
The earliest of interventions – bootie camp vs boot camp

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Give me a child until he is seven and I will give you the man, *Jesuit motto*

Conduct difficulties in childhood and adolescence have significant consequences for the individual, the family, and the community. Fergusson, Boden, and Hayne (2011) asserted “there is no other commonly occurring childhood condition that has such far-reaching and pervasive consequences for later health, development and social adjustment” (p. 60). Principal Youth Court Judge Andrew Becroft pointed out that challenging youth, with backgrounds of social, emotional, and socio-economic deprivation, are “considered by some to be hard-wired for a life of crime *by the end of their preschool years*” (2006, emphasis added). This poses a challenge. Should we (or could we) intervene earlier? The literature suggests we both could and should.

Early intervention is paramount, for two reasons: firstly, it costs less. “Interventions for younger children are significantly less costly because, as the child ages, interventions become more complex and are required in more domains” (Inter-agency Working Group [IWG], 2007, in their Inter-agency Plan for Conduct Disorder/Severe Antisocial Behaviour 2007-2012). In 2001, Member of Parliament Matt Robson released a report entitled “About Time”, in which he reported that “an intervention for a five year old who is aggressive and defiant is estimated to cost about \$5000 per case with a success rate of seventy per cent. Addressing the same behaviour at the age of twenty-five years costs \$20,000 and has a success rate of only twenty per cent.” The estimated the lifetime cost to New Zealand society of an adolescent chronically antisocial male is \$3 million (Scott, 2003, cited by IWG, 2007). While these calculations require considerable

adjustment for the present day, the principles are clear: earlier interventions are more cost effective, and have the potential to make significant savings – both economically and socially.

The second compelling reason for early intervention is that it is more likely to be effective. The IWG (2007) observed that interventions are significantly more effective with younger children, and “...programme effectiveness drops sharply with age” (p. 27). Ideally, interventions would be implemented and successful in early childhood and middle childhood. In practice, this does not occur reliably, and some children will require intervention into later childhood and adolescence. While the evidence to support intervention with this latter group is less compelling, it may be that the capacity for change is still greater in adolescence than adulthood, in light of neurological evidence that the adolescent brain continues to grow and develop into adulthood.

Unfortunately, there is not a “silver bullet” solution, particularly given that there is no single factor that explains why some young people display antisocial behaviour and others do not (Fergusson et al., 2011). Despite this, more and more research is highlighting particular groups of children who are more at risk.

Risk Factors for Child Offending

Table 1 summarises the top ten risk factors for future offending and/or antisocial behaviour (in order of importance), highlighting those which are most relevant for children under 13 years of age. These risk factors have been distilled from the

Christchurch and Dunedin longitudinal studies.

Table 1
 To ten risk factors in childhood for future offending and/or antisocial behaviour

Risk factors for children under 13		Risk factors for adolescents 13 years and older	
1	History of antisocial behaviour, behaviour problems, conduct disorder during childhood (lying, stealing, bullying, non-compliance, etc.) including contact with the law and arrest before age 12	1	Contact with antisocial peers (those involved in law-breaking, drugs, violence, gangs, etc.) (the more peers or contact, the higher the risk) from age 13 onwards
2	Use of tobacco, alcohol and/or other drugs, either weekly or more frequently, before age 12	2	General offences, number of prior offences (the more prior offences, the higher the risk) before the current age
3	Male gender	3	Aggression, fighting, violent offences
4	Low self-control, impulsive, poor ability to stop and think before acting during childhood	4	Low self-control, impulsive, poor ability to stop and think before acting
5	Hyperactive, poor ability to pay attention during childhood	5	Hyperactive, poor ability to pay attention
6	Involved in fighting, aggression, acts of violence before age 12	6	Poor supervision by parents/caregivers (knowing where young person is, who they are with, rules and consequences)
7	Low family income during childhood	7	Low levels of warmth, affection and closeness between parent(s) and young person
8	Neither parent had skilled work (that is, one or both are unemployed or in unskilled or semi-skilled jobs)	8	Tendency towards anxiety, stress
9	Neither parent left school with any qualifications	9	Few friends and social/recreational activities
10	One or both parents has a history of antisocial/criminal behaviour	10	Length of first incarceration (the longer the period, the greater the risk)

Source: Ministry of Justice (2008, p. 21).

Several of these risk factors are present even as early as the point of conception. Public health interventions to reduce foetal alcohol, methamphetamine, and nicotine exposure are vitally important to ensure that children are born without having to grapple with the complex consequences of exposure to alcohol and other drugs in utero. Community and governmental initiatives to reduce domestic violence and poverty are also of the utmost importance.

Psychological and psycho-social interventions can be implemented in the peri-natal and infancy periods to enhance attachment relationships between babies and parents even before antisocial behaviour

begins to emerge. It is encouraging that infant services within Child and Adolescent Mental Health Services (CAMHS) have proliferated in the past few years, many assessing and addressing attachment issues from the early months of life.

Once conduct difficulties begin to become apparent, which is often in the preschool years (Advisory Group on Conduct Problems, 2009), targeted interventions can be put in place. Intervention with this age group is vitally important, as an estimated 75-80% of severe antisocial behaviour in children (with concurrent increase in pro-social behaviour) can be successfully addressed prior to school entry (Church,

2003). Current provision of services to this group of very young children is inconsistent and disjointed. If a child presents solely with behavioural issues, without a comorbid condition, they are unlikely to receive services from a CAMHS. While some services are available through Ministry of Education early intervention services, these are also often contingent upon co-morbid conditions such as an Autistic Spectrum Disorder or a developmental disability. Fortunately reviews of service provision (such as those by the Conduct Disorder Inter-agency Working Group) are underway to improve this.

Effective interventions

The choice of an effective intervention depends on the age, developmental stage, and clinical presentation of the young person. For pre-school and primary school aged children, successful interventions tend to include behavioural parent training, such as the Incredible Years programme or Triple P (Positive Parenting Programme). These programmes attempt to teach parents explicit skills in monitoring and keeping track of their children's behaviour, giving clear instructions, encouraging compliance with instructions, refocusing attention from antisocial to prosocial behaviour, attending to and reinforcing appropriate behaviour, responding appropriately to inappropriate behaviour (using techniques such as planned ignoring, natural consequences, or time out from reinforcing activities), and to solve new child management problems (Advisory Group on Conduct Problems, 2009). Both Incredible Years and Triple P have a sound research base, established through multiple randomised controlled trials, including local studies. Both are widely available throughout New Zealand. The Incredible Years is most often delivered through publicly funded settings such as CAMHS and the Ministry of Education, and projects are underway to disseminate the Triple P programme.

It ought to be noted that many child offenders are in out-of-home placements,

and may even be in residential settings. This does not preclude the provision of evidence-based interventions such as behavioural parent training, but would require their adaptation.

Individual therapy for child offenders is less likely to be successful than family based interventions. Several theories for this have been proposed. Cognitive Behavioural Therapy (CBT) is one of the only research backed individual therapies for young people with conduct problems, but younger children, especially those who have been exposed to adversity and/or deprivation, often lack the emotional and cognitive maturity necessary for individual therapies such as CBT. Also, child offenders typically have “high levels of impulsivity and emotional reactivity, low verbal IQ, and/or callous/unemotional traits, making them poor candidates for CBT interventions” (McCart, Priester, Davies, & Azen, 2006).

While there are fewer studies investigating the effectiveness of multi-modal interventions such as Multi-Systemic Therapy (MST) for younger children, there is an emerging evidence base. Youth Horizons Trust in Auckland are currently providing MST to limited numbers of children from 10 years of age.

Recent years have seen the proliferation of documents summarising “what works” for the youngest of children with challenging behaviour (see Recommended Reading, below). We now know what it is possible to put in place, and the likely efficacy of each intervention; this includes knowledge from an emerging local literature. The challenge is for policy makers and politicians is to agree on bi-partisan, long-term solutions, rather than focusing on maximum change in an election cycle, or programmes with only face validity, such as Boot Camps. The challenge for individual clinicians is to identify and begin to address those factors that place our clients, or our clients' children, at risk of conduct difficulties. It is not easy work, but it is worthy work.

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Other Recommended Reading

- Advisory Group on Conduct Problems (2009). *Conduct problems best practice report*. Wellington, NZ: Ministry of Social Development.
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