The Royal Australasian
College of Physicians

The Health and Well-being of Incarcerated Adolescents

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Foreword

Representatives of the Royal Australasian College of Physicians (RACP) have worked together with nominated leaders from Indigenous communities in Australia and New Zealand to produce this policy. Incarcerated young people are among the most vulnerable people in our community, but their health is rarely seen as a priority. This is despite the fact that there is now increasing evidence that their health needs are greater than adolescents in non-custodial settings. There are no national standards or policies reflecting best practice for these groups in either Australia or New Zealand, rather each state, territory or district provides health care in their own way. The period of incarceration may be a window period in an adolescent's life. Despite the reasons for incarceration, the social background and the potential ill effects of prison, it may also be an opportunity to start to correct social and health disadvantages.

Internationally there are numerous position statements and guidelines for provision of health care to adolescents in incarceration. This policy is intended to set the standard for health care in these settings in Australia and New Zealand and also to be a framework on which improvement and standardisation of care can be based. The policy is consistent with similar international documents but pays specific attention to the over-represented number of Indigenous young people in custody in both Australia and New Zealand.

The challenge is to provide accessible, innovative and effective treatment to adolescents in custody, a population that is often beyond the reach of traditional health services.[1] In Australia, paediatricians have been at the forefront of advocacy efforts for public mental health policies and initiatives that focus on the needs of young people. They have promoted awareness that successful programs in childhood and adolescence lead to better outcomes in multiple domains, ranging from improved health care, enhanced learning and academic performance, to improved social skills and more successful relationships later in life. With increasing interest in reducing adolescent recidivism from federal, state, territory and local governments, the current challenge now is to encourage new ways of conceptualising treatment of adolescents with health problems within the youth justice system, preferably informed by evidence-based practice.

The time in custody provides an opportunity which must be taken to provide comprehensive health care provision to a population who have high levels of health care need and who frequently receive minimal health care when in the community. The RACP supports a service for adolescents in custody that provides health screening within 24 hours of entry into detention, and one that can document current health status as well as identify and intervene where appropriate for health risk behaviours.

The RACP recognises that incarcerated adolescents are more likely to experience poorer health and life outcomes and disproportionately high levels of disadvantage over that of the general population. The RACP acknowledges that the interactions between disadvantage, incarceration, poor health and well-being and life outcomes are complex.

Recommendations

The Royal Australasian College of Physicians (RACP) will advocate to governments to make changes to improve health and social outcomes for adolescents who are either in incarceration, or who have been released into the community.

Accordingly the RACP will advocate to the governments of Australia and New Zealand to:

- ratify the *United Nations High Commissioner for Human Rights Optional Protocol to the Convention against Torture (OPCAT);*[2]
- remove the reservation placed on the *United Nations Convention on the Rights of the Child (*CRC) to allow young prisoners in adult prisons in Queensland and New Zealand. Young people need to be safe and offered smoke-free areas while in juvenile justice centres.[3]

Full application of these conventions (listed in Appendix one) will ensure:

- involving clinicians in providing health care to adolescents and assist them to recognise the importance of supporting the rights and decision making abilities of incarcerated adolescents, and where possible, act to encourage and support these rights and faculties i.e. as per article 12 of the *United Nations Rights of Convention of the Child* to which Australia and New Zealand are signatories;
- providing Indigenous incarcerated adolescents in Australia with the choice of accessing services that include those provided by the Aboriginal Community Controlled Health Organisation (ACCHO) and Aboriginal Medical Services (AMS). Providing culturally specific services to Indigenous young people who are over-represented in the detention centre populations and affirming the principles of mutual respect as set out in the *United Nations Declaration on the Rights of Indigenous Peoples* to which Australia and New Zealand are signatories;
- ensuring adolescents within the youth justice system, and those detained in adult prisons be transferred to adolescent juvenile detention centres where they can receive developmentally appropriate services in alignment with the *United Nations Convention on the Rights of the Child* (appropriate legislative change may be required).

Advocate to the governments of Australia and New Zealand to **improve the provision of health services** for adolescents by:

- Promoting a tailored approach to health care provision for incarcerated adolescents using more intensive provision of services. This will be achieved by:

- Providing a holistic approach for individual case planning through integration into detention centre management processes;
- Providing best practice care and health services based on available evidence;
- Aligning standards of care provision to publicly available and endorsed guidelines and position statements regarding the provision of health care to adolescents;
- Employing health professionals who are independent of custodial organisations;
- Offering care that is developmentally appropriate, culturally safe, community based and sensitive regardless of the custodial setting, confidential, evidence-based and in keeping with best practice adolescent medicine principles;
- Developing standards of care throughout state, territory and districts that are targeted and sensitive to local needs;
- Providing confidential access to advice and education about safe sexual practices and contraception:
- Providing antenatal care for pregnant detainees as well as infant and child health care for any children kept in custody with their parent in the best interest of the child; and
- Provide health screening to all adolescents identified at risk. This includes screening for Fetal Alcohol Spectrum Disorder (FASD).

Advocate to the governments of Australia and New Zealand to provide **mental health services** for adolescents that are timely and co-ordinated to:

- Collaborate with staff to educate, promote and develop effective mental health programs in youth detention, and to reduce stigma toward mental health evaluation and treatment;
- Provide an opportunity for incarcerated adolescents to undergo a comprehensive medical history and examination promptly during and after incarceration. This includes screening for the presence of developmental or intellectual disability as part of a comprehensive screening service, health promotion and an integrated mental health and drug and alcohol service;
- Offer voluntary drug and alcohol counselling and provide adequate and timely feedback on mental health status and treatment outcomes to all young people in detention. These will include Indigenous-specific drug and alcohol programs;
- Provide appropriate services to females who have higher rates of mental illness and behavioural problems than males; and
- Facilitate referral of young people to community programs that deal with the health related issues that were identified following release from custody, thereby ensuring a continuity of care across the custodial and community settings.

Advocate to the governments of Australia and New Zealand to **monitor and evaluate health and social outcomes** for adolescents during and after incarceration to be reported annually:

- Encourage the use of a shared health record to facilitate continuity of care;
- Provide on-going monitoring and evaluation of a young person's physical, social and mental health state throughout their time in custody. Assist adolescents in incarceration to place an active focus on achieving optimal health outcomes for life (not just for the period of incarceration) that are co-ordinated and continuous for subsequent periods of incarceration and post-release from incarceration;
- Develop programs to assess, manage and reduce the risk of young people engaging in suicidal and deliberate self injurious behaviour in youth detention;
- Prioritise with other health professionals the health needs of incarcerated adolescents and adolescents released from incarceration;
- Use all available evidence in developing policy and programs to address the gaps in health, and social determinants of health, which exist for young people in custodial settings (including access to education);
- Prioritise the continual creation of further evidence to guide future policy responses and identify gaps in existing knowledge;
- Collect data on all health screening and assessment outcomes, recidivism tracking and risk factors and health and social outcomes; and
- Incorporate appropriate evaluation and monitoring to ensure that policies and programs meet all requirements and are effective in meeting the health needs of incarcerated adolescents.

Advocate to the governments of Australia and New Zealand to develop standardised **training and education programs** for all health professionals working with incarcerated adolescents to:

- Obtain appropriate knowledge and training in adolescent health;
- Operate independently outside of custodial hierarchies (be employed by non-custodial organisations);
- Develop ethical and legal frameworks that support the provision of confidential health care to adolescents in their jurisdiction;
- Ensure that laws that support the provision of confidential healthcare are put into practice in the custodial setting;
- Assess the competency of an adolescent to give consent or not to share information with others;
- Support the respectful communication between adolescents and their parents or guardians, taking into consideration the diversity of the adolescent's family and cultural backgrounds;
- Awareness of current policies and programs be included in all health undergraduate training courses to raise awareness and increase knowledge and skills and that includes physicians-in-training; and
- Offer the opportunity to include custodial staff in further education and support them in these wider roles of continuing education.

Executive summary

The aims of this document are to improve the delivery of health and social services provided to adolescents in the juvenile justice system by:

1. Improving management of health and social services to adolescents in the juvenile justice system and to continue these services when they are released into the community;
2. Reducing reoffending and recidivism into the juvenile justice system and increase vocational productivity through dealing with the social determinants of health via a "whole of Government" approach; and
3. Improving the training of health professionals who work with adolescents in the juvenile justice system.

The first target audience for this policy document is medical professionals whose responsibility is to provide safe, culturally specific and sensitive treatment and management for adolescents in juvenile justice systems. Secondly, this document is aimed at health departments and professional organisations responsible for the development, implementation and treatment of best practice for adolescents in juvenile justice systems and for monitoring the key social and health indicators.

Adolescents within the justice system suffer a broad range of psychosocial problems and decreased opportunities, and as a result, rank amongst the most disadvantaged group within the community. Due to the over-representation in custody of Indigenous groups in both Australia and New Zealand, the special needs of these young people need to be identified. The health status of incarcerated adolescents in Australia and New Zealand requires further study. A better understanding of the prevalence of the health problems of adolescents in detention is needed in order that resources are targeted to those most at need.

The recommendations form part of a framework for dealing in a systematic and holistic approach to improving health and social outcomes for adolescents. This approach acknowledges historical aspects of injustices and considers the importance of effective family support when providing health services.

The period of an adolescent's incarceration provides a window of opportunity to ensure well targeted health services are available for all incarcerated adolescents. For those who have repeated periods of incarceration the health provision should build on that previously provided. These services need to be continued once the adolescent returns to the community and they ideally should include parents/carers with a whole of government approach.

Guiding principles

Australia and New Zealand are signatories to a number of different international conventions (See appendix one for further information) that impact on the treatment of young people in detention, including:

- *The United Nations Convention on the Rights of the Child* (CRC);
- *United Nations Declaration on the Rights of Indigenous Peoples;*
- *The United Nations Convention on the Rights of Persons with Disabilities;*
- *The United Nations Rules for the Protection of Juveniles Deprived of their Liberty*;
- *The United Nations Standard Minimum Rules for the Administration of Juvenile Justice* (*Beijing Rules);* and
- *The United Nations High Commission for Human Rights Optional Protocol to the Convention against Torture (OPCAT).*

The CRC has been used to help promote the rights of children. It sets forth basic norms and standards which nations agree to pursue on behalf of their children, including:

- Protection from violence and abuse;
- Protection from exploitation;
- Adequate nutrition;
- Free primary education;
- Adequate health care; and
- Equal treatment regardless of gender, race or cultural background.

The OPCAT is an international agreement where state parties agree to international inspections of places of detention. The Australian Government signed the OPCAT in May 2009, but has not yet ratified the protocol. In 2007, New Zealand ratified the OPCAT after the enactment of amendments to the *Crimes and Torture Act 1989* (NZ).[4]

Recognising the special vulnerability of children in detention and their need for guidance, all of these goals are expressed with respect to the child's age and maturity - the child's best interests are always the paramount concern. It should be noted that while the CRC defines a child as a person under the age of 18 years, some jurisdictions in Australia continue to treat 17 year olds as adults within their criminal justice system (e.g. Queensland). Under New Zealand law children from the age of 10 years can be charged with murder or manslaughter and 17 year old offenders are dealt with by adult courts.[5] This is inconsistent with the principles of the CRC.

The World Health Organization (WHO) consensus statement on *Promoting the Health of Young People in Custody*[6] (2003) draws attention to the principles, policies and practices by which member countries agree to provide the best chance to maintain the health and well-being of young people in custody – helping them achieve a more positive, productive, satisfying and healthier lifestyle whilst they are in custody and on release.

The objectives are to:

- Promote the physical, mental and social aspects of the health of young people in custody;
- Help prevent deterioration of young people's health during or because of custody; and
- Help young people in custody develop the knowledge, skills and confidence they need to enable them to adopt healthier behaviours that they can take back into the community with them.

The RACP policy on the *Inequity and Health: a call to action* (2005)[7] notes that it is widely acknowledged that people from disadvantaged groups have poorer health outcomes than those in advantaged groups. Determinants such as income, employment, poverty, education and community connection impact upon the health status of individuals and the community. An individual's health is affected by personal feelings of power and belonging. Economically and socially disadvantaged groups have the poorest health and are the lowest users of preventative health services.

Young people in custody have a right to expect access to (at least) the same level of health care, including preventative health services, as other citizens. A position paper on the *Health Care for Incarcerated Youth*, by the Society for Adolescent Medicine[8] states that many young people entering custody have historically lacked comprehensive health care and have long-term neglected health needs. The paper also states that health care should be provided by personnel who must report to an authority other than the penal system, such as the public health department, while remaining integrated within the operations of the youth justice system. Health care professionals caring for detained youth within a detention facility should not participate in police or punishment processes, including evidence collection.

The health care provided to young people in custody should be evidence-based, however in some cases, high quality evidence is lacking and therefore interventions which are supported by the best available evidence are promoted. It is an accepted goal of medical practice to emphasise interventions of proven effectiveness, safety and cost-effectiveness.[9]

The Australian *National Preventative Health Strategy*[10] states that a co-ordinated and comprehensive approach to preventative health is needed. Action to improve health is required across a person's lifetime, starting early in life and with an emphasis on identifying the key opportunities to influence change. This policy is aligned with the Preventative Health Taskforce's approach to healthcare.

Confidentiality and Privacy [11]

Confidentiality is important in the development of a trusting relationship between an adolescent and a health professional, and provides the context in which effective assessment, screening and therapeutic interventions can occur, such as routine psychosocial assessment.[12] The provision of confidential health care underpins the provision of quality health care to adolescents and is an ethical and legal right for competent adolescents; without it, the healthcare transaction often fails. When

confidentiality is not assured it is known young people are less forthcoming, particularly with sensitive health information.[13] Young people in custody are likely to have had negative experiences with authority figures, so clarifying a health provision role rather than a custodial role may help develop trust.

In some instances conflict can arise between a health professional's ethical responsibilities to patients and those to the community via the courts. Medical records may be subpoenaed. Most States and Territories in Australia have legislation that embodies the Information Privacy Principles contained in the *Privacy Act 1988* (Cth). The Health Information Privacy Code, issued under the *Privacy Act 1993* (NZ), outlines the exceptions to confidentiality which allow for disclosure of medical records in New Zealand.[14]

Consent

Australian and New Zealand law recognises that individuals aged 18 years and over have full legal capacity, such that they are capable of making decisions relating to their own health care. Prior to that age, parents (or legal guardians) are entitled to consent to their child's medical and dental treatment. A parent's authority in this respect is not, however, absolute, as the law in Australia recognises that children become increasingly competent as they move towards adulthood. In New Zealand children of 16 and 17 years can give effective consent to medical treatment without needing consent from a parent or a guardian according to the *Care of Children Act 2004* (NZ). However, individuals under 16 years of age are not automatically prohibited from consenting to medical treatment and judgement must be exercised at each instance.[15]

Competence to consent to medical treatment is determined by clinical judgment of the adolescent's stage of development and their ability to understand what is being discussed, in the context of the relevant local or national legislation, and is primarily a clinical decision. The overarching principle is that children can consent as long as they have the capacity to understand the information and the implications of the procedure or treatment to which they are consenting. In most of Australia and New Zealand this common law position applies.

New South Wales (NSW) and South Australia (SA) have statutory provisions that apply. The *Minors (Property and Contracts) Act 1970* (NSW) allows a child aged 14 years or over to consent to his or her medical or dental treatment. This Act also allows parents of children under the age of 16 to validly consent to their child's medical or dental treatment. The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) prescribes that an individual of 16 years of age or over can consent to medical and dental treatment 'as validly and effectively as an adult.' Otherwise, a child can consent to treatment provided that a medical practitioner, supported by another medical practitioner, believes that certain treatment is in the best interests of the child and the child is 'capable of understanding the nature, consequences and risks involved'. The SA legislation also provides that medical treatment can be administered to a child if the child's parent or guardian consents to it.

Where patients lack mental capacity and do not understand the need for the treatment (for example, through intellectual disability and sometimes mental illness) a parent may give consent. However, the guardianship statutory procedures of each State and Territory may apply, particularly where treatment is in relation to major or non-therapeutic procedures. In New Zealand, legal guardians or someone with enduring powers of attorney can give consent for medical treatment if the patient is not competent to make informed consent. Under certain circumstances a doctor may provide treatment without consent if it is in the best interests of the patient and a legal guardian is unavailable.[15]

Background

Adolescents within the youth justice system suffer a broad range of psychosocial problems, as well as decreased social, educational and occupational opportunities.[16,17,18] Many come from backgrounds of risk and vulnerability and this population rank amongst the most disadvantaged group within the community.[19]

Young people aged between 10 and 16 years account for less than 10% of the total population in Australia, though they constituted approximately 25% of the offender population in 2000-01.[20] The number of young people in detention on an average day in Australia rose from 540 in 2004-05 to 630 in 2007-08 – a 17% increase. Data indicate that a person aged 10-17 years in 2007-08 was 1.2 times as likely to be in detention compared to 2004-05.[21] In 2007, the majority of young people in detention were male (91%).[22]

New Zealand's estimated resident population aged between 10 and 23 was approximately 20% of the total population in 2008. The Màori resident population was comparatively young with 28% of Màori being aged 10 to 23 years.[23] In 2008, 2855 young people between the ages of 10 and 24 were incarcerated[24] compared to the total number of incarcerated individuals (including those imprisoned, those with life sentences and those on preventative detention) of 7664. In 2008 there were 3713 people aged 10-24 with custodial sentences (including home detention). The total number of individuals with custodial sentences in 2008 was 10143.[24] This means that over one third of those with custodial sentences were under the age of 25.

The health status of incarcerated young people in Australia and New Zealand has never been studied in a standardised or comprehensive way across the two countries, however there have been examples of regional data being collected over the last few years.[25,26] Data is also available from international sources[3] and although this is useful to compare with local data, it is unlikely to be particularly relevant to the over represented Indigenous groups.

It has been known for a long time that incarcerated adolescents generally come from disadvantaged backgrounds. An example of which includes the disproportionately high number of Indigenous young people in the juvenile justice system in NSW.[25] This disparity is found in all states and territories with some variation in the over-representation between different regions. Màori young people are also over-represented within the New Zealand justice system.[27]

A better understanding of the prevalence of the health problems of young people in detention is needed in order that resources are targeted to those most at need. Young people admitted into European and North American youth detention centres suffer high rates of general health problems and psychiatric illness.[28,29,30,31] Australian studies have also reported an increased prevalence of a broad range of health problems, mental illness, substance misuse and sexually transmitted disease.[32,33,34,35,36,37,38] Furthermore, young people in youth detention suffer from high rates of co-

morbid health problems and mental disorders,[39] with up to 52% reported as suffering from three or more mental health problems, excluding conduct disorder.[37] Although the prevalence of dental disease in incarcerated adolescents in Australia is largely unknown, young people in American detention centres are reported to suffer high rates of cavities and other oral health problems[40] with many lacking comprehensive dental care and having long-term neglected oral health needs.[41]

Indigenous Detention Rates

The over-representation in detention of Indigenous young people relative to non-Indigenous young people remains very high, and is more extreme than that of adults.[42] In a NSW survey of young people in custody, 43% identified as being of Aboriginal and/or Torres Strait Islander background. Indigenous young people were 28 times more likely than non-Indigenous young people to be in detention in 2007.[21] A 2009 report found that despite only 6% of 10-17 year olds in the community identifying as Indigenous, Indigenous people accounted for 63.8% of all young people in detention.[43]

There were 1850 Màori between the ages of 10-24 with custodial sentences in 2008. The total Màori population with custodial sentences was 4942. This shows that Màori youth had disproportionate (37% of those Màori with custodial sentences, while only making up 28% of the total Màori population) numbers of individuals with custodial sentences. Màori accounted for 50% of all youth with custodial sentences.[24]

17 Year Olds in Adult Prisons

Queensland is the only jurisdiction in Australia in which 17 year olds are dealt with under the adult justice system and as a result 17 year olds can be detained in adult prisons. In New Zealand all 17 year olds are tried as adults and can serve their sentences within the adult justice system.[44]

There are specialist youth units for vulnerable male prisoners under 20 years of age which offer a tailored environment for vulnerable young prisoners.[45] Male youths (those aged 14 to 17 years inclusive) are automatically placed in a youth unit and extra spaces in these units are filled by 18 and 19 year olds. This means that youths of 17 years of age and under are mixing with legal adults.[46] It is a different situation with female youths as there are no specialised youth units aimed at females. Instead young female prisoners are incarcerated within mainstream women's prisons. Having female youths imprisoned in mainstream women's prisons, whether they mix with adults or are kept separate, limits their access to education and rehabilitative and therapeutic programmes tailored to their age group.[47]

Queensland Corrective Services[48] reported that, at 30 June 2008, there were 32 young people in Queensland adult prisons. The *United Nations Universal Declaration of Human Rights* proclaims that children are entitled to special care and assistance, and the *United Nations Convention on the Rights of the Child* declares that a child is every human being below the age of 18 years. Paragraph (c) of Article 37 states:

> *Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so.*

Incarcerated adolescents and adults should not be housed in the same facilities. Instead, children under the age of 18 years should be housed in facilities specific to adolescents. Jurisdictions not managing adolescents in this fashion are potentially in breach of the *United Nations Convention on the Rights of the Child.* The RACP calls for the immediate transfer of all 17 year olds to purpose built adolescent facilities where they can receive access to developmentally appropriate services.

Current Health Status of Incarcerated Adolescents

Studies in Australia and New Zealand consistently show that young people in detention are among the most socially disadvantaged and potentially vulnerable young people in the community. Around 80% of young people in detention have experienced multiple traumatic events during their lifetime,[49] and many young people enter detention with untreated physical health problems.[17,50,51] Longitudinal studies in New Zealand have shown that young people have an increased risk of poor health outcomes and are more likely to become violent, recidivist offenders if they did not have access to health care at critical stages of their development.[52]

In 2003, a large survey was completed in NSW that examined the health status of young people in custody.[53] It was a comprehensive review of both physical and mental health as well as social status and background, and was offered to all detainees in NSW over a two week period. Similar data has also been obtained from Victorian youth justice centres where 100 consecutive detainees were studied. The overall findings from these and other studies suggest that this group have higher rates of mental health problems, substance use issues, health risk behaviours, disconnection from school and social disadvantage than similar aged individuals in the general community. Approximately 40% had a parent in custody and 10% were parents themselves.

In Australia, the contribution that females made to the total incarcerated population declined from 17.2% in 1981 to 6.3% in 1998.[54] Females in youth detention report higher rates of mental illness, emotional problems and suicide or deliberate self injuring behaviours than males.[32,55,56] These problems are compounded through inadequate resources being focused on their gender-specific needs.[58]

Antenatal care must be provided to all females in detention either onsite or in specific antenatal clinics. The full range of options regarding any pregnancy must also be provided. In the case where a baby is kept in custody with its parent after birth, full and appropriate specialist health care must continue to be provided for the mother and child, including routine health checks and immunisations.

Physical health

As is often the case with many young people, the NSW survey found that surveyed detainees rated their own health quite highly. Most reported their health as either excellent, very good or good. This was also the case in the New Zealand Prisoner Health Survey which found that four out of five prisoners rated their general health as good, very good or excellent.[57] Despite this, asthma, ear infections and poor sleeping were commonly reported and many also reported injuries, with head injuries being common.[57] Approximately one third were found to have a hearing deficit. Older detainees were more likely to be overweight or obese. Despite the self rating of health being positive, it is clear that this is not the case for many and the situation is worse when other aspects of health are included, such as dental health.

In New Zealand two thirds of prisoners experience a head injury at some time in their life, over half of all prisoners indicated that they had been diagnosed with a chronic disease (the most common being asthma), over half of all prisoners were found to be overweight or obese and the most common communicable diseases were scabies and lice.[57]

All adolescents in detention therefore should have a comprehensive medical history and examination promptly after incarceration that can screen for physical health problems but also for other health concerns as outlined in the following sections. The NSW survey also found that despite denying experiences of abuse and neglect, 42% reported to having been physically abused, 11% sexually abused and 38% had experienced emotional neglect. These data were obtained using the Childhood Trauma questionnaire which assesses the degree to which people deny or minimize the experiences of abuse or trauma. A third had been in care or not living at home prior to detention and many were also identified as having significant learning difficulties.

Mental Health

Mental health disorders are significant public health problems affecting young people in youth detention.[58] Even after excluding conduct disorder, numerous studies have documented the higher prevalence of mental health disorders and behavioural problems among young people in the youth justice system when compared with the general population, with rates of up to 75% reported to fulfil the criteria for one or more diagnosable psychiatric disorders.[29,34,35] The broad range of psychiatric diagnoses over-represented in this cohort include attention-deficit/hyperactivity disorder, autism, mood and anxiety disorders, and post traumatic stress disorder. There is also significant co-morbidity with substance misuse and drug-induced psychosis. The NSW study found that 30% reported high or very high psychological distress implying that they may have a greater than 50% chance of anxiety or depressive disorder.[53]

A National Study of Psychiatric Morbidity in New Zealand Prisons found that individuals diagnosed with major depressive disorders, schizophrenia, post traumatic stress disorder and bipolar affective disorders were found at a much higher rate within prison populations than in the community sample.[59] Nearly one in four prisoners reported having a psychiatric or psychological condition that caused difficultly in every day activities and socialising.[57] It was also found that there are high rates of co-morbidity with major mental disorders and substance abuse or dependence.[59] There is a lack of research on the mental health problems of youth offenders however the statistics above show those high rates of mental illness are likely to be experienced by incarcerated youth.

Although Indigenous young people are over represented in youth detention facilities, there is currently no national database of the prevalence of mental disorders in Indigenous youth. The Australian Bureau of Statistics (ABS) National Health Survey[60] did not give details of the mental health of Indigenous Australians. However, a subsequent ABS publication[61] indicated that high levels of mental health problems in Indigenous Australians may be extrapolated from other health-related data. Indigenous Australians are reportedly diagnosed with increased rates of mental disorders due to

psychoactive substances, have higher hospital admissions for conditions classified as “mental and behaviours disorders” and have higher rates of suicide and deliberate self injury than non-Indigenous Australians. Similarly to Indigenous Australians there is little research on the prevalence of mental disorders in Màori youth, however past admission rates to psychiatric hospitals have shown that Màori males aged 15 to 19 years had higher rates of admission and readmission to psychiatric hospitals than non-Màori.[62] While not comprehensive, it does suggest that Indigenous young people in detention are likely to suffer from higher rates of mental health and substance misuse disorders than their non-Indigenous peers.[32]

Suicide

Young people in the youth justice system have suicide prevalence rates four-times that of other young people,[63] with high levels of suicidal ideation (29%) and a history of attempted suicide (21%), with 7% making a recent attempt.[64] In 2003, Howard[65] reported similar high rates, as did Stathis *et al* in 2007.[32] Furthermore, young people in youth detention who have a past history of attempted suicide are at long-term risk of deliberate self injury (DSI) and have increased rates of future suicide attempts.[64,66,67,68] There is limited knowledge about the risk factors for suicide and DSI in young people, though toxic peer modelling, mood or anxiety disorders and substance misuse have been implicated.[69,70,71]

New Zealand has a relatively high suicide rate compared to internationally. Research on suicide within prisons has found that inmates are 4-6 times more likely to kill themselves than non-inmates.[72] The rate of Màori inmates committing suicide is much higher than the overall suicide rate for Màori. Màori, particularly young male Màori, have much higher rates of suicide than non-Màori.[73] Research has also found that younger inmates, those between the ages of 15 and 19 are at the greatest risk of committing suicide.[72]

Such risk factors are common in young people within the youth justice system. However, despite the high rates of previous suicide attempts and DSI in incarcerated youth, there are few published studies that have assessed the effectiveness of policies and procedures implemented by Australian detention centres to identify and manage young people who are potentially at acute risk of such behaviours.[74]

Intellectual Disability

People with intellectual disability (ID) and other developmental disabilities are considered more at risk of mental illness than the general population, [75] however prevalence data on those with ID is both lacking and inconsistent. Issues that include different definitions of ID across different jurisdictions, differences in methods used to identify ID and differences in diversionary options that may exist to prevent people with ID from entering prisons between jurisdictions all make comparison of prevalence rates across studies difficult.

High prevalence rates of mental illness have been reported indicating that four in ten young people with an ID have significant mental health needs, and one in ten young people with mental health needs also have an ID.[76] Cognitive and academic testing has shown that around three-quarters of

young detainees have impaired cognitive functioning and around one-third have literacy and numeracy abilities typically seen in young people with IDs.[17] A 2009 study found 10% of young male prisoners to have IDs suggesting that this group are prevalent but easily hidden in mainstream criminal systems.[77] Approximately 1.7% of prisoners in New Zealand reported that they needed or received help due to an ID.[78] Although New Zealand has specialised units aimed at incarcerated adults with IDs there are no specialist inpatient youth forensic facilities.[79]

There has been increasing international, national and local recognition of the need for more appropriate responses and services for individuals within the criminal justice system who have an ID. There are a number of barriers within the present service system in regard to meeting the needs of individuals with intellectual and developmental disabilities, and one of the significant obstacles in obtaining care for these populations is the relative lack of expertise available to provide specialised care. Appropriate services overseen by a case manager are required.

Health Risk Behaviours

High levels of health risk behaviour and thrill-seeking behaviours have been identified among incarcerated adolescents[16] including: unsafe sexual practices, alcohol abuse, illicit drug use, tattooing and tobacco use. Information is required as to what health interventions are currently being provided to incarcerated adolescents, and comprehensive health services for incarcerated youth need to provide screening, treatment and health promotion. The highest risk factors for young people in prison were identified as the use of drugs (non prescribed or used for a purpose other than what they were prescribed for) prior to prison and currently smoking tobacco (both roughly 80%) in the 2005 New Zealand Prisoner Health Survey.[80]

Sexual Health

Adolescent pregnancy and sexually transmitted infections (STIs) disproportionately affect young people who are socioeconomically and culturally disadvantaged. Aboriginal young women are overrepresented among adolescent mothers as well as presenting with chlamydia and gonorrhoea infections in higher numbers than the rest of the population.[81] It is known that incarcerated youth have higher rates of chlamydia infection.[82] A NSW survey of incarcerated youth found that 33% of young men and 44% of women either never used condoms or used them less than half the time.

In New Zealand, STIs are common among those aged 15 to 24. The most commonly reported infections are chlamydia, gonorrhoea, genital warts and genital herpes.[62] Multiple STIs were much more common among Màori and Pacific peoples.[83] Over a quarter of incarcerated females had been diagnosed with chlamydia and approximately 15% of female prisoners had contracted an STI.[62] This is much higher than the male prison population of which only approximately 8% had contracted chlamydia and only approximately 6.5% has contracted another STI.[62]

The use of barrier contraceptives is occasional for many and the median age of first sexual intercourse is 13 years, with most reporting more than one sexual partner. This puts the majority of detainees at risk of STIs and blood borne virus infection including HIV. There is no research on the median age of first sexual intercourse of incarcerated youth in New Zealand.

Preventative sexual health services should be provided to this population (e.g. the National Human Papillomavirus Vaccination Program).[84] Seeking consent to take a sexual history is an important and essential part of the process, and screening for health risk behaviour including psychosocial and sexual development among adolescents is recommended as preventative practice.

Drugs and Alcohol

The RACP and the Royal Australian and New Zealand College of Psychiatrists have acknowledged the dangers of alcohol misuse across the lifespan.[85] Risks of alcohol and illicit drug abuse is increased in young people with a childhood history of social and psychological adversity,[86,87,88] all of which are commonly found in those in custody. Issues that include dangerous use and early initiation are common among incarcerated adolescents, and the Australian Institute of Criminology found that adolescents' substance using patterns were very similar regardless of Indigenous status.[89]

Evidence has indicated that incarcerated adolescents report significantly higher rates of drug use in a one month period than non-offending adolescents report in a year.[90] The link between drug and alcohol misuse and delinquency is complex. Up to 70% of adolescents report being intoxicated at the time of their offence.[91] Young people who are detained or arrested by police report higher incidence of substance use than the general adolescent population, though less than the young people in detention,[92] suggesting that youth in detention rank at the extreme end of the spectrum, with rates approaching 90% reported in some studies.[90]

In NSW, detained young people had higher rates or use of alcohol (95%), cannabis (87%), stimulants (53%), inhalants (48%), sedatives (44%), hallucinogens (41%) and opioids (26%), than school students or young people generally.[93] Risky binge drinking (63%) and injecting drug use (24%) were particular concerns,[94] as was increasing use of amphetamines (56%) and opioids (50%).[95]

It is estimated that 80% of young people coming before the Youth Courts in New Zealand have alcohol or drug, dependency or abuse issues that are connected with their offending.[96] In the New Zealand Prisoner Health Survey it was identified that approximately 81% of those aged under 25 years used illicit drugs prior to entering prison.[97]

A NSW study of detained youth reported that few drug programs exist for and was used by young offenders: 29% had made an attempt at drug rehabilitation – mostly counselling. Whilst

only 8% had been admitted to residential drug rehabilitation programs, another 25% felt they needed such programs.[93] In response to this, the then NSW Department of Family and Community Services introduced alcohol and other drug counsellors into NSW Juvenile Justice Centres and expanded the number of counsellors in community-based programmes.

The NSW Young People on Community Orders Health Survey found that 58% of responders wanted to, or had tried to give up substance abuse during the past year. Compliance was low for those reported to receive treatment (18%), and despite 40% of the sample being in need of treatment (as indicated by their drug use pattern) only 10% reported thinking they needed or wanted treatment, indicating motivation for treatment was low.[98]

Research suggests that mandated treatment works at least as well as "voluntary" treatment, and higher treatment gains are found for adolescent offenders compared to adult offenders.[99] Given the obvious economic, social and personal costs incurred with untreated drug and alcohol abuse and the nexus between this abuse and crime, it seems that there is much to gain – and little to lose – by improving the detection of problematic drug and alcohol use in young offenders and by strengthening their access to suitably intensive substance abuse treatment programmes.[98]

In the New Zealand Drug and Alcohol Strategy, the Department of Corrections aims to double the number of placements for prisoners in Drug Treatment Unit programs to 1,000 per year.[100] However this compared to an estimated prison population of 9023 in 2011 leaves only a small proportion of prisoners able to access treatment services.[101]

The need to address drug and alcohol use disorders is an important health issue for young people in custody. There is a need for Addiction Medicine specialists to develop and use their expertise in assessing and managing young offenders with substance use disorders. This should occur in adolescent detention centres and in community programs servicing young offenders (such as youth drug & alcohol court programs). The significant co-morbidity between drug and alcohol misuse and mental health problems is now recognised at national and state levels.[102,103,104] Acknowledging the limitations of separate service delivery for mental health and drug and alcohol treatment, the *National Drug Strategy*[105] emphasised the need for closer ties between substance use and mental health services and specifically identified the need for specialised services for people in the justice system.[62] Limited evidence exists for age-specific interventions for this population and further research into this is required.

Despite considerable evidence of the high levels of co-morbid mental health problems and drug and alcohol use disorders among young people in custody,[106,107,108] and emerging evidence that brief motivational interventions are beneficial in reducing alcohol misuse among adolescents,[85] there are limited counselling programs within youth detention specifically designed to meet the needs of this vulnerable population.[109] Given the increased interest in

reducing adolescent crime and recidivism, the current challenge is to support the development of innovative models for the assessment, management and treatment of adolescents with co-morbid drug and alcohol use, and mental health problems within the youth justice system, preferably informed by evidence based-practice.

Tobacco Use

It is known that people who take up smoking as teenagers tend to become heavier smokers, are less likely to give up[110] and more likely to develop diseases caused by smoking.[111] The NSW 2003 Young People in Custody Survey revealed that the average age of tobacco smoking commencement was 12 years for both male and female adolescent detainees and that despite smoking bans in NSW juvenile detention centres, 58% of those surveyed self-identified as regular smokers. Given the high prevalence of smoking in youth detention, the development of effective treatment approaches to smoking cessation for incarcerated youth is important. Incarceration represents a unique public health opportunity to initiate contact with this group and improve the health of a large number of adolescents. Roughly 82% of those aged under 25 years identify as current smokers. Màori are more likely to be smokers than non-Màori.[112] New Zealand is planning to introduce a prison-wide smoking ban in July 2011, however there is concern that without well resourced rehabilitation programmes the policy will not work.[113]

The *National Preventative Health Strategy*[10] states that completely smoke-free correctional facilities have been introduced successfully overseas and that efforts are required to ensure that all juvenile correctional facilities are smoke-free and for appropriate smoking cessation supports to be provided.

Providing Health Care in Custodial Settings

Preventative programs can be better aligned to advance the health and emotional well-being of incarcerated adolescents. Despite young people in detention suffering high rates of poor general health and psychiatric morbidity, many lack access to appropriate health care in the community.[28] Their time in custody potentially provides an opportunity for comprehensive health care provision to a population who have high known levels of health care need and who frequently receive the least healthcare when in the community. Health care professionals working within the youth justice system are confronted by any number of issues including acting at the interface of multiple systems (family services, police, youth justice, education and family court), negative community perceptions toward delinquent youth, role conflict and confidentiality issues, as well as the practical problems in addressing the multiple needs of a disadvantaged population.

Working with young people in the healthcare setting is different from working with children or adults. It is known that most teenagers are relatively physically healthy and therefore a routine

screening of illnesses e.g. asthma, epilepsy etc followed by a physical examination is unlikely to identify many health problems compared with doing the same in an older population where hypertension, obesity, vascular disease among others may be identified. Adolescents in custody are known to have higher levels of health risk behaviour and mental health problems as well as social disadvantage. Health screening and service provision based on traditional adult models of taking a routine medical history, physical examination and investigation is therefore not the most appropriate methodology for this population.

The time in custody is potentially an opportunity to provide comprehensive health care to a population who have known high levels of health care need and who frequently receive the least healthcare when in the community. The College supports a service for young people in custody that provides timely health screening after incarceration that can document current health status as well as identify and intervene where appropriate for health risk behaviours. This should begin within the first 24 hours of admission. This assessment should form the basis of an ongoing health plan which should include opportunistic interventions including immunisations, sexual, mental and dental health clinics, and not just basic health care. Immediate risks identified must be managed, including intoxication/drug withdrawal, risk of self harm, or other medical conditions (e.g. asthma and diabetes).

Due to the over representation in custody of Indigenous groups in both Australia and New Zealand, the special needs of these young people need to be identified. All health staff working in custodial settings should be adequately trained to deal with these issues. Australia and New Zealand are multicultural societies, so cultural sensitivity does not only apply to Indigenous groups. All detainees from culturally and linguistically diverse backgrounds should be offered interpreters if English is their second language. Religious and other cultural differences should not only be tolerated but respected.

Mortality rates of adolescents after release from custody are higher[114,115] than for same aged people who have not been in custody. This is illustrative of their poor level of health care in the community. A comprehensive health care plan upon release from custody should be developed for all adolescent detainees. This includes timely access to specialist services as well as ongoing care for any physical or mental health conditions. Linkages should be made to community services to provide ongoing care following release from custody. Given that many young people are only incarcerated for short periods of time, this aspect of health care provision can be the most challenging.

Mental Health Care

Effective consultation in adolescent detention settings requires a sound knowledge of the organisational structure, policies, procedures, and other systems issues relevant to mental health issues and the routine schedule of youths in the institution.[116] In Australia, differences between states

and territories in the administration and running of their detention facilities make it difficult to form national recommendations.

Youth detention centres have the potential to provide significant opportunities for individual therapy and group programs for young people with mental health problems. However, to achieve a realisation of this potential, detention facilities need to develop philosophies and procedures which facilitate the development of therapeutic as opposed to punishing environments.[117]

Evidence-Based Treatment

Custodial health care in Australia and New Zealand is not provided or administered in a standardised way. There is no national or unifying document outlining healthcare guidelines, policies or procedures. Healthcare is usually provided by agencies separate from the custodial agencies and they each have their own guidelines and policies. International guidelines and position statements recommend both minimum and ideal standards for healthcare provision to incarcerated adolescents.[118,119] No such documents exist in Australia and New Zealand, though the National Standard Guidelines for Corrections in Australia does summarise the basic healthcare requirements for adults in custody.[120] It recommends physical and psychological health screening on reception, and that all prisoners have access to evidence-based health services provided by competent registered health professionals. It also provides some guidance on services for pregnant women in detention and children residing in prison. This document is endorsed by all Australian state and territory correctional services, but there is no detail on its implementation. As already stated, the administration and delivery of these services are different in each region.

Evidence-based treatment in custody is limited, however there is increasing data on current health care status and needs for adolescents and children in custody, both nationally and internationally. There is also fairly consistent best practice and minimum standards literature available regarding custodial health for adolescents which can be used to guide service delivery as well as specific guidelines for specific health care needs e.g. sexual health screening. The literature on adolescent health best practice principles indicates that treatment and care modalities for incarcerated adolescents need to be firmly and inalienably underpinned by best practice, including patient's informed consent and confidentiality.

It is clear that culturally sensitive services should be incorporated into any health service provided to detained youth. Underpinning ongoing development and improvement to these services is data collection and evaluation of current services to facilitate constant review and change as required to meet standards. Data collection must be part of health services for adolescents in custody in Australia and New Zealand.

Conclusions

Incarcerated young people suffer a broad range of health problems and rank among the most vulnerable people in our population. The time in custody provides an opportunity for comprehensive health care and targeted interventions to a group with known high levels of need and who have limited access to and uptake of care when in the community. The overall aim is to optimise the health and well being of incarcerated youth during and ideally after detention. This involves identifying their health risks and facilitating their capability to function within the wider community. A better understanding of the prevalence of these health problems is needed so that resources can be targeted to those most in need. The over-representation of Indigenous groups within youth detention is of concern and the special needs of these groups need to be identified so that health services target the needs of these groups.

This policy is intended to set the standard for appropriate health care for incarcerated adolescents in Australia and New Zealand and also to provide a framework on which to improve and standardise care provided. This RACP policy is consistent with international documents and pays specific attention to the needs of over represented Indigenous groups within Australia and New Zealand.

Appendix

The United Nations Convention on the Rights of the Child
Available at: http://www2.ohchr.org/english/law/crc.htm

United Nations Declaration on the Rights of Indigenous Peoples
Available at: http://www.un.org/esa/socdev/unpfii/en/drip.html

The United Nations Convention on the Rights of Persons with Disabilities
Available at: http://www.un.org/disabilities/

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty
Available at: http://www2.ohchr.org/english/law/res45_113.htm

The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules)
Available at: http://www2.ohchr.org/english/law/pdf/beijingrules.pdf

The United Nations Universal Declaration of Human Rights
Available at: http://www.un.org/en/documents/udhr/

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
Available at: http://www2.ohchr.org/english/law/cat-one.htm

Glossary

Adolescent:

Children and young people under the age of 18 years. (*The United Nations Convention on the Rights of the Child*).

Custodial Setting:

Includes all custodial settings or secure accommodation used for children and young people dealt with by the criminal justice system.

Detention:

The maintenance of a person in custody or confinement while awaiting a court/tribunal decision or trial.

Health:

A state of complete physical, social and mental well being, and not merely the absence of disease. (WHO, 1948)

Incarceration:

The process of confining and segregating populations into specialist institutions for the purposes of punishment, treatment or care.

Young Person:

Young person between the ages of 10 and 19 years (The World Health Organization (WHO).

Youth:

The United Nations, for statistical purposes, defines 'youth', as those persons between the ages of 15 and 24 years. This definition was made during preparations for the International Youth Year (1985), and endorsed by the General Assembly (see A/36/215 and resolution 36/28, 1981).

Other definitions include the transition from child to adult, a period of great and rapid emotional, physical and intellectual change, a time of transition, and a time when individuals can experience significant fluctuations in health and well being.

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