

# **ADOLESCENTS IN CUSTODY: IMPLICATIONS FOR SUICIDE PREVENTION**

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RECENTLY WE PUBLISHED THE FINDINGS OF A STUDY OF THE MENTAL HEALTH of young people in custody in Adelaide (Kosky et al. 1990). The survey was not remarkable for its science, but it was unique in two respects. Firstly, we were able to use comparative data on measures of symptoms reported by normal schoolchildren in Adelaide and also by non-offending youngsters who had been referred for psychiatric help at the Children's Hospital, both groups being of similar age to those who we surveyed in the remand centre. Secondly, it was unusual for social or behavioural science researchers to have access to remanded youth. Mostly, studies have been limited to offenders who were referred for pre-sentence psychiatric or psychological reports, a relatively select few. It seems that this study is among the first psychiatric survey of youth in custody.

## **Young People in Custody in South Australia**

South Australia has a progressive record of trying to keep young people out of lockup. Many offenders are diverted into non-custodial programs, foster parent or other non-institutional settings to await trial. The population who is remanded in custody is rather small, but troublesome. The Department of Family and Community Services, which is responsible for the custodial care of these youngsters, was understandably concerned about their welfare. Anxiety has been heightened in the staff by concern about suicidal behaviour among the young people in their care and, especially, since the sittings of the Royal Commission into Aboriginal Deaths in Custody, staff at the Remand Centre were particularly conscious of their responsibilities for the welfare of the young people who are locked up. It is a measure of the progressive thinking, confidence in the staff and concern for the welfare of the children, especially on the part of the Chief Executive Officer of the Department of Family and Community Services, Sue Vardon, that we were given permission to work in the remand centre and to have access to the remandees. Nothing in our report should be

construed as being critical of the staff who, consistently, did their best for the young people in their care.

Our sample number was 82, and these were conservative admissions to the South Australia Remand Centre for Juveniles (SAYRAC) over a six-month period in 1989. Three only refused to cooperate and one was unable to complete the data gathering because of poor knowledge of English so the total final sample was 78. In the comparative samples, there were 240 schoolchildren and 82 psychiatric referrals. The average age of the samples was 15 years for the remandees and schoolchildren and 13 years for the psychiatric sample.

In each group, the adolescents were asked to fill out a standard questionnaire (the Youth Self Report, Achenbach & Edelbrock 1987) about how they were feeling in the previous month. Some of the questions and the number of each sample responding positively to them, are shown in Table 1 (for boys) and Table 2 (for girls). There were 115 of these questions altogether and Tables 1 and 2 show just those items which were particularly concerned with symptoms of depression, suicidal thoughts and substance use. Reference to these tables shows the level of symptomatology among Adelaide schoolchildren is relatively low overall, less than six per cent of this sample reported positive responses to the symptom check list.

*Table 1*

**Prevalence of 'very true' (or 'often true') Reported Symptoms in Males**

Factor	Community (n=122) %	Remand (n=55) %	Clinic (n=53) %
Trouble concentrating	13.4	34.5	28.3
Trouble sitting still	10.0	36.4	30.2
Cries	0	0	15.1
Harms self	4.2	12.7	11.3
Feels unloved	5.0	12.7	15.1
Feels worthless	3.35	3.6	19.65
Accident prone	5.0	18.2	21.2
Nightmares	3.3	7.3	15.1
Not liked	3.3	7.3	11.3
Fearful/anxious	5.9	12.7	19.2
Suicidal thoughts	4.1	12.7	11.3
Trouble sleeping	5.9	20.0	15.1
Unhappy/sad/depressed	2.5	12.7	9.4
Alcohol/drugs	1.75	61.8	7.5
Worries a lot	13.2	20.0	7.0

This level is in keeping with (or slightly lower than) other surveys of general population of adolescents in Australia, New Zealand and the USA (Mitchell et al. 1988; Curry et al. 1988; Kosky & Silburn 1984). Especially interesting is that less than five per cent of these 15-year-olds reported alcohol or drug use (not tobacco). Only 21 per cent reported having suicidal thoughts.

By contrast, the remand group and the psychiatric referral group gave every indication of having a significant proportion of sick adolescents. High levels of positive response to the symptom list characterised both groups and, in general, there were three to four times more positive responses in these groups to each symptom than in the school group. With respect

to alcohol and drug use, over 60 per cent of the boys remanded and 48 per cent of the remanded girls reported positively.

*Table 2*

**Prevalence of 'very true' (or 'often true') Reported Symptoms in Females**

Factor	Community (n=118) %	Remand (n=23) %	Clinic (n=29) %
Trouble concentrating	11.9	26.1	32.1
Trouble sitting still	4.2	21.7	20.7
Cries	6.8	39.0	34.5
Harms self	0.8	17.4	6.9
Feels unloved	1.7	39.1	10.3
Feels worthless	4.2	13.0	17.9
Accident prone	2.5	21.7	17.9
Nightmares	5.1	17.4	24.1
Not liked	2.6	13.0	13.8
Fearful/anxious	4.2	17.4	27.6
Suicidal thoughts	3.4	21.7	17.2
Trouble sleeping	5.9	26.1	24.1
Unhappy/sad/depressed	6.9	34.8	17.2
Alcohol/drugs	0.9	47.8	6.9
Worries a lot	15.3	52.2	41.4

When the symptoms were grouped into clusters, little difference was found between the remand and clinic groups on symptoms relating to depression, somatic (bodily) complaints, self-destructive symptoms or symptoms relating to delinquency (the mean score for the remand group was 19 and for the clinic group 14). In these clusters, the mean scores were (statistically) significantly greater than in the school group. Overall, the remand group showed a slightly stronger tendency to report more 'acting out' symptoms than the clinic group, but this was not great and, in any case, both groups had higher levels of emotional symptoms than in the school group.

The self-report questionnaire we used allows for a total score to be made for the samples. This score has, previously, been compared to a group of young people who were psychiatrically ill, so that a 'cut-off' score has been derived by the designers. The proportion of any sample who score above this cut-off score would be likely to be considered to belong to this group of psychiatrically ill young people. Overall, less than 10 per cent of the school population scored in this category. Forty per cent of the clinic sample were above the cut off point and this would be expected. However, what was surprising was that 40 per cent of the remand sample also scored in the category of the likely (psychiatrically-ill) cases!

Our survey thus shows that among young people on remand nearly half are likely to be in need of psychiatric assessment and care. However, this is not the only issue that was uncovered by our survey. We found significant social and educational deficiencies among this group.

Of the remand group, whose average age was 15 years (range 11-17 years), only 24 per cent were living at home. The rest were living with friends, intermittently with relatives or in children's homes or in 17 per cent of cases, were living on the streets. Despite their age, only 15 per cent were still at school. Most (79 per cent) had left school in year 8, the first

year of high school in South Australia. Not surprisingly 75 per cent were unemployed and, equally unsurprisingly, 60 per cent had been in custody previously. It is often thought that the young people remanded in custody represent the criminal element among adolescents—even the 'hardened criminal'. However, the main offences with which the young people in our sample had been charged were breaking and entry (20 per cent) and theft (20 per cent), and those behaviours could be seen in terms of their need to survive out of home.

Motor vehicle thefts accounted for only 15 per cent of charges. Assault or weapon charges also accounted for only 15 per cent of charges. Overall, our research team found these young people to be unhappy but cooperative. Many said they had never had the opportunity to mention how they felt to anyone previously.

### **Implications**

The adolescents in custody comprised a group of young people almost totally lacking in social or family support. They were, mostly, out of home, out of school and out of a job. Probably, many, because of their educational deficiencies and young age were unemployable. It seems hardly surprising that they should continue to offend and continue to be sent to custody, where they are adequately fed and where, however grim the environment may seem to us, it is clean and dry. Their life in SAYRAC is structured and is relatively worry-free, and the staff are kind and affectionate.

In the past, delinquency prevention strategies and the management of delinquents have been governed by social constructs of offending behaviour. It has been widely assumed that the social factors are paramount and that changes in the school or in the home environment provide ways to prevent delinquency. The other older method of delinquency prevention is the punishment model of custodial (prison) care but it is widely acknowledged that this does not prevent recidivism. For this reason, in South Australia, as few as possible adolescents are incarcerated (some other states seem to be going the other way and locking up more children).

#### *Needs of adolescents in custody*

What emerges from our study is a profile of the needs of adolescents who find themselves in custody. Our findings suggest that current approaches to delinquents may be missing a vital point. We consider that many of the young people in custody are feeling unloved, unwanted, and worthless. Some, perhaps as many as a third of all adolescents in custody, may be suffering from depressive illnesses. Depressive illnesses are sometimes caused by psycho-social stresses (such as being unwanted or rejected or losing a loved one), but they can also be caused by biological factors. Among these are included genetic predispositions, physical (especially viral) illnesses, the effects of chemicals, or the long-term effects of minimal brain damage. Most commonly, depressive illnesses result from a combination of these factors.

Depressive illnesses are commonly confused with plain unhappiness or misery, and it is mistakenly thought that they can therefore be dealt with by gentle encouragement alone. However, depressive illnesses are characterised by persistent pervasive sadness and worry, not really responsive to this approach. There are sometimes suicidal thoughts, often poor sleep, poor concentration, irritability and feelings of worthlessness, helplessness and hopelessness. People suffering depressive illness are at high risk for suicide. Depressed people find it difficult to work, to concentrate, to learn or to relate to others and they may use alcohol or drugs to try to alleviate their chronic unhappiness. If a significant proportion of adolescents in custody have depressive illness, it is inappropriate for them not to get

psychiatric treatment, since the treatment of depressive illness is one of the most effective in modern medicine.

None of our study sample had a psychiatric assessment prior to or on admission. Therefore, apart from overlooking young people who may be in need of treatment, an added strain is placed on the staff who have to guess which youngsters among those in their care are most likely to attempt suicide.

Clearly, if we are to continue to lock up young people, we need to improve our ability to identify those who are mentally disturbed. We can do this by:

- Having a psychiatric assessment of all new admissions (but this would be quite impractical given current resources);
- training staff to be more sensitive to signs and symptoms. (This would be valuable but there is often a considerable turn-over of staff and individual variations in people's ability to recognise emotional signs);
- by allowing young people, on admission, to complete a short standard questionnaire (for example, the Youth Self Report on General Health questionnaire—shortened version). Those who generate a score above the 'cut-off' point could be referred to a medical practitioner who may make a psychiatric referral. In this way, many of those in need of treatment might be identified, although some could be missed.

A better model, though, would be one which did away with the need for custodial remand. In most cases in our study, the offences did not seem to warrant the custodial order—rather this was made because the young person lacked any social or family supports, or had failed to be stabilised in another institution. We feel that the current system is not adequately catering for the emotional needs of those young people and it is this aspect which has so far been neglected.

By comparison with the SAYRAC group, young people referred to psychiatric services are very rarely held in closed and barred units. Indeed, most states have adolescent inpatient units which are either in beautiful National Trust mansions (Rivendell in New South Wales and Hillview in Western Australia) or purpose built modern apartments (Victoria and Queensland). These places are comfortable and well furnished; they look and feel warm. They encourage the development of age-appropriate individual and social expressions. They are open and normalising. Friendly relationships are encouraged between the young people and the staff who are, nevertheless, aware of the need for kind yet consistent and firm limits on behaviour. Visiting and interaction with the community resources are encouraged. The needs of families in breakdown are considered and family therapy is usually a part of the management. Educational and vocational deficiencies are dealt with by special teaching staff. Social deficiencies are helped by enhancing individual responsibility, through modelling on staff and by encouragement and support. Such therapy has a long tradition in psychiatry. Despite usually having some of the most 'difficult' young people, such adolescent inpatient units can develop strong team and community spirit. In philosophy, style, tradition and practice they seem the antithesis of youth detention centres. In particular, their predominant focus on the emotional needs of the young people provides a major contrast to the youth detention system. Yet, our survey suggests that both systems may be dealing with young people in similar emotional difficulties.

Finally, there are some day centres which have been developed to deal with young people who have emotional, educational and social deficiencies. Originally developed in New York, these centres take the form of special schools with curricula which includes programs for special educational rehabilitation, development of vocational skills, social skills

groups, family therapy, individual psychotherapy and (where appropriate) medication. The young people live with their families, or in foster or other substitute care. Multi-discipline staff include special educational teachers, child psychiatrists, clinical psychologists and social workers. An example of this type of day centre is the New School in Western Australia which was established in 1982 associated with a Child and Adolescent Psychiatry Clinic in the northern suburbs of Perth.

## **Conclusion**

In summary, our survey of adolescents in custody focussed attention on their emotional needs. They reported levels of emotional and behavioural symptoms four times that of normal adolescents and similar to that reported by young people in psychiatric services in Adelaide. We consider that these young people are at risk for self-destructive behaviours and many may need psychiatric treatment. They also have striking social and educational deficits. Currently these needs are overlooked, which may be one reason for the high recidivism rates. The provision of a home, the treatment of depressive illnesses if present, remedial education, vocational rehabilitation and intensive programs for the development of age-appropriate social skills would seem to offer a better alternative for these difficult young people, than the 'punishment' model which currently dominates their lives.

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