration and failure. They usually show poor academic achievement and may be disliked by their teachers and classmates. Faced with frustration and exclusion, the child or youth may resort to bullying and antisocial behaviour and may group with other students who are in a similar situation. Lack of suitable classes, limited resources in the school system, and the need for teachers to have basic child management and parenting skills makes it very difficult to work effectively with CD children in school. Children with CD may be treated effectively in day treatment programs, but good follow-up and transition planning is necessary if treatment gains are to be maintained in regular classrooms.

Two common school-based treatment approaches for CD children that have research support are contingency management (Abramovitz, 1994) and the use of token economies (Kazdin, 1977) to reinforce positive behaviour and reduce negative behaviours. During the last 10 years, a number of school-based programs have been developed to address conduct problems, including anger management, conflict resolution, social problem solving, and social skill training. Most of these programs have little empirical support for their ability to change problem behaviours or to maintain changes after the program ends (Dodge, 1993; Tolan & Guerra, 1994).

Some of the more promising strategies for the prevention of conduct disorders involve preschool children (National Crime Prevention Council, 1996; Zigler and others, 1992) and school-aged children (National Crime Prevention Council, 1997) in multifaceted programs that involve the school (or day care centre), family and community such as the Metropolitan Area Child Study (MACS) program (Grant and others, 1998).

Recommended interventions in the school includes:

- Assess for developmental disorders, especially auditory processing problems
- Placement in a suitable class (e.g., day treatment, special education, behaviour class)
- Referral to appropriate academic resources (e.g., literacy training, life skills, vocational school)
- Educate teachers about effective behaviour management for CD students
- Build a strong alliance between parents and school
- Promote prosocial interactions with peers at school

## 6.5 Peer Intervention

Since adolescents rely more on peers than parents or teachers for values and direction, intervention with adolescents should include a focus on peers as well as family (Feldman & Weinberger, 1994). Adolescent-onset CD is often associated with membership in a group of antisocial youth. To avoid conduct-disordered behavior, intervention may be necessary to remove the youth from an antisocial group and help them to develop a new peer group. Since CD youth often lack appropriate social skills, they may need specific coaching on making and keeping friends, learning new ways of using free time, and joining positive activities and organizations in the community.

There has been research support for multi-systemic therapy (MST) that treats conduct-disordered adolescents (including serious and violent offenders) in their social settings while combining family and community interventions (Borduin and others, 1995; Henggeler and others, 1998, 1990, 1987a, 1987b), but concerns have been raised that MST may miss psychiatric problems and comorbid disorders (Fouras, 1999).

The Earls court Under 12 Outreach Project (ORP) is an example of multifaceted intervention for boys between 6 and 12 years of age who commit mild to serious offenses. Several evaluative research studies indicate that the ORP is effective in reducing CD behaviours and police contact among a group that is at risk of repeat offending (Day & Hrynkiw-Augimeri, 1996; Hrynkiw-Augimeri and others, 1993).

The ORP consists of eight components, including an after-school structured group to teach self-control and problem-solving techniques, a 12-week parent training group to teach effective parenting skills, family counselling, in-home academic tutoring, school advocacy and teacher consultation, victim restitution, individual befriending to link the boys with structured community-based activities, and continuing groups. Earls court has recently developed a multifaceted program for aggressive, antisocial girls based on similar principles.

Other evidence-based peer group intervention programs include Skillstreaming (Goldstein, Gershaw & Sprafkin, 1995) and Aggression Replacement Training (Goldstein & Glick, 1994).

Recommended intervention with peers includes:

- Peer intervention to replace deviant peer group with socially appropriate group
- Promote prosocial interactions with peers at school

## **6.6 Community Intervention**

Many youth with CD are involved with the juvenile justice and/or welfare systems. These systems may be used constructively to support parental authority, obtain needed resources to address behaviour problems, and coordinate services. There is evidence that multi-systemic therapy (MST) is an effective intervention for CD youth that may be delivered in community settings (Henggeler and others, 1998, 1990).

Recommended intervention with other systems and agencies includes:

- Work with juvenile justice and child welfare systems to introduce or support court supervision and limit-setting
- Work with social welfare agencies to help family gain access to case managers, benefits, services, and community supports
- Work with other agencies (e.g., Big Brothers and Big Sisters) to obtain mentors and access to programs

## **7. TREATMENT SETTINGS**

Treatment of CD usually takes place in outpatient and community settings, although residential treatment may be indicated by severe family dysfunction, marked noncompliance, or persistent involvement with a deviant peer group. Many children with severe CD have been rejected by their families and have experienced a high level of placement breakdowns. These children are very difficult to manage outside of a residential treatment program.

Although the effectiveness of different types of residential treatment have not been thoroughly tested, treatment foster care appears to be the preferred residential treatment option for children under 12 who commit moderate to severe offenses and require out-of-home placements (Goldberg, 1999). CD youth who are sexual perpetrators may need placement in a specialized sex offenders program.

Residential treatment programs should include a therapeutic milieu with community processes and structure, such as a level system. The family or caregiver, if they are connected with the child, should be involved in treatment, including social learning (parent training) and family therapy. The child should be involved in an appropriate school program. Individualized treatment plans should address specific treatment for comorbid disorders and include programs to improve social functioning (e.g., assertiveness, anger management), if relevant. There should be ongoing treatment coordination with school and other systems

(juvenile justice and social services).

There appears to be research support for multisystemic therapy as a home-based or community-based treatment alternative for youth with conduct disorder. Multisystemic therapy involves changing the multiple systems that affect the child's behaviour, including the child, family, school, peers and community (Henggeler and others, 1998, 1990, 1987a, 1987b). Recent research supports the use of home-based MST as an alternative to emergency psychiatric hospitalization in reducing the symptoms of youth with CD problems (Henggeler and others, 1999). This form of therapy also appears to be effective for CD youth who have substance abuse problems.

Criteria for CD usually do not justify hospitalization unless there are symptoms of substance abuse, self-destructive or suicidal behaviour, or homicidal or aggressive behaviour that warrant the concurrent diagnosis of ADHD, intermittent explosive disorder, mood disorder, bipolar disorder, or substance abuse disorder.

An evaluation of a short-term residential hospital-based behavioral program in Nova Scotia showed some benefits for CD female adolescents, but not for males (Ansari and others, 1996). Pharmacotherapy (medication) should not be initiated immediately. Hospitalization should include a therapeutic milieu, involvement of the child's family (including parent training and family therapy), individual and group therapy, specific therapy for comorbid disorders, social skills training, academic programming (including special education or vocational training), and involvement of relevant systems (juvenile justice, social welfare, education) to ensure discharge and follow-up planning to return the child to the community as soon as possible.

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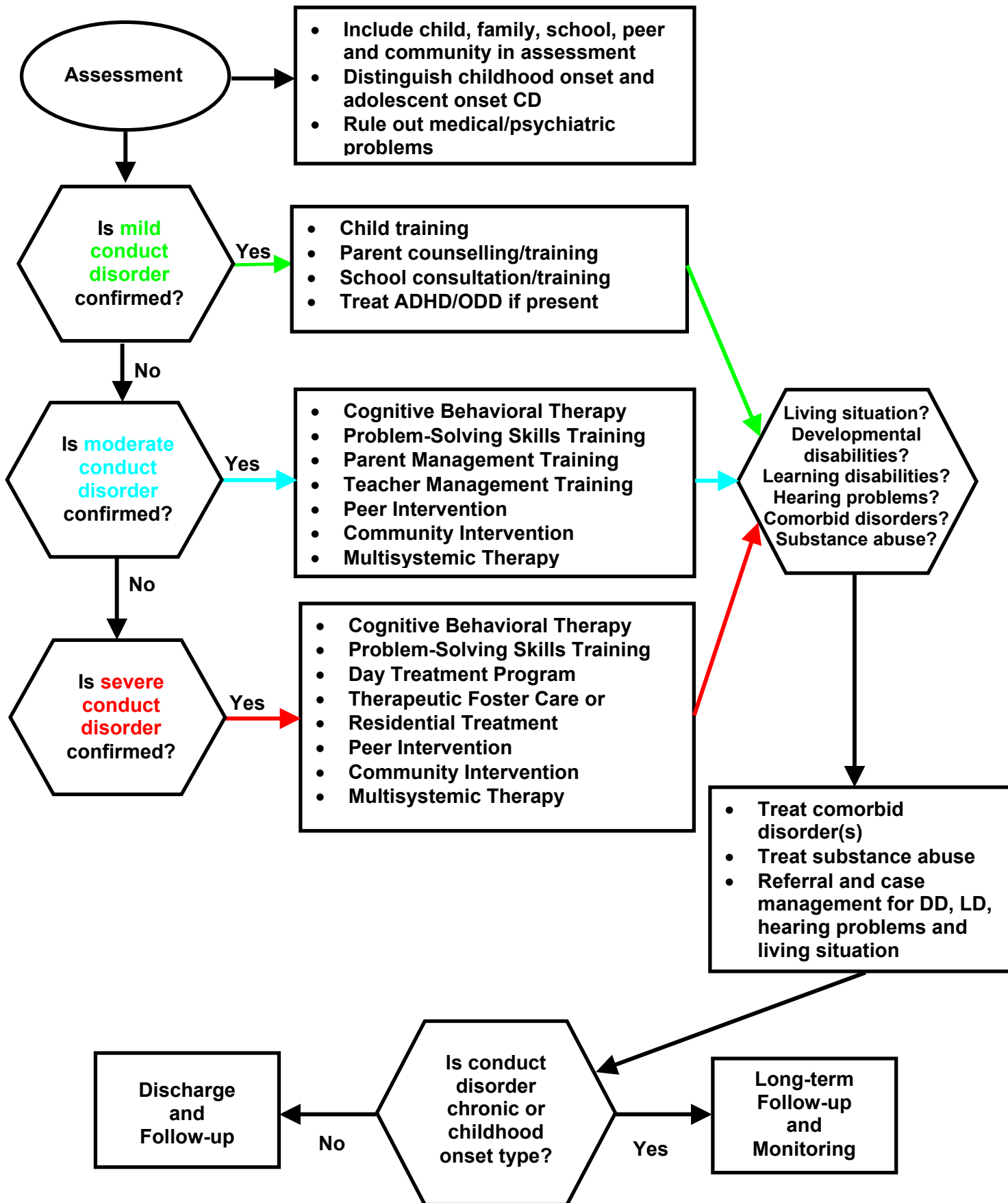
## SECTION 3

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Children and Adolescents with Conduct Disorder:

### **Clinical Pathways**

# Decision Path for Children and Adolescents with Conduct Disorder



## SECTION 4

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Children and Adolescents with Conduct Disorder:  
**Evidence Based Parent Training Programs**

# **Selected Evidence Based Practices for Children and Adolescents with Conduct Disorder: Parent Training and Peer Group Interventions**

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## **INTRODUCTION**

These program overviews describe selected evidence based programs for addressing conduct disorder in children and adolescents. Each of the Parent Training Programs and Peer Group Intervention Programs is supported by substantial research that demonstrates the program's effectiveness.

The importance of addressing multiple domains in the effective treatment of Conduct Disorder has been well established (see "Children and Adolescents with Conduct Disorder: Findings from the Literature and Clinical Consultation in Ontario"). Two key domains include 1) working with the parents of children and adolescents with Conduct Disorder to provide parent training, and 2) peer group interventions. Parent Training is important for helping parents both to understand the events that tend to result in problem behaviours and to develop skills for dealing with these behaviours more effectively. Peer Group Interventions are necessary to help the child or adolescent develop social skills and problem solving abilities and to offer pro-social options for children and adolescents who otherwise would tend to gravitate toward an antisocial peer group.

Although there are many program models for both Parent Training and Peer Group Intervention in use throughout North America, relatively few of them are supported through rigorous research.

The programs featured here were identified through the Expert Panel, the Focus Groups, and a survey of senior clinicians in Children's Mental Health Centres in Ontario on effective peer group interventions being used in practice. Each of the identified programs was reviewed and the available research supporting each program was carefully examined. Of the programs identified and reviewed, only those demonstrating the strongest evidence were selected for inclusion. A considerable number of preventive programs also exist, however inclusion in this selection of programs was limited to approaches that have been shown to be effective with a population where significant conduct problems are already established.



## PARENT TRAINING PROGRAMS

TITLE	AGE RANGE	GENERAL COST OF PROGRAM MATERIALS	NUMBER OF SESSIONS
<b>ADOLESCENT TRANSITIONS PROGRAM</b>	11 – 14 years	To be determined late summer 2001	12
<b>COPE</b>	3 -12 years	Low	8–16
<b>DEFIANT CHILDREN</b>	2 -12 years	Low	10–12
<b>INCREDIBLE YEARS</b>	2 -12 years	High	10–14
<b>PARENTING WISELY</b>	9 - 18 years	Moderate to high	1–2
<b>SNAP™</b>	6 - 12 years	Low	12

<b>PROGRAM TITLE</b>	<b>ADOLESCENT TRANSITIONS PROGRAM</b>
<b>AUTHOR / DEVELOPER</b>	Thomas Dishion and Kathryn Kavanagh University of Oregon Eugene, Oregon
<b>TARGET GROUP</b>	<ul style="list-style-type: none"> <li>• Families of 11 to 14 year olds (early adolescents) at risk for antisocial behaviour, substance abuse and depression.</li> <li>• Broad cross section of parents (curriculum to be adapted to the education level and cultural orientation of families)</li> </ul>
<b>GOALS</b>	<p><u>Long-term goals:</u></p> <ul style="list-style-type: none"> <li>• Arrest of the development of adolescent antisocial behaviours and drug experimentation.</li> </ul> <p><u>Intermediate goals:</u></p> <ul style="list-style-type: none"> <li>• Improvement of parent family management and communication skills.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Ecological theory</li> <li>• Social learning theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>The curriculum is based on family management skills of encouragement, limit setting and supervision, problem solving, and improved family relationship and communication patterns. These extensively researched skills (Patterson, 1992) follow a step-wise approach toward effective parenting skills and strategies for maintaining change.</p> <p>Groups provide a balance between skill development and discussion. Each session includes a review of home practices, and introduction of a new family management and communication skill. Parents engage in oral or written group exercises, discussion, role plays, and setting up home practice activities. Videotapes demonstrate family management and communication skills using a wrong way / right way format.</p> <p>Group work is supported by weekly phone contact by the group leader and four individual family meetings. These individual meetings are for purposes of tailoring skills to</p>

	<p>individual family needs and for family discussion of their progress. The first session occurs in the family's home and allows each member to individually identify the changes that he or she would like to make during the program. The other three sessions are available for families after the three key family management components that address encouragement, limit setting and problem solving. These sessions are intended to assist families to tailor skills to their individual needs and to develop strategies for addressing barriers affecting implementation of skills.</p> <p>The curriculum covers:</p> <ul style="list-style-type: none"> <li>• Group processes, goals, neutral requests, and tracking</li> <li>• Pinpointing and active listening</li> <li>• Contracts and reinforcements</li> <li>• Trouble-shooting the behaviour change plan</li> <li>• Supervision</li> <li>• Guidelines and rules re limit setting</li> <li>• Setting limits</li> <li>• Limit setting on challenging behaviours</li> <li>• Listening skills</li> <li>• Bringing up a problem</li> <li>• Negotiation</li> <li>• Strengths, barriers, and strategies.</li> </ul>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Group (ideally 8 families, i.e., 8 to 16 parents)</li> <li>• Individual family meetings</li> <li>• Mid-week phone contact by group leader</li> </ul>
<b>FREQUENCY AND DURATION OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• Weekly sessions of 90 minutes</li> <li>• 12 parent group meetings and 4 individual family meetings.</li> <li>• Monthly booster sessions for at least three months post completion of group.</li> </ul>
<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>• Training on site or at the University of Oregon Family Centre. Onsite training costs approximately \$1000 per day plus travel expenses. Up to 15 participants.</li> <li>• Leader's guide, parent workbook, and 6 videos (10 minutes each) are required. Program materials and prices are expected to be available by the end of the summer of 2001.</li> </ul>

	<ul style="list-style-type: none"> <li>• Groups can be run by one or two leaders. One group leader (masters or bachelor level) is recommended for every 10 families.</li> <li>• A paid parent consultant is recommended to facilitate the group process and parent participation.</li> <li>• Parent incentives (family activities, e.g. dinners, movies, bowling) should be given to one or two families per session.</li> <li>• Snacks, and child care support (babysitting money or on site childcare) are recommended.</li> </ul>
<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Training on site or at the University of Oregon Family Centre. Onsite training costs approximately \$1000 per day plus travel expenses. Up to 15 participants.</li> </ul>
<b>CORRESPONDING PEER INTERVENTION PROGRAM</b>	Based on studies conducted during development of the program, the adolescent portion is contraindicated (See Selected References). In their current work, the authors have adapted the peer intervention to a 6 week, school-based (Grade 7), universal program, i.e. for all students – not only high risk students.
<b>CONTACT INFORMATION</b>	<p>Kate Kavanagh  Project Alliance  2738 NE Broadway  Portland, OR 97232  Phone: 503-282-3662  Fax: 503-282-3808  <a href="mailto:Katek@hevanet.com">Katek@hevanet.com</a></p>
<b>SELECTED REFERENCES</b>	<ul style="list-style-type: none"> <li>• Dishion, Thomas, J. and Andrews, David W. (1995). Preventing Escalation in Problem Behaviors with High-Risk Young Adolescents: Immediate and 1-Year Outcomes, <i>Journal of Consulting and Clinical Psychology</i>, Vol.63, No.4, 538-548.</li> </ul> <p>Families with children aged 11-14 were randomly assigned to intervention conditions consisting of: Adolescent Transitions Program (ATP) parent focus, ATP teen focus, ATP parent and teen focus, self-directed change with ATP materials only. A quasi-experimental control group was also recruited. Parent focus and teen focus interventions</p>

resulted in immediate beneficial effects on behaviour problems at school. Longitudinal trends suggest that the parent focus may reduce subsequent tobacco use, compared with all other approaches. Interventions that aggregated high-risk youths into groups, however, showed the highest escalations in tobacco use and problem behaviour at school, beginning at termination and persisting at follow-up.

- Dishion, Thomas J., Andrews, David W., Kavanagh, Kate, and Soberman, Lawrence H.; in DeV. Peters, Ray, & McMahon, Robert J. (Eds.) *Preventing Childhood Disorders, Substance Abuse, and Delinquency*. Sage Publications: 1996.

To test the effectiveness of implementing ATP in schools, 63 families were randomly assigned to: community-based implementation or school-based implementation. All families received both the teen-focused and the parent-focused interventions. The basic components of ATP were effective in engaging students and their parents and in improving parent-child relations. In addition, the parent-focus curriculum had a short-term effect on the incidence of aggressive and delinquent behaviours in young teens. Parent training and involvement in schools were supported as effective strategies for improving student behaviour, and in reducing the escalation of drug use during the year after program participation. The teen-focus curriculum, although enhancing parent-child relations, did not influence problem behaviour in short-term evaluations.

### **Additional References**

Dishion, Thomas J., and Kavanagh, Kathryn. (2000). A Multilevel Approach to Family-Centered Prevention in Schools: Process and Outcome. *Addictive Behaviors*, Vol. 25, No. 6, pp. 899-911.

<b>PROGRAM TITLE</b>	<b>COPE The Community Parent Education Program</b>
<b>DEVELOPER / AUTHOR</b>	Charles E. Cunningham, Rebecca Bremner, and Margaret Secord Hamilton Health Sciences Corporation
<b>TARGET POPULATION</b>	<ul style="list-style-type: none"> <li>• Higher risk, socially isolated families (including recent immigrants or where English is a Second Language)</li> <li>• Parents of children ages 3 to 12 at risk for, or having, disruptive behaviour disorders</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>• Improved parenting skills</li> <li>• Acquisition of problem solving skills</li> <li>• Improved family functioning</li> <li>• Development of supportive personal networks for logistical assistance, information, support and encouragement</li> <li>• Increased awareness and utilization of local resources, e.g. extracurricular programs for children during high risk unsupervised periods</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Family systems theory</li> <li>• Social-cognitive psychology</li> <li>• Social learning-based parenting programs</li> <li>• Group process</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>COPE uses a facilitative approach to skill acquisition, i.e. Coping Modeling Problem Solving, whereby participants formulate their own solutions.</p> <p>The format for COPE sessions includes:</p> <ul style="list-style-type: none"> <li>• Social networking and community resources - encouragement of supportive contacts within the group; resource information.</li> <li>• Subgrouping - 5 to 7 member subgroups work together to promote active participation.</li> <li>• Success oriented homework review - review by each member of situations where preceding session's strategies were applied successfully, enhancing self esteem and a sense of personal success. Subgroup leaders summarize examples to the larger group.</li> </ul>

- Trouble shooting videotaped parenting errors - parents formulate solutions to errors observed by identifying mistakes and discussing potential consequences. They then formulate alternatives to the errors and consider their relative merits.
- Modeling proposed strategies – large group suggests several situations to which the session’s strategy might be applied. The leader models each solution proposed by the group with a group member playing the role of the child.
- Brainstorming application – subgroups generate a range of different situations, behaviours, or problems to which the session’s strategy might be applied. Subgroup leaders present ideas to the larger group.
- Rehearsing solutions – in groups of two, parents rehearse application of the strategy to personally selected problems via role playing. Parents whose children are attending the social skills activity group may be given an opportunity to practise in a series of structured interactions with their child.
- Planning homework – parents set goals and consider strategies to prompt and reinforce application.

COPE’s curriculum focuses on:

- Encouraging positive behaviour and improving parent-child relationships - attending and reward strategies)
- Balancing family relationships - balancing time and attention among siblings; attending to several children simultaneously
- Avoiding conflicts - strategies for ignoring minor disruptions, disengaging from escalating confrontations, controlling thoughts which intensify anger
- Managing transitions - shifting child’s attention by reinforcing positive behaviours, transitional prompts to assist the child, ignoring protests, reinforcing follow-through
- Increasing compliance - parents learn to organize daily activities in to a series of when-then sequences where task completion is rewarded
- Improving self-regulation - cognitive strategies to support planning and application of plans re. potentially problematic situations
- Responding to antisocial behaviour - emotionally neutral commands, warning, effective consequence

	<ul style="list-style-type: none"> <li>• Point systems - parents develop a home based token economy</li> <li>• Coordinating child management plans - parents develop strategies for informing key individuals, e.g. teachers, babysitters, coaches, re plans, enhancing a collaborative approach to behaviour management</li> <li>• Solving outstanding problems - parents formulate a general problem solving approach and apply it to selected difficulties.</li> </ul>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Large group</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• 2 hours weekly for 8 to 16 weeks.</li> <li>• Shorter courses may be achieved by combining sessions addressing similar issues, deleting advanced topics, or breaking the program into a series of 3 to 4 session modules.</li> <li>• To sustain gains, parents are encouraged to join a monthly booster session group for graduates of all COPE courses.</li> </ul>
<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>• 1 leader minimum. Good opportunity for trainee to co-lead.</li> <li>• COPE Leader's Manual (\$40)</li> <li>• Videotape (\$50)</li> <li>• VCR and television</li> <li>• Paper, crayons, games, etc. for children's group</li> <li>• Refreshments for both groups</li> </ul>
<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Training is optional. Level I Training for 2 days, including the manual and tape, costs approximately \$210. Level II consists of a co-leading opportunity, for which there is no charge. Level III is a "brush up" one day program, costing \$100. Training is held in the Hamilton / Burlington area</li> </ul>
<b>CORRESPONDING PEER GROUP INTERVENTION</b>	<p><b>Children's Social Skills Activity Group</b>  This group is designed to provide child care, introduce children to parenting skills, provide parents with an opportunity to practice new skills, improve parental</p>



	<p>participation, and enhance social competence. The program should try to include siblings age 3-12.</p>
<b>CONTACT INFORMATION</b>	<p>Randi Knight  COPE Program  Chedoke Child and Family Centre  Children's Hospital, Hamilton Health Sciences Corporation,  Chedoke Campus,  Box 2000, Southam Building, Room 113  Hamilton, ON L8N 3Z5  Phone: 905-521-2632 Ext. 2.</p>
<b>MODIFICATIONS/ ADAPTATIONS</b>	<p>Yorktown Child and Family Centre  2468 Eglinton Ave. W., Toronto M6M 5E2  Phone: 416-394-2424  Contacts: Catherine Moffat or Irene Altimira Ext. 28</p> <ul style="list-style-type: none"> <li>• Children's Group: Training children through skill-building activities appropriate to developmental norms; birth to age 12.</li> <li>• Multicultural COPE, offered in English and Spanish; combines social support, education, professional resources, volunteer skills (parent leadership) to meet the needs of the multicultural community. Emphasis is on communication, discipline techniques, stress and anger management. Multicultural videotape with family scenarios. Children's groups as well.</li> <li>• Adapted version for the Somali community</li> <li>• Shelter COPE: Adapted version for women and children who have recently left an abusive relationship</li> </ul> <p>Available: Videotape and accompanying leader's manual in English (\$30).</p> <p>To discuss training, contact Irene Altimira, ext.28.</p>
<b>SELECTED REFERENCES</b>	<ul style="list-style-type: none"> <li>• Cunningham, Charles E., Bremner, Rebecca, &amp; Boyle, Michael, Large Group Community-Based Parenting Programs for Families of Preschoolers at Risk for Disruptive Behaviour Disorders: Utilization, Cost Effectiveness, and Outcome. <i>Journal of Child Psychology and Psychiatry</i>, 36, pp.1141-1159, 1995.</li> </ul> <p>This randomized controlled trial compared the community based large group program with a clinic based, individual parent training program, and a waitlist control group. Parents in the community groups reported greater</p>

	<p>improvements in behaviour problems at home and better maintenance of these gains at 6-month followup. A cost analysis showed that, with groups of 18 families, community parent training groups are more than 6 times as cost effective as clinic / individual programs.</p> <ul style="list-style-type: none"> <li>• Cunningham, C.E., Davis, J.R., Bremner, R., Dunn, K.W., &amp; Rzasa, T. (1993). Coping modeling plus problem solving versus mastery modeling: Effect on adherence, in-session process, and skill acquisition in a residential parent training program. <i>Journal of Consulting and Clinical Psychology</i>, 61, 871-877.</li> </ul> <p>Fifty staff in a residential staff training program were randomly assigned to: mastery modeling (videotaped models demonstrated new skills), coping modeling problem solving (CMPS, where participants formulated their own solutions to errors depicted by videotaped models), or a waitlist control group. The skills of all groups improved, but CMPS participants attended significantly more training sessions, arrived late to fewer sessions, completed more homework, interacted more positively during sessions, reported significantly higher personal accomplishment scores, and rated the program more positively than those who participated in the more didactic mastery modeling condition.</p>
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**Additional References:**

Cunningham, C.E. (1990). A Large-Group, Community-Based, Family Systems Approach to Parent Training. In Russell A. Barkley, *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*. New York: Guilford Press, 1990.

<b>PROGRAM TITLE</b>	<b>DEFIANT CHILDREN</b>
<b>DEVELOPER / AUTHOR</b>	Russell A. Barkley
<b>TARGET POPULATION</b>	<ul style="list-style-type: none"> <li>Parents of children aged 2 to 12 with noncompliant, defiant, oppositional, stubborn, or socially hostile behaviour alone or with other childhood disorders.</li> </ul> <p>“Children older than 12 years of age or those who are seriously aggressive and assaultive with others should not be considered for this program. They often do not respond or their reaction to the procedures results in an escalation of family conflicts... However, at the conclusion of other forms of treatment, e.g., more intensive in-clinic or residential treatment, this program can be suitable for parents to prepare them for the child’s return home.” (Barkley, p5)</p>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>Improved parental management skills and competence in dealing with child behaviour problems, particularly noncompliant or defiant behaviour.</li> <li>Increased parental knowledge of the causes of childhood defiant behaviour and the principles and concepts underlying the social learning of such behaviour.</li> <li>Improved child compliance with commands, directives, and rules given by the parents.</li> <li>Increased family harmony</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>Social learning theory</li> <li>Behaviour modification</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>Based on Patterson’s work (1982), Barkley explains that noncompliance / defiance in children is a result of negative patterns of interaction in the parent-child relationship, but also child characteristics (temperament, cognitive characteristics), parental characteristics, and contextual factors (e.g., parental isolation, marital status).</p> <p>Key concepts of the Defiant Child program include:</p> <ul style="list-style-type: none"> <li>Make consequences immediate</li> <li>Make consequences consistent</li> <li>Establish incentive programs before punishment</li> </ul>

	<ul style="list-style-type: none"> <li>• Anticipate and plan for misbehaviour</li> <li>• Recognize that family interactions are reciprocal</li> </ul> <p>The program may be taught as a self-contained unit, or it can be integrated into ongoing family therapy or parent counseling. Normally the complete set of 10 steps should be taught, and should remain in sequence:</p> <ol style="list-style-type: none"> <li>1. Why children misbehave</li> <li>2. Pay attention!</li> <li>3. Increasing compliance and independent play</li> <li>4. When praise is not enough: poker chips and points</li> <li>5. Time out and other disciplinary methods</li> <li>6. Extending time out to other misbehaviour</li> <li>7. Anticipating problems</li> <li>8. Improving school performance from home: the daily school behaviour report card</li> <li>9. Handling future behaviour problems</li> <li>10. Booster session and follow-up meetings. (at 1 month and then at 3 months).</li> </ol> <p>Each session begins with a review of the previous session's homework and any other events the family wishes to share. Failure to complete homework is addressed if necessary. New material, concepts and methods are introduced through modeling or demonstration. If training is being done with an individual family, practice methods within the session are encouraged, ideally using a one-way mirror. For group training, there is discussion of the methods and any problems that families anticipate with implementation. Homework for the coming week is assigned. Praise, encouragement and positive feedback are provided throughout each session.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Groups (preferred modality) of 6 to 10 families</li> <li>• Individual families</li> </ul> <p>The decision of group vs. individual therapy may be based on issues relating to parental education level; type, number and severity of the child's problems; degree of family stress; and extent of individual attention a family may require.</p>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• For parent training groups, weekly sessions of 2 to 2½ hours for 10-12 weeks</li> <li>• For individual families, weekly sessions of 1 hour – flexible program length.</li> </ul>

<b>RESOURCES</b>	<p><i>Defiant Children</i> (Second Edition, 1997)  <i>A Clinician's Manual for Assessment and Parent Training</i>  The Guilford Press, NY (\$55.95 Canadian)  ISBN 1-57230-123-6  (Reproducible assessment forms and handouts are included in the Manual)</p> <ul style="list-style-type: none"> <li>• Spanish version of assessment tools and parent handouts are available from publisher (\$19.95US)</li> <li>• Companion video program with accompanying manuals: <i>Understanding the Defiant Child</i> (\$95US) and <i>Managing the Defiant Child: A Guide to Parent Training</i> (\$95US)</li> </ul>
<b>CONTACT INFORMATION</b>	<p><u>To purchase the manual:</u>  Parentbooks  201 Harbord St.  Toronto Ontario M5S 1H6  Phone: 1-800-209-9182 or 416- 537-8334  Fax (416) 537-9499  <a href="http://www.parentbookstore.com">www.parentbookstore.com</a></p> <p><u>CMHO contact who is knowledgeable about this program:</u>  Connie Ross  The Phoenix Centre for Children and Families  Suite 200, 130 Pembroke St. West  Pembroke, ON K8A 5M8  Phone: 613-735-2374 Ext. 236</p>
<b>MODIFICATIONS / ADAPTATIONS</b>	<p><u>Raising Children with ADHD</u> (Parent training and children's groups) adapted from <i>Defiant Children</i>.  Aisling Discoveries Child &amp; Family Centre  325 Milner Ave., Suite 110  Scarborough, ON M1B 5N1  Phone: 416-321-5464  Contact: Yvonne Bohr</p>
<b>SELECTED REFERENCES</b>	<ul style="list-style-type: none"> <li>• Forehand, R.L. &amp; McMahon, R.J. (1981). <i>Helping the noncompliant child: A clinician's guide to parent training</i>. New York: Guilford Press.</li> </ul> <p>This reference addresses the efficacy of procedures described by Barkley, including: improving parental selective attending, improving parental deliverance of commands, and parental use of time out.</p>

	<ul style="list-style-type: none"><li data-bbox="537 237 1365 415">• Anastopoulos, A.D., Shelton, T.L., DuPaul, G.J. &amp; Guevremont, D.C. (1993). Parent training for attention-deficit hyperactivity disorder: Its impact on parent functioning. <i>Journal of Abnormal Child Psychology</i>, 21, 581-596.</li></ul> <p data-bbox="537 457 1365 636">This article addresses the efficacy of procedures described by Barkley, including: improving children’s solitary play behaviour; parental use of time out; and parental planning and activity scheduling as problem prevention measures (particularly before entering public places).</p>
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<b>PROGRAM TITLE</b>	<b>THE INCREDIBLE YEARS: Parent and Child Training Series</b>
<b>DEVELOPER / AUTHOR</b>	Carolyn Webster-Stratton University of Washington Seattle, Washington
<b>TARGET POPULATION</b>	<ul style="list-style-type: none"> <li>• Parents and Teachers who work with children, ages 2-10, at high risk for developing conduct disorders, delinquency and substance abuse, e.g. families living in poverty, families with child protection issues.</li> <li>• Parents of children with conduct problems, ages 2-12, e.g., aggressive behaviour, defiance, destructive acts, noncompliance</li> <li>• Preschool, day care and early elementary teachers of students with conduct problems, ages 2-8</li> <li>• Parents at risk for abuse or neglect</li> <li>• Culturally diverse families (programs available in Spanish)</li> </ul>
<b>GOALS</b>	<p><u>For parents:</u></p> <ul style="list-style-type: none"> <li>• Strengthened parental competencies</li> <li>• Involvement in children's school experiences to promote children's academic and social competencies and reduce conduct problems.</li> </ul> <p><u>For children:</u></p> <ul style="list-style-type: none"> <li>• Strengthened social and academic competence</li> <li>• Reduced behaviour problems</li> <li>• Increased positive interactions with peers, teachers and parents.</li> </ul> <p><u>For teachers:</u></p> <ul style="list-style-type: none"> <li>• Strengthened teacher competence and home-school connections</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Social learning theory</li> <li>• Cognitive theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	The Incredible Years training programs have been strongly influenced by Gerald Patterson's social learning model which emphasizes the importance of the family and teacher socialization processes.

Trained leaders show parent groups videotaped situations of parents and children, and encourage discussion and problem solving. Participants discuss principles of childrearing and practice new skills through role playing and home practice.

- The Early Childhood BASIC Parent Training Program (ages 2-7) involves group discussion and a series of 250 video vignettes, teaching parents interactive play and reinforcement skills, nonviolent discipline techniques, logical and natural consequences, and problem solving strategies.
- The School Age BASIC Parent Training Program (ages 5-12) is a multicultural program that emphasizes strategies for older children, e.g. logical consequences, monitoring, problem solving with children, and family problem solving. It addresses how to support the child's education; promoting positive behaviours; and reducing inappropriate behaviours.
- ADVANCE Parent Training, a supplement to the Basic program, addresses other family risk factors, such as depression, marital discord, poor coping skills. It focuses on parent interpersonal issues, e.g. effective communication and problem-solving skills, anger management and ways to give and get support.
- The early childhood or the school-age BASIC program can be supplemented by the EDUCATION Parent Training Program (Supporting Your Child's Education) which covers topics such as: promoting children's confidence, fostering good learning habits, participating in homework and using parent conferences to advocate for your child. There is also a Teacher Training Program which addresses classroom management skills.

About 60% of each session consists of group discussion, problem solving, and support; 25% is videotape modeling; and 15% is teaching.

The leader calls parents every 2 weeks re. their progress and any difficulties with homework assignments. Also, the leader assigns each participant a "buddy". Buddies are



	<p>expected to speak during the week to share progress on homework and update each other if sessions are missed. Buddies are changed every few weeks.</p> <p><b>Note:</b> For comprehensive overviews of all programs, visit <a href="http://www.incredibleyears.com">www.incredibleyears.com</a> and click on OJJDP Review under Articles.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• BASIC programs can be self-administered or delivered to groups of 10-14 participants. ADVANCE programs are delivered to groups.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<p>BASIC: Two hours weekly for 12-14 weeks</p> <p>ADVANCE: Two hours weekly for 10-12 weeks (after BASIC)</p>
<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>• Especially for BASIC groups, it is preferable to have two group leaders, but one is adequate. Ideally, there should be one male and one female leader. Parents who have completed the program can receive training as co-leaders from certified trainers.</li> <li>• A VCR is required for program implementation.</li> <li>• There are separate leader manuals, parent, teacher and child books and posters for each of the three versions of the program. There are also videotapes with vignettes to facilitate group discussions, weekly homework assignments, weekly “refrigerator notes” and magnets. Audiotapes are available for the parent book, in both English and Spanish.</li> <li>• Costs vary depending on curriculum chosen and whether individual components versus complete sets are ordered.</li> <li>• Individual BASIC programs (ages 2-7), which are available in English or Spanish, range from \$330US. A set of all 4 BASIC programs costs \$1300US.</li> <li>• The ADVANCE Programs (ages 4-10) range from \$295US to \$395US, with all 3 available for \$775US.</li> </ul>

	<ul style="list-style-type: none"> <li>• SCHOOL AGE BASIC Parent Training Programs (age 5-12) cost from \$295US to \$495 each, with all 3 available for \$995US.</li> <li>• BASIC, ADVANCE and SCHOOL AGE BASIC programs (total of 10) can be purchased for \$2695US.</li> <li>• The Dina Dinosaur curriculum includes feeling spinning wheels, posters, laminated cue cards, stickers, books for children and life size puppets. Individual DINA programs range from \$145US to \$375US. Package of all 6 is available for \$975US.</li> <li>• It is considered essential to offer transportation, childcare and dinners, particularly when working with low income families.</li> <li>• <i>The Incredible Years</i> (guide for parents) is available (\$19.95) through Umbrella Press in Toronto (see Contact Information)</li> <li>• For full list of products, see website.</li> </ul>
<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Group leader certification is highly recommended by the program developer and is required if the program is to be evaluated as part of a research program. A certified leader may then become certified as a mentor of group leaders, i.e. he or she may qualify to train other trainers</li> <li>• Each workshop, for 25-30 participants, typically lasts for 3 days. Fees are negotiated according to the number of days of training and whether training includes one or more curricula. Travel costs are additional.</li> </ul>
<b>CORRESPONDING PEER GROUP INTERVENTION</b>	<p><u>Dina Dinosaur's Social Skills and Problem-Solving Curriculum</u> for working with children in small groups in 18-20 two hour group sessions. Tapes are narrated by child-size puppets using fantasy, role play and cooperative activities. The curriculum is designed to strengthen children's social and emotional competencies, e.g. understanding and communicating feelings; using effective problem solving strategies; managing anger; practicing friendship and conversational skills, and appropriate classroom behaviours.</p>

<p><b>CONTACT INFORMATION</b></p>	<p>Incredible Years  1411 8<sup>th</sup> Avenue West,  Seattle, WA 98119  Phone: 888-506-3562 or 206-285-7565  <a href="http://www.incredibleyears.com/research/evaluation.htm">www.incredibleyears.com/research/evaluation.htm</a>  <a href="mailto:Incredibleyears@seanet.com">Incredibleyears@seanet.com</a></p> <p>To order <i>The Incredible Years</i> (book for parents):  Umbrella Press  56 Rivercourt Blvd.,  Toronto, ON M4J 3A4  Phone: 416-696-6665</p>
<p><b>SELECTED REFERENCES</b></p>	<ul style="list-style-type: none"> <li>• Webster-Stratton, C, Hollinsworth, T, Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost effective training programs for families with conduct-problems children. <i>Journal of Consulting and Clinical Psychology, 57 (4): 550-553</i></li> </ul> <p>Parents of 114 children, ages 3 to 8, with conduct problems were randomly assigned to one of four groups: IVM (individually/self administered videotape modeling); BASIC (videobased group therapy); GD (group therapy alone); or waitlist control group. Relatively few differences were noticed between treatment groups, but these differences favoured BASIC training. Cost effectiveness was the major strength of the IVM program. Results indicated that all the significant improvements reported immediately posttreatment were maintained one year later. About two thirds of the entire sample showed clinically significant improvements. There were very few differences between the three treatment conditions, except for the consumer satisfaction measure indicating that the BASIC training was superior.</p> <ul style="list-style-type: none"> <li>• Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. <i>Journal of Consulting and Clinical Psychology 62(3): 583-593.</i></li> </ul> <p>Parents of 78 families with children with Obsessive Compulsive Disorder or Conduct Disorder received the BASIC parent training and were randomly assigned to either ADVANCE training for 12 weeks or no further contact. ADVANCE children showed significant increases in the total number of solutions generated during problem</p>

	<p>solving, most notably in prosocial solutions vs. aggressive solutions. There were significant improvements in marital interactions for ADVANCE parents' compared to the parents that did not receive ADVANCE.</p> <p><b>Note:</b> For a comprehensive summary of evaluation studies of the Incredible Years, including: parenting program claims, evaluation methods, evidence of efficacy, and full references, see <a href="http://www.incredibleyears.com/research/evaluation.htm">www.incredibleyears.com/research/evaluation.htm</a></p>
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**Additional References:**

Strengthening America's Families: [www.strengtheningfamilies.org](http://www.strengtheningfamilies.org)

Webster-Stratton, C. (2000). The Incredible Years Training Series, *Juvenile Justice Bulletin*, Washington, DC: U.S. Department of Justice. (Available through Incredible Years website.)

<b>PROGRAM TITLE</b>	<b>PARENTING WISELY</b>
<b>DEVELOPER / AUTHOR</b>	Donald Gordon Ohio University Athens, Ohio
<b>TARGET POPULATION</b>	<ul style="list-style-type: none"> <li>• Families at risk with children from 9 -18 years of age</li> <li>• Parents who may face barriers to parent education and family treatment, particularly low-income, at-risk populations. Suitable for illiterate parents and for those who prefer a private parent training experience.</li> <li>• English and Spanish versions.</li> <li>• French version expected before the end of 2001.</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>• Enhanced family relationships and decreased conflict.</li> <li>• Parenting skills to prevent or arrest the development of serious problems such as: delinquency, academic failure, substance abuse, violence, irresponsible and reckless behaviour, chronic family conflict, and depression.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Social learning theory</li> <li>• Family systems theory</li> <li>• Cognitive behavioural theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>Through a self-administered, self-paced CD-ROM program (no previous computer experience required), parents view video scenes of common family problems. The program is based on the Functional Family Therapy model developed by James Alexander (University of Utah), and presents problems and explanations within a family systems context.</p> <p>Parents must think and select responses for the program to continue. For each problem selected, parents choose a solution, see it enacted, and listen to a critique of their chosen response.</p> <p>The program covers:</p> <ul style="list-style-type: none"> <li>• Communication skills</li> <li>• Problem solving skills</li> <li>• Speaking respectfully</li> <li>• Assertive discipline</li> <li>• Reinforcement</li> </ul>

	<ul style="list-style-type: none"> <li>• Chore / homework compliance</li> <li>• Supervising children associating with negative peers</li> <li>• Step-family problems</li> <li>• Single parent issues</li> <li>• Violence and others</li> </ul> <p>The program can be used as a family intervention to promote conversation among parents and teens, and the development of the same skills by both generations. A therapist can reinforce learning from the program. Parenting Wisely can be used prior to a first family therapy session, e.g. for waitlisted clients, as an adjunct to therapy, or as a booster session after therapy.</p> <p>The program advises parents to seek additional professional help if their family problems do not improve significantly with this program.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Interactive CD-ROM</li> <li>• Video series.</li> <li>• Delivered individually with families or in groups.</li> <li>• May be used in home or in clinical settings.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• 2.5 to 3 hours over one to three sessions</li> </ul>
<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>• One staff member, who does not require clinical skills, can deliver the program, i.e. turn on the computer and show the family how to move the cursor on the screen. For home viewing, agencies might need to drop off and pick up a laptop computer.</li> <li>• Required: Pentium 166 Mhz or higher with 16MB or more RAM, 4X CD-ROM or better, Windows 95 or later with sound card and speakers.</li> <li>• Required: CD-ROM (\$900US) in English or Spanish. Disc comes with kit (manual for community implementation, five parent workbooks, program completion certificates, brochures, referral cards and floppy disk with evaluation forms). Replacement supplies are available, but certificates, brochures and referral cards may be photocopied.</li> </ul>

	<ul style="list-style-type: none"> <li>• For multiple computer sites, multiple copies of the CD-ROM must be purchased, and are available at a discount.</li> <li>• Required: Parent workbooks (one per family @ \$8.75 to \$5.75US depending on quantity ordered)</li> <li>• Videotapes (English or Spanish) can be used as a booster for in-home use after the family has used the CD-ROM. The Parenting Wisely Video Series includes: Service Provider's Guide, 3 parent workbooks, poster, floppy disc with evaluation forms, scoring keys, program evaluation guide. Cost is \$150US for purchasers of CD-ROM, and \$250US for others. Individual Tapes (Part I,II,III) cost \$99.50US each</li> <li>• Incentives to get parents to the program are strongly recommended, e.g. restaurant coupons, movie tickets, gift certificates, etc. Also recommended is childcare and transportation.</li> </ul>
<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Training for the agency is not required. One-day training is available for staff in dissemination of the program in communities (\$1500US for Donald Gordon, or \$600 for a staff member).</li> <li>• Free telephone consultation by the developer is available.</li> </ul>
<b>CORRESPONDING PEER INTERVENTION PROGRAM</b>	<ul style="list-style-type: none"> <li>• CD-ROM and videos can be used along with teens and preteens.</li> </ul>
<b>CONTACT INFORMATION</b>	<p>Family Works Inc.,  20 East Circle Drive, Suite 190  Athens, OH 45701  Tel: 866-234-WISE(toll free), or 740-593-9505  Fax: 740-597-1598  Website: <a href="http://www.familyworksinc.com">www.familyworksinc.com</a></p>
<b>MODIFIED VERSIONS / ADAPTATIONS</b>	<ul style="list-style-type: none"> <li>• <i>The Wise Parent</i> is a 3 CD set covering the same information and video scenes as in <i>Parenting Wisely</i>. It is designed for parents comfortable with computers and whose educational attainment is higher, as the reading level is 12th grade. <i>The Wise Parent</i> assumes parents</li> </ul>

	<p>are motivated to get the information, since they purchase the program themselves for home use and does not force them into particular content. (\$99US for all 3, or \$33.95US each).</p>
<p><b>SELECTED REFERENCES</b></p>	<ul style="list-style-type: none"> <li>• Kacir, C.D., and Gordon, D.A. (1999) Parenting Adolescents Wisely: The effects of an interactive video-based parent training program in Appalachia. <i>Child and Family Behaviour Therapy</i>, 21(4), 1-22.</li> </ul> <p>Thirty-eight mothers of middle school students (average scores in the clinically deviant range) were randomly assigned to either Parenting Adolescents Wisely (PAW) or a control group. One month after using the PAW program, the group showed significant increases in knowledge of parenting skills and principles and children showed significant reductions in problem behaviours. The control group did not show changes. Four months later, the treatment group showed more improvements, while the control group showed no change. Most of the treated group showed scores in the normal range while none of the control group showed such change.</p> <ul style="list-style-type: none"> <li>• Segal, D., Chen, P., Gordon, D.A., Kacir, C., &amp; Gylys, J. (1999). Parenting Adolescents Wisely: Comparing interactive computer-laserdisk and linear video methods of intervention in a parent training program.</li> </ul> <p>Parents of children who were being seen at mental health centres for behaviour problems were randomly assigned to a Parenting Adolescents Wisely (PAW) interactive video disk group, or a PAW videotape (linear) group. The content of the two programs was very similar, but the learning format was either interactive or passive. Scores improved with both groups, showing reductions in child problem behaviours. One-third to one-half of the children in both groups showed changes into the normal of functional range of behaviour. Parents showed significant improvements on knowledge of effective parenting principles and skills, and on a self-report measure of use of the parenting skills taught in the program.</p>

**Additional References:**

Strengthening Families: [www.strengtheningfamilies.org](http://www.strengtheningfamilies.org)



<b>PROGRAM TITLE</b>	<b>SNAP™ (Stop-Now-and-Plan: Parenting Training)</b>
<b>DEVELOPER / AUTHOR</b>	Earls court Child and Family Centre Toronto
<b>TARGET GROUP</b>	<ul style="list-style-type: none"> <li>Families with children under age 12 who are exhibiting disruptive, noncompliant, and aggressive behaviours</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>Teaching parents about SNAP™, a self-control and problem-solving skill taught to their children, and how they can encourage their children's use of SNAP™ at home and at school.</li> <li>Teaching parents effective parenting skills.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>Social learning theory</li> <li>Cognitive theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>SNAP™ is part of the multifaceted Under 12 Outreach Project (ORP) of the Earls court Child and Family Centre. The central objective of the ORP is to reduce police contact among a population at risk of engaging in criminal activity. Core components include SNAP™ groups for children and the complementary parent groups.</p> <p>SNAP™ is a cognitive tool taught to children to help them control their behaviour, think about the consequences of their behaviour, and develop socially appropriate plans. It is taught to parents as an anger management technique to help them remember not to discipline when emotionally aroused, to think about what they want to achieve, and to administer a non-violent consequence appropriate to the circumstances.</p> <p>The leader introduces a specific parent/child problem and applicable parenting skill at each session. After the opening discussion, the leader works through the skill as outlined, asks parents for examples of how to use it, models the skill, and then calls for volunteers to role-play using it. Parents receive a homework assignment at the end of each session.</p> <p>It is strongly recommended to begin each session with structured stretch/relaxation exercises. This is followed by review of homework, group discussion, and role-play of the</p>

	<p>session's parenting skill. Homework promotes the use of the new parenting skill during the week at home. Praise and encouragement re. homework completion are very important.</p> <p>Topics covered typically include:</p> <ul style="list-style-type: none"> <li>• Introductory session re SNAP™ for parents</li> <li>• Stopping stealing</li> <li>• Tracking (watching and noting) child behaviour</li> <li>• Monitoring and routines</li> <li>• Listening and encouraging</li> <li>• Giving commands</li> <li>• Charting rewards (2 sessions)</li> <li>• Time out (2 sessions)</li> <li>• Problem Solving</li> <li>• Home and school relations</li> </ul>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Small group</li> <li>• The group leader calls each parent during the week to inquire about use of the skill addressed in the previous session, and to encourage attendance at the next meeting.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• 1½ hour sessions for 12 weeks, held at the same time as the children's groups.</li> </ul>
<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>• <b>Use of SNAP™ without a license is strictly prohibited.</b> Licenses are available from EarlsCourt for \$1.</li> <li>• One group leader per parent group. Parents who are graduates of the groups and show leadership potential are encouraged to co-lead subsequent groups. Paraprofessionals can implement the program with supervision by professionals through use of a one-way mirror, two-way telephone, and taping sessions with voice-over for review. Professional group leaders can also be used.“ Only group leaders trained in the principles of behaviour management and behaviour change, and skilled in contingent reinforcement, modeling, role playing, and group management should attempt to use (SNAP™). A basic knowledge of stretch and relaxation exercises is also required.”</li> </ul>

	<ul style="list-style-type: none"> <li>• Childcare: Siblings that are younger or older than the child in the SNAP™ group are cared for in a structured activity group where the SNAP™ approach is used. Children do crafts, games, etc.</li> <li>• VCR and television</li> <li>• Games, arts and craft materials</li> <li>• Dollar-value prizes</li> <li>• <u>SNAP™ Resource Kit</u> - including manuals, assessment tools, 2 training videos, booklets (\$150, or \$143 if 10+ kits ordered). Individual components also available.</li> </ul> <p>Manuals:  SNAP™ Children’s Group Manual  SNAP™ Parent Group Leader Manual  SNAPP Stop-Now-And-Plan-Parenting: Parenting children with behaviour problems (for parents and parent-educators)</p> <p>Assessment Tools:  Early Assessment Risk List for Boys  Early Assessment Risk List for Girls</p> <p>Training Videos:  SNAP™  Stopping Stealing</p> <p>Booklets:  Lying, Bullying, Stopping Stealing, SNAP™, Brothers and Sisters Learn SNAP™, Tips for Troubled Times (parent companion guide to SNAP™ Parent Group Leader Manual)</p> <p>Also available to purchasers of kit: SNAP™ large hand-held puppet (\$125).</p> <ul style="list-style-type: none"> <li>• Taxis or tickets for public transportation are recommended to encourage attendance.</li> <li>• Snacks for parents and children’s groups.</li> </ul>
<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Optional training and consultation about implementation are available from Earls court. Training off-site (from ½ day to 5 days) costs \$2000 per day; reduced fee for training at Earls court.</li> </ul>

<b>MODIFICATION / ALTERNATIVES</b>	<ul style="list-style-type: none"> <li>• <u>SNAPP – Stop-Now-And-Plan-Parenting</u> SNAPP is a program designed for intervention with individual families. It focuses on interactional sequences that occur in families, inside and outside of the home, and the effect that family members have on each other during interactions. The program utilizes modeling, role playing and homework practice of skills to encourage change in parent-child interactions.</li> </ul> <p>As parents are seen as the primary agents of change, families set their own goals, and strategies are designed to meet the family’s needs. Specific skill training includes: tracking, positive communication techniques, rewarding, disciplining, monitoring, and problem solving.</p>
<b>CORRESPONDING PEER GROUP INTERVENTION</b>	<ul style="list-style-type: none"> <li>• SNAP™ (Stop Now and Plan) - See description in this document.</li> </ul>
<b>CONTACT INFORMATION</b>	<p>Leena Augimeri Earlscourt Child and Family Centre 46 St. Clair Gardens Toronto, Ontario M6E 3V4 Phone: 416-654-8981 Email: <a href="mailto:laugimeri@earlscourt.on.ca">laugimeri@earlscourt.on.ca</a> Website: <a href="http://www.earlscourt.on.ca">www.earlscourt.on.ca</a></p>
<b>SELECTED REFERENCES</b>	<ul style="list-style-type: none"> <li>• Day, D.M. &amp; Hrynkiw-Augimeri, L. (1996). Serving children at risk for juvenile delinquency: an evaluation of the Earlscourt Under 12 Outreach Project (ORP) Final Report submitted to Department of Justice, Sept. 1996.</li> </ul> <p>Of 32 children, aged 6-11, with clinically significant behavioural problems / police contact, half were randomly assigned to the Intermediate Treatment Group (ITG) (Under 12 Outreach Project: Transformer Club peer intervention, Parent Group and Individual Befriending, Tutoring) and half were assigned to the Delayed Treatment Group. “Children in the ITG evidenced significant reductions in behaviour problems, according to their parents, but not their teachers. Significant decreases were also observed in their self-reported delinquent behaviour. ...Children in the ITG reported that they had less positive attitudes toward antisocial behaviour and that fewer of their peers engaged in antisocial behaviour...”(p77) "Parents in the ITG also showed significant reductions in their level of stress related</p>

	<p>to the parent-child relationship as well as some positive increases in their attitudes toward parenting and perceived self-competence in managing child behaviour problems.” (p78)</p> <ul style="list-style-type: none"> <li>• Hrynkiw-Augimeri, L., Pepler, D., &amp; Goldberg, K. (1993). An outreach program for children having police contact. <i>Canada’s Mental Health</i>, 42, 7-12.</li> </ul> <p>Fifty-four boys and 10 girls with clinically significant behavioural problems / police contact participated in the Under 12 Outreach Project (ORP), including Transformer Club, Parent Group and Individual Befriending. “There were significant improvements in parents’ ratings of total, externalizing and internalizing behaviour problems...” (pp. 9-10) “There were significant improvements from admission to 6 month follow-up on parent ratings of total, externalizing and internalizing behaviour problems, and social competence...” (p.10)</p>
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**Additional References:**

Under 12 Outreach Project (ORP) Research Summary. Toronto: Earls court Child and Family Centre, Draft October 12, 2000.

Levene, Kathryn (1998). SNAPP Stop-Now-And-Plan Parenting: Parenting children with behaviour problems. Toronto: Earls court Child and Family Centre

## SECTION 5

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Children and Adolescents with Conduct Disorder:  
**Evidence Based Peer Group Intervention Programs**

## PEER GROUP INTERVENTION PROGRAMS

TITLE	AGE RANGE	GENERAL COST OF PROGRAM MATERIALS	NUMBER OF SESSIONS
<b>AGGRESSION REPLACEMENT TRAINING (ART)</b>	12 -18 years	Low	3 per week for 10 to 14 weeks
<b>I CAN PROBLEM SOLVE (ICPS)</b>	4 -12 years	Low	Up to 3 per week for the school year
<b>SKILLSTREAMING</b>	4 -18 years	Low	2 per week for the school year
<b>SNAP™ (STOP NOW AND PLAN)</b>	6 -12 years	Low	12

<b>PROGRAM TITLE</b>	<b>AGGRESSION REPLACEMENT TRAINING: A Comprehensive Intervention for Aggressive Youth</b>
<b>DEVELOPER / AUTHOR</b>	Arnold P. Goldstein, Barry Glick, John C. Gibbs
<b>TARGET GROUP</b>	<ul style="list-style-type: none"> <li>• Aggressive youth, aged 12-18.</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>• Improved social skills</li> <li>• Reduced incidents of rearrest</li> <li>• Enhanced community functioning</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Social learning theory</li> <li>• Structured learning</li> <li>• Systems theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>The multimodal, psychoeducational curriculum addresses prosocial, interpersonal skills (i.e. what to do instead of aggression), Anger Control Training (to teach youth what not to do if provoked), and Moral Reasoning Training (to promote values that respect the rights of others, and help youths want to use the interpersonal and anger management skills taught). ART has been described as an expansion of the Skillstreaming approach.</p> <p>The skill development curriculum is implemented through modeling, role-playing, performance feedback, and transfer training. The curriculum includes:</p> <ul style="list-style-type: none"> <li>• Beginning social skills</li> <li>• Advanced social skills</li> <li>• Skills for dealing with feelings</li> <li>• Alternatives to aggression</li> <li>• Skills for dealing with stress</li> <li>• Planning skills</li> </ul> <p>The Anger Control Training component of the program teaches youth to respond to their own anger-arousing experiences (“hassles”), which they record in a log, through:</p> <ul style="list-style-type: none"> <li>• Identifying triggers</li> <li>• Identifying cues</li> <li>• Using reminders (e.g. self-statements, such as “stay calm”)</li> </ul>



	<ul style="list-style-type: none"> <li>• Using reducers (e.g. deep breathing)</li> <li>• Using self-evaluation</li> </ul> <p>Moral education, conveyed through discussion meetings, is intended to raise the adolescent's level of fairness, justice and concern with the rights and needs of others.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Small group (maximum 6-8 participants)</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• One group session weekly in each of the 3 program components (i.e. 3 group sessions per week) for 10 to 14 weeks or longer.</li> </ul>
<b>RESOURCES</b>	<p><i>Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth</i> Arnold P. Goldstein, Barry Glick &amp; John C. Gibbs Champaign, IL: Research Press (\$22.45US)</p> <ul style="list-style-type: none"> <li>• 2 group leaders</li> </ul>
<b>MODIFICATIONS / ALTERNATIVES</b>	<ul style="list-style-type: none"> <li>• <u>EQUIP Program</u> ART combined with a Positive Peer Culture approach. Designed to be a motivational, skills-oriented intervention. <i>The EQUIP Program: Teaching youth to think and act responsibly through a peer-helping approach.</i> J.C. Gibbs, G.B. Potter, &amp; A.P. Goldstein (1995) Champaign, IL: Research Press (\$24.95US)</li> </ul>
<b>CONTACT INFORMATION</b>	<p><u>To purchase ART, Skillstreaming or EQUIP:</u> Research Press 2612 North Mattis Avenue Champaign, IL 61822 Phone: 1-800-519-2707 / 217-352-3273 Fax: 217-352-1221 <a href="http://www.researchpress.com">www.researchpress.com</a></p> <p><u>For consultation about Aggression Replacement Training</u> (based on Goldstein's work) Roberts/Smart Centre Suite 500, 1335 Carling Avenue Ottawa, ON K1Z 8N8 Contact: Francine Chappus Phone: 613-728-1946 Ext. 230</p>

**SELECTED REFERENCES**

- Goldstein, Arnold P. & Glick, Barry (1994) Aggression Replacement Training: Curriculum and Evaluation. *Simulation and Gaming, Vol. 25, No. 1(March)*.

This article discusses a series of efficacy evaluations which combine to suggest that ART appears to promote social skills acquisition and performance, improve anger control, decrease the frequency of acting-out behaviours, and increase the frequency of constructive, prosocial behaviours both within and outside of institutional settings.

- Feindler, Eva L. & Scalley, Maria (1998). Adolescent Anger-Management Groups for Violence Reduction (Chapter 6). In T. Ollendick and K. Storber (Eds.) *Group Interventions in the School and Community*, Allyn & Bacon, 99.100-118.

Information about the etiology of youth violence, a review of research supporting the use of anger management for violence reduction, interventions in institutional and community settings, and specific implementation techniques and issues.

Re EQUIP:

- Leeman, L.W., Gibbs, J.C., Fuller, D., & Potter, G. (1991) Evaluation of a multi-component treatment program for juvenile delinquents. *Aggressive Behaviour, 19, 281-292*.

57 incarcerated male juvenile offenders were randomly assigned to the EQUIP program (ART plus positive peer culture), a control group that received a motivational message, or a no-training control group. The recidivism rate for EQUIP participants remained low and stable, i.e. 15% at both 6 months and 1 year, while the average recidivism rate for the control groups was nearly 30%. As well, institutional conduct improvements were highly significant for the EQUIP relative to the control groups re. self-reported misconduct, staff-field incident reports and unexcused absences from school.

<b>PROGRAM TITLE</b>	<b>I CAN PROBLEM SOLVE (ICPS) An Interpersonal Cognitive Problem-Solving Program</b>
<b>DEVELOPER / AUTHOR</b>	Myrna B. Shure
<b>TARGET GROUP</b>	<ul style="list-style-type: none"> <li>• Children from 4 to 12 years of age, at risk for developing conduct disorder or other disorders, e.g. depression.</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>• Teaching children problem-solving skills to help resolve or prevent interpersonal problems and antisocial behaviour.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Cognitive problem-solving</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>ICPS teaches children “<i>how</i> to think, not <i>what</i> to think”. It guides children to think for themselves, evaluate their own ideas, and come up with multiple solutions to problems on their own. Skills are taught through games, stories, puppets, and role playing.</p> <p>While this program is designed primarily for classroom settings, it can be of use in a clinic setting, i.e. for a social skills groups. It includes both formal lessons and specific suggestions for incorporating ICPS principles in child interactions.</p> <p>“Lessons”, which should be referred to as “games” when appropriate, are grouped into pre-problem-solving and problem-solving skills. The ICPS words and other pre-problem-solving concepts set the stage for the problem-solving skills, which are associated with:</p> <ul style="list-style-type: none"> <li>• Alternative solutions</li> <li>• Consequences</li> <li>• Solution-consequence pairs</li> <li>• Means-end thinking.</li> </ul> <p>Having children associate what they think with what they do in real life situations is essential to the success of the program.</p> <p>Central to ICPS is the process of problem-solving dialoguing, which helps children to try again if their first attempt to solve a problem fails, and to learn to cope with</p>

	<p>frustration. The process assists children to:</p> <ul style="list-style-type: none"> <li>• Identify the problem</li> <li>• Appreciate their own and others' feelings</li> <li>• Think of solutions to the problem</li> <li>• Anticipate the consequences of a solution.</li> </ul>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Group. For very young children, groups of 2 or 3; possibly larger for older children. Group size should be determined by nature and extent of behavioural issues among participants.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• The programs are designed for use in a classroom setting where they could be implemented through 40-45 minute sessions three times per week, with consistent reinforcement of skills in day to day interactions. According to the developer and others, however, the program can also be useful in clinical settings, e.g. for social skills groups. In a classroom setting, e.g. day treatment, the full program could be completed well within the school year.</li> </ul>
<b>RESOURCES</b>	<p><i>I Can Problem Solve</i>  <i>An Interpersonal Cognitive Problem-Solving Program</i>  (Second Edition, 2001) (\$39.95US)  Versions for Preschool, Kindergarten and Early Elementary levels</p>
<b>TRAINING</b>	<p>Training is optional. See Contact Information below.</p>
<b>CORRESPONDING PARENT TRAINING PROGRAM</b>	<p><u>Raising a Thinking Child</u>  <i>Raising a Thinking Child Workbook</i> (\$19.95US).  For families with children aged 4-7. This workbook stands alone as a parenting manual and can be used by clinicians with parents to help reinforce the ICPS approach at home.  <i>Raising a Thinking Preteen</i> (new)  For families with children aged 8-12.</p>
<b>MODIFICATIONS / ALTERNATIVES</b>	<ul style="list-style-type: none"> <li>• Preschool ICPS</li> <li>• Kindergarten and Early Elementary Grades ICPS</li> <li>• Intermediate Elementary Grades ICPS</li> </ul>
<b>CONTACT INFORMATION</b>	<p><u>To purchase books:</u>  Research Press  2612 North Mattis Avenue  Champaign, Illinois 61822  Phone: 1-800-519-2707 / 217-352-3273  Fax: 217-352-1221  <a href="http://www.researchpress.com">www.researchpress.com</a></p>

	<p>Parentbooks  201 Harbord St.  Toronto, ON M5S 1H6  Phone: 1-800-209-9182 or 416- 537-8334  Fax (416) 537-9499  <a href="http://www.parentbookstore.com">www.parentbookstore.com</a></p> <p><u>To arrange training or obtain phone consultation:</u>  Myrna B. Shure, Ph.D.  MCP Hahnemann University, MS 626  245 N. 15<sup>th</sup> St., Philadelphia, PA 19102  Phone: 215-762-7205  Fax: 215-762-8625  E-mail: <a href="mailto:mshure@drexel.edu">mshure@drexel.edu</a></p>
<p><b>SELECTED REFERENCES</b></p>	<ul style="list-style-type: none"> <li>• Shure, Myrna B. Research Summary (available from Research Press and author).</li> </ul> <p>A five year longitudinal study of children trained in kindergarten, or kindergarten and Grade 1, and followed through Grade 4, was the culmination of 20 years of research. The study's primary aim was to address long-term effectiveness of ICPS on cognitive and behavioural outcomes. 542 inner-city African-American low SES kindergarten children were studied. Children trained by their teachers in kindergarten, in kindergarten and Grade 1, and by their teachers in kindergarten and their mother in Grade 1, were compared to never-trained controls. On external (impulsivity), internal (inhibition), and total problem scores, the two-year trained group emerged dramatically superior in both boys and girls. In the mother-trained group, children whose mothers best applied ICPS dialogues were still maintaining significant gains at the end of Grade 4.</p> <ul style="list-style-type: none"> <li>• Shure, Myrna B. Final Report (Oct. 1993) to Department of Health and Human Services, Public Health Service, National Institute of Mental Health. (Available from author).</li> </ul> <p>This 5 year longitudinal study involved an initial sample of 562 inner city black low SES kindergarten youngsters. The impact of the following ICPS interventions was assessed: in kindergarten only (trained by teacher); kindergarten and first grade (trained by teacher); kindergarten (trained by teacher) and first grade (trained by mother); and never trained controls. The most dramatic findings were that at</p>

	<p>the end of grade 2, mother-trained girls were the least impulsive, the least inhibited, and showed the fewest total behaviour problems with the same being true for boys trained by their teachers one or both years. Within the mother-trained group, the linkage between mothers' application of the training to real life and both boys and girls behavioral gains remained as long as they were studied, through grade 4.</p>
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<b>PROGRAM TITLE</b>	<b>SKILLSTREAMING</b>
<b>DEVELOPER / AUTHOR</b>	Arnold P. Goldstein and Ellen McGinnis
<b>TARGET GROUP</b>	<ul style="list-style-type: none"> <li>Children and adolescents aged 3-18 with aggression and other prosocial skill deficits.</li> </ul> (There are separate Skillstreaming programs for: the Preschool child, the Elementary School child, and the Adolescent.)
<b>GOALS</b>	<ul style="list-style-type: none"> <li>Improved interpersonal skills, including management of aggression.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>Social learning theory</li> <li>Structured learning</li> <li>Systems theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>Note: This description applies to the Adolescent Skillstreaming program. For references regarding programs for other age groups, see Modifications below.</p> <p>There are four core training procedures: modeling, role-playing, performance feedback and generalization training. Trainers lead the group through the following steps:</p> <ul style="list-style-type: none"> <li>Define the skill</li> <li>Model the skill</li> <li>Establish the skill need</li> <li>Select role-player</li> <li>Set up the role-play</li> <li>Conduct the role-play</li> <li>Provide performance feedback</li> <li>Assign skill homework</li> <li>Select next role-player</li> </ul> <p><u>The Skillstreaming Curriculum for Adolescents</u> includes:</p> <ul style="list-style-type: none"> <li>Beginning Social Skills: listening, starting a conversation, having a conversation, asking a question, saying thank you, introducing yourself, introducing other people, giving a compliment.</li> </ul>

	<ul style="list-style-type: none"> <li>• Advanced Social Skills: asking for help, joining in, following instructions, apologizing, convincing others.</li> <li>• Skills for Dealing with Feelings: knowing your feelings, expressing your feelings, understanding the feelings of others, dealing with someone else's anger, expressing affection, dealing with fear, rewarding yourself.</li> <li>• Skill Alternatives to Aggression: asking permission, sharing something, helping others, negotiating, using self-control, standing up for your rights, responding to teasing, avoiding trouble with others, keeping out of fights</li> <li>• Skills for Dealing with Stress: making a complaint, answering a complaint, being a good sport, dealing with embarrassment, dealing with being left out, standing up for a friend, responding to persuasion, responding to failure, dealing with contradictory messages, dealing with an accusation, getting ready for a difficult conversation, dealing with group pressure.</li> <li>• Planning Skills: deciding on something to do, deciding what caused a problem, setting a goal, deciding on your abilities, gathering information, arranging problems by importance, making a decision, concentrating on a task.</li> </ul> <p>The book includes a full chapter on increasing trainee motivation and reducing resistance.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Small group, i.e. 6-8 trainees; or as low as 2 to start, e.g. if very aggressive.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• 45-50 minutes, twice per week optimally, allowing for practice between sessions.</li> <li>• Groups typically run through the school year, but can be run for as few as 2 days, e.g. in short term custody / detention settings. Groups can be open-ended.</li> <li>• Recommended duration relates to the number of skills selected for teaching.</li> </ul>
<b>RESOURCES</b>	<p><i>Skillstreaming the Adolescent: New Strategies and Perspectives for Teaching Prosocial Skills</i> (Rev. ed., 1997)  Arnold P. Goldstein and Ellen McGinnis  Champaign, IL: Research Press (\$17.95US)</p>



	<p><u>Supplementary components:</u>  Skillstreaming Student Manual  Skill Cards – 400 cards with behavioural steps for 50 skills  Program Forms (reproducible)  Skill Cards (purchased or made by leaders or participants)  Skill step posters  Video: People Skills Doing'em Right (Elementary Level) – 17 minutes (\$95US)  Video: People Skills Doing'em Right (Adolescent Level) – 17 minutes (\$95US)</p>
<b>TRAINING</b>	<p>Training is optional.</p> <ul style="list-style-type: none"> <li>• The Skillstreaming Video: How to Teach Students Prosocial Skills – 26 minutes (\$365US). Includes copy of Skillstreaming the Elementary School Child and Skillstreaming the Adolescent.</li> <li>• Video Workshop: Teaching Prosocial Behaviour to Antisocial Youth: Six-part video program (6 hours) focusing on Skillstreaming and to a lesser extent on Aggression Replacement Training and the Prepare program. Includes Workshop Supplement (\$495US).</li> <li>• For other training options, see Contact Information below.</li> </ul>
<b>MODIFICATIONS / ALTERNATIVES</b>	<p><u>For other age levels:</u>  <i>Skillstreaming in Early Childhood: Teaching Prosocial Skills to the Preschool and Kindergarten Child</i> (1990)</p> <p><i>Skillstreaming the Elementary School Child: New Strategies and Perspectives for Teaching Prosocial Skills</i> (Rev. Edition: 1997)</p> <p><u>Related Programs</u></p> <ul style="list-style-type: none"> <li>• Aggression Replacement Training (ART)  An expansion of the Skillstreaming approach. (See description elsewhere in this document.)</li> <li>• EQUIP  An expansion of the Skillstreaming and ART approaches; ART combined with a Positive Peer Culture approach. Designed to be a motivational, skills-oriented intervention.  <i>The EQUIP Program: Teaching youth to think and act</i></li> </ul>

	<p><i>responsibly through a peer-helping approach.</i>  J.C. Gibbs, G.B. Potter, &amp; A.P. Goldstein (1995)  Champaign, IL: Research Press (\$24.95US)</p>
<p><b>CONTACT INFORMATION</b></p>	<p><u>To purchase Skillstreaming, ART or EQUIP materials:</u>  Research Press  2612 North Mattis Avenue  Champaign, IL 61822  Phone: 1-800-519-2707 / 217-352-3273  Fax: 217-352-1221  <a href="http://www.researchpress.com">www.researchpress.com</a></p> <p><u>For local training:</u></p> <ul style="list-style-type: none"> <li>• “Social Skills Training for Anti-Social Children and Adolescents”. This is one of three part in a series “Treating Antisocial Behaviour”, which also includes Anger Control Training and Parent Skill Training.  Contact: Rick McCendie  150 Montreal Rd., Suite 207,  Ottawa, ON  Phone: 613-220-3815  <a href="mailto:rickmcc@magma.ca">rickmcc@magma.ca</a></li> <li>• “The Goals and Means Program” (social skills training based on Goldstein’s work, with additional generalization components). Available from:  Roberts/Smart Centre  1335 Carling Ave., Suite 500,  Ottawa, ON K1Z 8N8.  Contact: Francine Chappus  Phone: 613-728-1946 Ext. 230  2 day workshop; fee to be determined.</li> </ul> <p><u>For training by Goldstein:</u>  Arnold P. Goldstein  Center for Research on Aggression  Syracuse University  805 South Crouse Avenue  Syracuse, New York 13244  Phone: 315-443-9641</p>
<p><b>SELECTED REFERENCES</b></p>	<ul style="list-style-type: none"> <li>• Goldstein, A.P., Gershaw, N.J., &amp; Sprafkin, R.P. (1985). Structured Learning: Research and practice in psychological skills training. In L’Abate &amp; M.A. Milan (Eds.), <i>Handbook of social skills training and research</i>. New York: Wiley.</li> </ul>

	<p>Explores the history and development of psychological skills training in general and the Skillstreaming approach in particular, including its constituent methods, curriculum, and research evaluations.</p> <ul style="list-style-type: none"><li>• Goldstein, A.P., Gershaw, N.J., &amp; Sprafkin, R.P. (1995). Teaching the adolescent: Social skills training through Skillstreaming, in G. Cartledge &amp; J.F. Milburn (Eds.), <i>Teaching social skills to children and youth</i>. Boston: Allyn &amp; Bacon.</li></ul> <p>A description of the Skillstreaming method as utilized with adolescent populations. Examined are the developmental relevance of this approach, methods and application, curriculum, means for enhancing trainee motivation, and the Aggression Replacement Training and Prepare Curriculum expansions of the approach.</p>
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<b>PROGRAM TITLE</b>	<b>SNAP™ (Stop-Now-and-Plan: Peer Group Intervention)</b>
<b>DEVELOPER / AUTHOR</b>	Earls court Child and Family Centre Toronto
<b>TARGET POPULATION</b>	<ul style="list-style-type: none"> <li>• Children from 6 to 12 years of age who are exhibiting disruptive, noncompliant, and aggressive behaviours</li> </ul>
<b>GOALS</b>	<ul style="list-style-type: none"> <li>• Decreasing children’s antisocial behaviour</li> <li>• Increasing children’s social competence.</li> </ul>
<b>THEORETICAL FOUNDATION</b>	<ul style="list-style-type: none"> <li>• Social learning theory</li> <li>• Cognitive theory</li> </ul>
<b>PROGRAM OVERVIEW</b>	<p>SNAP™ is part of the multifaceted Under 12 Outreach Project (ORP) of the Earls court Child and Family Centre. The central objective of the ORP is to reduce police contact among a population at risk of engaging in criminal activity. Core components include SNAP™ groups for children (“Transformers Clubs”), and complementary parent groups.</p> <p>SNAP™ (Stop Now And Plan) is a cognitive behavioural approach designed to help children control impulsivity, think about the consequences of their behaviour, and develop a socially appropriate plan. The basic self-control and problem-solving skill taught is reinforced through practice in different situations at each Transformer Club meeting. Children learn how to stop themselves, snap their fingers, say “SNAP”, take a deep breath, and think about what they want to achieve and its consequences.</p> <p>Meetings include brief periods of unstructured play, discussion, modeling, coaching and behavioural rehearsal, structured play, and relaxation. Each of the seven activities that comprise the format of each meeting has a name related to Transformers toys. The theme (Transformers) can be adapted to other popular themes of interest, provided that it is presented consistently and imaginatively throughout the program.</p> <ul style="list-style-type: none"> <li>• <i>Smooth Landing</i>: Arrival time, allowing for free play that reinforces prompt arrival and permits latecomers to join unobtrusively.</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Docking Bay</i>: Children begin to explore a problematic social situation that requires their use of SNAP™. These may include situations such as joining in, stealing, dealing with angry feelings, dealing with accusations, etc.</li> <li>• <i>Code Engage</i>: Group leaders model “thinking aloud” by enacting a problem-solving process that uses SNAP™, and sometimes requires enactment by one or two children. Children participate in role plays, which are videotaped, with quiet intervention by leaders to maximize success and support the child’s emotional involvement. Constructive feedback to video playbacks is encouraged.</li> <li>• <i>Moonwalk</i>: Planned recreational activity, preferably in gym or outdoors. SNAP™ and conflict mediation by leaders are used.</li> <li>• <i>Galactic Ingestion and Code Mission</i>: Snack is provided. Homework for the week is handed out, to be pasted by the children in their “passbooks”. Passbooks are to be brought to the club each meeting. They are checked by group leaders during arrival time, so that completed Code Missions can be charted to recognize accomplishments. Children completing four code missions may select a small, dollar-value prize.</li> <li>• <i>Levelling Off</i>: A sequence of routines designed to expose the children to the possibilities of relaxation exercises.</li> </ul> <p>Mid-way through the sessions, the club visits a police station, providing police contact in a neutral context. In addition, a teacher open house may be held.</p>
<b>MODALITY</b>	<ul style="list-style-type: none"> <li>• Structured small group (maximum 7 participants). The mixing of boys and girls is not recommended. Generally, the age of children in each group should not vary more than two years, and siblings should be placed in separate groups.</li> <li>• Telephone support during the week re completion of club homework and goals. There may also be individual befriending offered by a group leader or Project volunteer.</li> </ul>
<b>DURATION AND FREQUENCY OF SESSIONS</b>	<ul style="list-style-type: none"> <li>• 1½ hour after-school group for 12 weeks, held at the same time as parent training groups.</li> </ul>

	<ul style="list-style-type: none"> <li>• Ongoing Friday night and Saturday clubs for high-risk boys who have completed the Transformer's Club program.</li> </ul>
<b>RESOURCES</b>	<p><b>Use of SNAP™ without a license is strictly prohibited.</b> Licenses are available from Earls court for \$1.</p> <ul style="list-style-type: none"> <li>• Two group leaders for a group of 7 children. "Only group leaders with skills in contingent reinforcement using social and token reinforcers and related skills, such as ignoring, giving demands, role-playing, and group behaviour management, should attempt to use (the SNAP™) manual."</li> <li>• VCR and television.</li> <li>• Games (e.g., Jenga, Lego)</li> <li>• Dollar-value prizes</li> <li>• <u>SNAP™ Resource Kit</u> - including manuals, assessment tools, 2 training videos, booklets (\$150, or \$143 if 10+ kits ordered). Individual components also available</li> </ul> <p>Manuals:  SNAP™ Children's Group Manual  SNAP™ Parent Group Leader Manual  SNAPP Stop-Now-And-Plan-Parenting: Parenting children with behaviour problems (for parents and parent-educators)</p> <p>Assessment Tools:  Early Assessment Risk List for Boys  Early Assessment Risk List for Girls</p> <p>Training Videos  SNAP™  Stopping Stealing</p> <p>Booklets  Lying, Bullying, Stopping Stealing, SNAP™, Brothers and Sisters Learn SNAP™, Tips for Troubled Times (parent companion guide to SNAP™ Parent Group Leader Manual). Some available in Portuguese and Spanish.</p> <p>Also available to purchasers of kit: SNAP™ large hand-held puppet (\$125).</p>

<b>TRAINING</b>	<ul style="list-style-type: none"> <li>• Optional training and consultation about implementation are available from Earls court. Training off-site (from ½ day to 5 days) costs \$2000 per day; reduced fee for training at Earls court.</li> </ul>
<b>CORRESPONDING PARENT TRAINING</b>	<ul style="list-style-type: none"> <li>• SNAP™ Parent Group – See description in this document.</li> <li>• SNAPP- Stop-Now-And-Plan Parenting – For individual families</li> </ul>
<b>CONTACT INFORMATION</b>	<p>Leena Augimeri  Earls court Child and Family Centre  46 St. Clair Gardens  Toronto, Ontario M6E 3V4  Phone: 416-654-8981  Email: <a href="mailto:laugimeri@earls court.on.ca">laugimeri@earls court.on.ca</a>  Website: <a href="http://www.earls court.on.ca">www.earls court.on.ca</a></p>
<b>SELECTED REFERENCES</b>	<ul style="list-style-type: none"> <li>• Day, D.M. &amp; Hrynkiw-Augimeri, L. (1996). Serving children at risk for juvenile delinquency: an evaluation of the Earls court Under 12 Outreach Project (ORP) Final Report submitted to Department of Justice, Sept. 1996.</li> </ul> <p>Of 32 children, aged 6-11, with clinically significant behavioural problems / police contact, half were randomly assigned to the Intermediate Treatment Group (ITG) (Under 12 Outreach Project: Transformer Club peer intervention, Parent Group and Individual Befriending, Tutoring) and half were assigned to the Delayed Treatment Group. “Children in the ITG evidenced significant reductions in behaviour problems, according to their parents, but not their teachers. Significant decreases were also observed in their self-reported delinquent behaviour...Children in the ITG reported that they had less positive attitudes toward antisocial behaviour and that fewer of their peers engaged in antisocial behaviour...” (p77) “Parents in the ITG also showed significant reductions in their level of stress related to the parent-child relationship as well as some positive increases in their attitudes toward parenting and perceived self-competence in managing child behaviour problems.” (p78)</p> <ul style="list-style-type: none"> <li>• Hrynkiw-Augimeri, L., Pepler, D., &amp; Goldberg, K. (1993). An outreach program for children having police contact. <i>Canada’s Mental Health</i> 42, 7-12.</li> </ul>

	Fifty-four boys and 10 girls with clinically significant behavioural problems / police contact participated in the Under 12 Outreach Project (ORP), including Transformer Club, Parent Group and Individual Befriending. “ There were significant improvements in parents’ ratings of total, externalizing and internalizing behaviour problems...”(pp. 9-10) "There were significant improvements from admission to 6 month follow-up on parent ratings of total, externalizing and internalizing behaviour problems, and social competence...” (p.10)
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**Additional References:**

Under 12 Outreach Project (ORP) Research Summary. Toronto: Earls court Child and Family Centre, Draft October 12, 2000.

Levene, Kathryn (1998). SNAPP Stop-Now-And-Plan Parenting Manual. Toronto: Earls court Child and Family Centre.



## APPENDIX 1

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### Members of the Expert Panel and Regional Focus Groups on Conduct Disorder

**EXPERT PANEL  
CHILDREN AND ADOLESCENTS WITH CONDUCT DISORDER**

Colin Dart, Community Resource Services

Ken Goldberg, Earls court Child and Family Centre

Dr. Fred Matthews, Central Toronto Youth Services

Xavier Plaus, Roberts/Smart Centre

Dr. Fred Schmidt, Lakehead Regional Family Centre

Dr. Bruce Williams, Youthdale Treatment Centres

## **FOCUS GROUP PARTICIPANTS CHILDREN AND ADOLESCENTS WITH CONDUCT DISORDER**

Tom Walters, Lakehead Regional Family Centre

Leslie Hegge, North of Superior

Michelle Bernier-Wilson, Child and Family Centre, Sudbury

Bill Sanowar, Child and Family Centre, Sudbury

Suzanne Stevens, Child and Family Services, Timmins

Yvette Ruscitti, Child and Family Services, Timmins

Dawn Van Leeuwen, Child and Family Services, Timmins

Dr. Peter Bohm, Algonquin Child and Family Services

Jeffrey Hawkins, Algonquin Child and Family Services

Pat Malane, New Path Youth and Family Counselling Services of Simcoe County

Sergio de Sousa, Trenton Counselling Centre

Art Mattews, Whitby Psychiatric Hospital

Andrew Bennett, Child and Adolescent Centre, William Osler Health Centre

Yvonne Bohr, Aisling Discoveries Child & Family Centre

Dr. Carole Sinclair, Hincks/Dellcrest Centre

Pam Howard, Hincks/Dellcrest Centre

Paul Chalmers, Etobicoke Children's Centre

Wendy Wolfman, Jerome Diamond Centre

Betty Ann Hill, Nelson Youth Centres

Ian Murray, Child and Adolescent Centre, William Osler Health Centre

Ted Ridely, Chedoke Child and Family Centre

Mary Ann Murray, Pathways for Children and Youth

Dr. Francine Chappus, Roberts/Smart Centre

Steve Martin, Open Doors for Lanark Children and Youth  
Rosalind Forster, Cornwall General Hospital  
Deena Shorkey, Cornwall General Hospital  
Cam McCleod, Eastern Ontario Young Offenders Services  
Vickie Jennings, Eastern Ontario Young Offenders Services  
Lynn McCleary, Children's Hospital of Eastern Ontario  
Amber McCart, Child and Youth Wellness Centre  
Dr. Jean Walters, Ottawa Children's Aid Society  
Dr. Sue Bath, Royal Ottawa Hospital  
Dr. Rick McCendie, Crossroads Children's Centre  
Dr. Mark Totten, Youth Services Bureau  
Barrie Evans, Madame Vanier Children's Services  
Anna Woodson, Madame Vanier Children's Services  
Sandra Fieber, Craigwood Youth Services  
Rod Potgeiter, Oxford Child and Youth Centre  
Greg Frey, CPRI  
Terry Bouchard, Maryvale  
Laurie Robinson, kidsLink  
Judi Parsons, Western Area Youth Services  
Sue Lessard, Lutherwood CODA  
Laurie Humphries, Huron Perth Centre  
Renate Edge-Giesbrecht  
Beth Burnett, Chatham-Kent Integrated Children's Service  
Cathy Morrow, Children's Achievement Centre