Journal of Adolescent Health 54 (2014) 521–526

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Original article

Complex Health Needs in the Youth Justice System: A Survey of Community-Based and Custodial Offenders

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Article history: Received July 5, 2013; Accepted October 2, 2013
Keywords: Adolescent; Detention; Incarcerated; Juvenile justice; Mental health; Drug dependence; Sexual health; Health services

A B S T R A C T

Purpose: Estimate the prevalence and annual frequency of health risk indicators in young people serving community-based orders (CBOs) and custodial orders in the state of Victoria, Australia.
Methods: Cross-sectional survey of 242 young people serving CBOs and 273 serving custodial orders in Victoria in 2002–2003. Validated measures included the Composite International Diagnostic Interview for substance dependence, Short Mood and Feelings Questionnaire for depression, and Psychosis Screening Questionnaire for psychosis symptoms. Prevalence estimates were adjusted for sampling bias and age- and sex-adjusted for between-group comparisons. Prevalence estimates were applied to 2010–2011 Victorian youth justice data to estimate annual frequencies at the state level.
Results: The prevalence of substance dependence, poor mental health, and risky sexual behavior was high in both groups. Age- and sex-adjusted prevalence estimates were generally higher among those serving custodial orders; however, extrapolating prevalence estimates to statewide youth justice data generally resulted in higher estimated annual frequencies among CBOs. For example, the estimated prevalence of any substance dependence was 66% (95% confidence interval [CI], 60–72) in those serving custodial orders and 34% (95% CI, 26–42) in CBOs, but the estimated frequency of substance dependence in CBOs in 2010–2011 was 970 (95% CI, 750–1,180), compared with 490 (95% CI, 450–530) in those serving a custodial order.
Conclusions: There is a compelling case for scaling up health services for young offenders in custody and in the community, and for routinely monitoring the health of young offenders serving custodial and community orders.

IMPLICATIONS AND CONTRIBUTION

Complex health needs are increasingly documented in young offenders receiving custodial orders. We found that substance dependence, poor mental health, and sexual risk behavior were common among those under community supervision and in custody. These data make the case for coordinated, quality health services for all youth justice clients, including those under community supervision.

In Canada, the United Kingdom, Australia, and many other developed countries, young people are incarcerated only as a sanction of last resort, with most serving some form of non-custodial (community-based) order [1,2]. In Australia, the rate of community supervision for young offenders is around 6.4 times that for custodial orders [1]. In 2010–2011, young people

Conflicts of Interest: None of the authors has any potential, perceived, or real conflict of interest to declare. None of the authors received an honorarium, grant, or other form of payment to produce the manuscript. The study sponsors had no role in study design; collection, analysis, and interpretation of data; or writing and submitting the manuscript for publication.

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1054-139X/$ – see front matter
http://dx.doi.org/10.1016/j.jadohealth.2013.10.003

under youth justice supervision in Australia were disproportionately male (84%) and from disadvantaged neighborhoods [1], but little is known about the health needs of this growing population.

Evidence from international studies suggests that young offenders are characterized by poor physical health, mental disorders, substance use disorders, and externalizing disorders [3,4]. Before entering custody, many young offenders engage in significant health risk behaviors [4,5]. Much less is known about young offenders in Australia; however, one study of young offenders in detention in New South Wales (NSW) found that 87% had at least one mental disorder [6]. For a variety of individual and structural reasons, young offenders typically underuse general and mental health services, particularly in the community [7,8].

Youth detention centers are highly structured settings where the threshold for accessing health services is often low, and at least in some jurisdictions, systems for managing complex presentations are relatively well developed [9]. In these jurisdictions, the frequency of health service use among young offenders is typically higher in custody than in the community [8], with corresponding improvements in general and mental health [10]. Nevertheless, elevated rates of morbidity and mortality have been widely documented after return to the community [11–14].

Although most young people under youth justice supervision in Australia are serving community-based orders (CBOs), little is known about their health status or needs. Studies in the United States [15], United Kingdom [8], and Australia [16] have documented similar levels of health need among young offenders in custodial and community settings. However, to provide appropriate coverage of health services for young offenders, it is necessary to understand both the prevalence and the absolute number of young people with health needs, in custody, and under community supervision. In this study we (1) compared the demographic, offence-related, substance use, mental health, and sexual risk behaviors of young offenders serving community-based and custodial orders; and (2) estimated the number of young offenders—according to order type—with selected conditions and risk factors under supervision in the state of Victoria in 2010–2011.

Methods

Participants

Between May 27, 2002, and October, 1, 2003, we interviewed sentenced young offenders in Victoria, with roughly even division of participants with a CBO and a custodial order. Those eligible to participate had received a court sentence, not continuous from a previous sentence, between May 21, 2002, and August, 31, 2003. Those admitted to custody on remand (pretrial detention) or in the community awaiting preparation of pre-sentence reports were ineligible but may have subsequently been sentenced and recruited. For duty of care reasons, young people in custody with acute psychological distress were excluded from the study, although this occurred rarely. In the custody arm, sampling occurred in all three Victorian Juvenile Justice centers. In the CBO arm, participants were recruited from all Melbourne metropolitan regions and one rural region.

Procedures

As soon as practicable after sentencing, all eligible young persons were referred to the study. Potential participants had the nature and implications of the study explained to them and provided written, informed consent. Custodial participants were interviewed in a private room within 1 week of sentencing; CBO participants were generally interviewed at Juvenile Justice sites in the community, but some occurred in other community settings. At the conclusion of the interview, CBO participants were given a AU$20 voucher and participants in custody had AU$20 credited to their private accounts.

Interviews were conducted by trained research staff using laptop computers. Study laptops were programmed to automatically skip non-applicable sections of the survey according to the participant's responses to key questions; interviews typically took 30–60 minutes to complete. Participants were encouraged to self-navigate the interview, recording their responses on the laptop, while interviewers read each question aloud from the computer screen and responded to any questions. Participants were permitted to skip questions they did not wish to answer and to conceal their answers from the interviewer if they wished. These processes were designed to maximize rapport between researcher and participant, reduce literacy concerns, and encourage candid responses. When applicable, custodial participants were asked to report responses relevant to the period before admission. The study was approved by the Human Research Ethics Committees of the Victorian Department of Human Services and the Royal Children's Hospital, Melbourne.

Measures

The survey was composed of 366 items including demographics, educational, and vocational experiences, violence and sexual assault, offence history, family history of mental illness, and imprisonment. Depression symptoms in the past 2 weeks were assessed using the Short Mood and Feelings Questionnaire, a self-report, 13-item, unifactorial screener for depressive disorder in children and adolescents with established reliability and validity [17]. Scores range from 0 to 26, with scores of $\geq$11 indicative of clinically significant symptoms of depression [18,19].

Psychosis symptoms were assessed using the Psychosis Screening Questionnaire, a six-item screening instrument for symptoms of psychotic disorder, including thought insertion, paranoia, strange experiences, and previous diagnosis of schizophrenia. Scores on the Psychosis Screening Questionnaire range from 0 to 7, and scores of $\geq$3 indicate possible psychotic disorder [20].

Participants who indicated that they had deliberately harmed themselves in the past 6 months were asked to describe what they did. Responses were post-coded by a psychiatrist and a clinical psychologist into definite self-harm.

Hazardous drinking was measured using the AUDIT-C, a short version of the Alcohol Use Disorders Identification Test (AUDIT) consisting of three items assessing usual quantity and frequency of alcohol consumption. AUDIT-C scores of $\geq$3 for females and $\geq$4 for males are considered indicative of hazardous alcohol consumption [21]. Illicit substance dependence was assessed by the Composite International Diagnostic Interview, version 2.1 [22]. Frequency of alcohol and tobacco use in the past month, and illicit substance use ever, were assessed by self-report.