Psychiatric Disorders in Incarcerated Youth

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In Canada, It is estimated that there are 2,100 incarcerated youths per million (Leetsi, 1994). The incarceration rate in the United States is 2,450 per million (Moone, 1998). These adolescents reside in institutions with varying standards of care, with treatment and correctional philosophies that are as diverse as the quality of staff training and experience. Additionally, sentencing practices generally bear no relationship to the mental health needs of these adolescents.

In Canada, the annual cost of incarceration per adolescent is $95,000, more than twice the average $40,000 per year required for adult incarceration (Young, 1994). ***Incarceration continues to be an expensive and intrusive intervention, but has yet to produce the desired results of reduced recidivism*** Disruptive behavior disorders, which are common in this population, are increasing in prevalence and have the potential to become the leading public health concern in youth.

Juvenile delinquency has historically been linked with psychiatric disorders (Koenigsberg Ct al, 1977). The comorbidity of psychiatric disorders with Oppositional Defiant Disorder and Conduct disorder has long been reported (McManus et al, 1984; Healy & Bronner, 1926). Lewis et al (1973, 1979) reported on the tendency of custodial institutions to focus on punishment at the expense of careful diagnosis and treatment of coexisting neuropsychiatric disorders in incarcerated youth. It has also been reported that incarcerated youths and those in psychiatric hospitals or treatment centers have very similar psychiatric characteristics (Cohen et al, 1990).

The relationship between delinquency and psychiatric disorders, although complex, reveals some consistent patterns. First, former delinquents have a high risk for psychiatric disorders as adults (Lewis et al, 1973; Loobins, 1966). Second, the greater the number of offenses and the earlier the occurrence of the first offense in adolescence, the greater the risk of psychiatric disturbance in adulthood (Koenigsberg et al, 1977). In spite of these findings and others, juvenile custodial facilities continue to lack the necessary psychiatric resources for the treatment of incarcerated adolescents.

In a recent controlled study in which the Diagnostic Interview for Children and Adolescents -Revised (DICA-R) was used to evaluate 49 adolescents in two secure custody facilities in the Toronto area, Ulzen and Hamilton (1998) found that the presence of multiple psychiatric disorders in these incarcerated adolescents was more the rule than the exception. They reported that 63.3% of incarcerated adolescents had two or more disorders, 22.4% had one disorder and only a minority, 14.3%, had no psychiatric disorders. This strongly suggests that ***a focus on the mental health needs of incarcerated adolescents should be as much a priority as behavioral and correctional concerns in such institutions.***

The most significant measures of family adversity that were associated with incarceration status were physical abuse, family breakup, and violence between parents. Additional associated findings identified with incarceration status were excessive drinking by

parents, the presence of learning problems in youth and history of mental illness in parents.

Both externalizing and internalizing psychiatric disorders were common, contrary to the intuitive notion that most of these adolescents almost exclusively have externalizing disorders. The psychiatric disorders were present at the following frequency:

- Oppositional Defiant Disorder 44.9%
- Alcohol dependence 38.8%
- Conduct disorder; present depression and/or separation anxiety disorder 30.6%
- Attention Deficit Hyperactivity Disorder, mania, dysthymia and/or overanxious disorder 26,5%
- Posttraumatic stress disorder 24.5%
- Past depression 24.3%

Incarcerated adolescents who had been physically abused had a greater number of disorders than those who were not abused.

There were some gender related trends. ADHD and conduct disorder were less common in females than in males. The rate of present depression amongst females was 72.7% compared with 18.4% in males. Alcohol dependence in females was 63.6% compared to 31.5% in males. Other internalizing disorders such as dysthymia, over-anxious disorder, and posttraumatic stress disorder were all significantly more common in females.

Substance abuse was also highly prevalent in this population with 39% of incarcerated adolescents meeting criteria for alcohol dependence. Marijuana was the substance used by the highest proportion of incarcerated adolescents at 69.4%, followed by street drugs (cocaine, crack, speed, LSD or PCP) at 57.1%. Inhalants were used by only 14.3%.

Psychotic symptoms were reported more frequently in incarcerated adolescents compared to the matched community group. On average, 2.8 psychotic symptoms were reported per incarcerated adolescent as compared to 1.1 in the community group. Seventy five percent of incarcerated adolescents reported one or more psychotic symptoms. The most frequently reported symptoms of psychosis were suspiciousness, hearing thoughts spoken out loud, the feeling that people could read their minds, and perception of being able to read someone else's mind.

Discussion

The findings of Ulzen and Hamilton (1 99S) confirm and add to findings of earlier studies on the presence of significant psychiatric morbidity in incarcerated adolescents. (McManus et al., 1994; Gibbons, 1970; Offer et al, 1979; Lewis et al, 1987). This study is methodologically superior to earlier ones in that the instrument used for diagnosis was normed for adolescents. The added presence of a non-clinical, non-delinquent community comparison group was an additional strength. Disorders which were reported in this study but undetected in previous studies, included dysthymia, separation anxiety, over-anxious disorder and post traumatic stress disorder It is difficult to say whether anxiety disorders were present as a function of the state of incarceration itself or resulted from the

numerous out-of-home placements that typically preceded a youth's incarceration.

Far from being an incidental concern, *identification and treatment of psychiatric disorders in incarcerated youths should be a priority in the consideration of rehabilitative interventions because mental disorders have long been implicated in recidivism amongst delinquent youths* (Ganzer, 1972). Lack of treatment results and higher rates of multiple psychiatric problems is being seen in arrested adults (Abram & Tepling, 1991). The successful treatment of even one of the comorbid disorders may lower the symptom levels of associated disorders and possibly reduce the risk of recidivism (Puig-Antich, 1982).

Family adversity and the psychosocial stressors common in these adolescents require both preventative interventions and significant attention during periods of incarceration. Incarceration should, therefore, be seen as an opportunity for detailed psychiatric assessments, and specifically tailored mental health interventions to treat individual and family problems prevalent in this population. The identification of both causal risk factors and protective factors in these youths, should form an integral part of the intervention strategies.

In spite of these findings, many custodial facilities do not have extensive mental health resources, nor are there any standards for training front line staff in such institutions that would require a more detailed understanding of mental health disorders. Clearly, these youths have more complicated mental health disorders than adolescents ordinarily treated in clinical settings. *Frontline correctional staff therefore, need to acquaint themselves with the psychiatric complexity of adolescent who are incarcerated and also need to receive adequate training to improve their skill level in meeting the needs of these adolescent*. Correctional programs for adolescent youth should include comprehensive treatment programs which should not be seen as being at odds with the correctional mission, but more likely to support that mission by reducing the rate of recidivism through adequate treatment of coexisting psychiatric disorders. The degree to which mental health disorders are treated in such facilities varies greatly and it behooves us in the mental health field to research this area and also to engage ourselves in longitudinal studies which will eventually provide evidence to support the usefulness of aggressive treatment of psychiatric disorders in this population. This would reduce both direct and indirect costs related to incarceration and provide for greater success in the rehabilitative efforts directed towards these youth.

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