A MENTAL HEALTH PERSPECTIVE ON JUVENILE JUSTICE

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This paper will address the question, "What is the role of mental health, and in particular the psychiatrist, in working with young offenders?" The paper will describe how, in developing a Forensic Psychiatry Unit, we have moved away from a traditional psychiatric approach that emphasises assessment, towards a broader interpretation of our role.

The unit attempts to:

- identify a mental health focus for therapeutic intervention;
- apply some principles of psychotherapy to work in this setting; and
- address issues of organisational and institutional functioning.

The paper will attempt to justify this broader role for the psychiatrist in juvenile justice in the context of work in partnership with the Department for Family and Community Services.

Traditional Model

Psychiatrists are quite good at recognising depression, differentiating drug withdrawal from psychosis, and even at identifying those young people at risk from suicide. We can offer a range of discrete interventions, such as the prescription of drugs, or we can authoritatively state that "this kid does not have a psychiatric disorder" and thereby justify a graceful exit.

There are two disadvantages of such an approach. First, residential carers and others often continue to regard the young person as "crazy" in spite of negative pronouncements from psychiatrists.

Alan was one such young man. When I met him in a juvenile detention centre he had been seen by six different psychiatrists in relation to offending and care issues. No psychiatrist had seen him more than once, and each had pronounced him free of psychiatric disorder. The juvenile justice system
continued to perceive him as odd, but had not been able to engage a psychiatrist in some kind of collaboration to understand that oddness.

A second reason for rejecting the traditional approach is that "objective" psychiatric symptoms do not necessarily correspond well to levels of distress or dysfunction. For example, of two people who commit a violent crime, who is healthier—the one who feels remorse about it, or the one who lacks remorse? The one who is remorseful is more likely to tell a story that can be construed as representing symptoms of depression or anxiety, while the colder, remorseless individual is often dismissed as having a "personality disorder".

Darryl is a fourth generation sex offender. His great grandfather sexually abused Darryl's grandfather, who abused Darryl's father, who abused him. When I met Darryl, he had no symptoms of anxiety, depression or psychosis, and I was unable to make a substantive psychiatric diagnosis. Yet the psychiatric perspective is important in understanding his behaviour and formulating his management (this is, of course, not to deny the importance of a sociological perspective).

Forensic Psychiatry Unit

It appears to be because of dissatisfaction with the traditional psychiatric approach that the Department of Family and Community Services was enthusiastic about establishing a Forensic Psychiatry Unit. The Unit is part of a broader Adolescent Outreach Service of the Adelaide Children's Hospital, Division of Child and Adolescent Mental Health Service (CAMHS). The unit was developed as part of CAMHS strategy to improve services to a range of young people not well served by existing systems. As part of that strategy the unit approached the Department of Family and Community Services, which agreed to divert funds from employing sessional psychiatrists and consolidate them towards the development of the Forensic Psychiatry Unit. As a result the unit agreed to take on responsibility for:

- court reports ordered by the Judges of the Children's Court in relation to offending;
- providing a psychiatric service to juvenile detention centres;
- being available for consultation to Family and Community Services field workers, and to accept appropriate referrals from the field.

The Forensic Psychiatry Unit is a small unit with a clinical staff of less than one full-time equivalent, but with the indispensable services of full-time secretarial support. As Commissioner Brian Burdekin pointed out in opening the unit, current staffing will be inadequate to ensure our survival. So we have started on a risky course, deliberately trying to expand the traditional psychiatric role in presenting ourselves as psychotherapists and even social scientists. We do not ask ourselves, "does this person have a psychiatric diagnosis?", but rather, "can we contribute to this person's overall care and
development from a psychiatric perspective?". In so doing we risk uncertainty, anxiety and conflict. So what can we offer in the process?

**Psychotherapeutic Principles**

*Love is not enough*

It is unlikely that young offenders will be made better just by us being nice to them. In our experience, even when there is a clear mental health focus, such as unresolved grief, young offenders will rarely respond to the offer of a sympathetic ear. We therefore see the need to be more confrontational (I use confrontation in the sense of "bringing face to face", to be contrasted with rubbing the young person's nose in his problems, which is a disempowering and potentially destructive process). Of course, therapeutic confrontation can, and often does, make young people angry. It should not, however, be used to humiliate them, but rather to raise their level of anxiety about their circumstances to the point where they are more able to overcome their resistance to working for change.

I am not just talking about making young people cry. I not infrequently see young men who are very easily moved to tears, only to find that these tears are unauthentic and represent another layer of covering up of deeper, more terrifying emotions; for example, in one recent case, the acknowledgment of feelings of hatred towards the father.

*Dealing with our own negative feelings*

Many of the young people with whom the unit deals, have done awful things and are unattractive and unpleasant in their relationships with others. A psychotherapeutic perspective can help us to avoid our natural tendency to become impatient or dismissive. Staff who spend every day with such difficult young people often benefit from discussing their work with an outside consultant.

*Sensitivity to communication*

Much offending behaviour has a communicative side to it, although the communication is often difficult to read. One might find useful the metaphor of a brick thrown at a window with a message attached. Our first response to such an assault would be to protect ourselves, to feel angry about the mess and inconvenience, and to want to get hold of the culprit. All of these responses are valid, but as psychiatrists we must also pay attention to the message on the brick. Thus we must ask ourselves, what are the young people telling us by their irritating and aggravating behaviour. It is our contention that, at least in the early stages of offending, there are useful messages attached to the bricks. Perhaps it is only when we adults do not pay attention to the messages that kids start throwing bricks without them.
Recognition of the limitations of our techniques

One trouble with psychotherapy is that most young offenders are not very interested in it. Traditional psychotherapy is primarily a verbal technique and as psychiatrists we have a verbal bias, so that we need to change our techniques in working with these young people. Thus, to develop therapeutic interventions we rely on partnerships with workers from other areas with different expertise, such as teachers, residential carers and those with practical skills.

We also rely on other teenagers. The group is the setting of choice for working with adolescents, and we are much more likely to be able to make productive interventions in groups than with individuals. When available, the family is an important focus for intervention, but too often the family has disintegrated to the point where it cannot help us.

Social Psychiatry

A further extension of the role of the psychiatrist is to offer an understanding of institutions.

Continuity of care

An example is the continued frustration in most systems with long-term planning for foster placements. Many of the young people who come into the juvenile justice system have been in multiple foster placements over many years, and we all recognise the lack of security of those placements and the apparent lack of long-term planning. Yet perhaps it is organisationally impossible for welfare departments to think about, and plan for, children in time scales of years. This is not a criticism of such agencies, but rather an observation about their essential qualities. For example, with transfers, resignations et cetera, the average life of a relationship between a social worker and a client is probably substantially less than a year. Even senior positions within such agencies have high levels of mobility, and because services are decentralised, an individual may have contact with several different district offices. How can planning occur over years in such a system? Psychiatrists can make a useful contribution to this debate. We can also contribute to debates about how pragmatic and idealistic considerations should be balanced when the state contemplates taking guardianship over young people whose parents have failed them.

Therapeutic environments

A sub-population of young offenders spends a considerable time in large and small institutions during custodial sentences and in residential placements. Such environments can be made more or less therapeutic. We see it as a role for psychiatrists to recognise and comment on some of the difficulties of this task and to consult with such institutions to help create a therapeutic environment. For example, residential care workers are required to be custodians, yet are also on some levels expected to be therapists, without the
training and support necessary for this task. This paper argues that residential carers should not be expected to be therapists. It is important to emphasise that there is a distinction between, on the one hand, being a therapist, and on the other, contributing to a therapeutic environment. Residential carers are well placed to perform the latter task, and even to be therapeutic towards kids, often in a way that formal therapists cannot; nevertheless, it is unreasonable to expect a residential carer to take on specific therapeutic tasks with a young person.

*The role of the psychiatrists in sentencing*

The psychiatrist has a limited role to play in court procedures such as sentencing. We can provide information and process it in a way that makes it more meaningful for judges, but our role should not go much further. It is important not to overstep our responsibility for the mental health needs of young people and to enter into areas of parental responsibility and/or legal judgment.

*The public face of forensic psychiatry*

The media contain so much inaccurate information and poor interpretation of facts that it seems we psychiatrists should use our authority and whatever respect we command from the public to put forward a balancing point of view. While we are not trained sociologists, we can offer a psychosocial perspective.

**Conclusion**

In conclusion, psychiatrists are doctors not only with expertise in diagnosing and treating mental illness, but also with skills in psychotherapy and an understanding of organisational and institutional functioning which should be applied to our work with young people in the juvenile justice area. It is in this way that we hope our new service will address the very real mental health needs of young people in the juvenile justice system.