TYPES OF PSYCHIATRIC TREATMENT

Treatment of delinquents

Carol Sheldrick

This is the tenth of a series of articles on treatment of child psychiatric disorders.

Definition

As West points out delinquency is a sociolegal category.¹ The definition of a juvenile delinquent, in the UK at least, is a young person between the age of 10 (the age of 'criminal responsibility') and 17 years who has been prosecuted and found guilty of an offence that would be classified as a 'crime' if committed by an adult. These offences normally result in the opening of a criminal record file at Scotland Yard but do not include more minor drunk and disorderly, common assault, and motoring offences.

The size of the problem

Research findings are consistent in showing that the majority of young people (particularly boys) have committed delinquent acts at some time. Not all boys appear in court, but self report studies do pick out many of the boys with official records and the higher the score on a schedule of self reported offences, the greater the likelihood of the young person having an official conviction record.²⁻⁴ Farrington,⁵ using data from the Cambridge study, a longitudinal study of 400 boys living in inner London and selected randomly from six adjacent primary schools^{4 6-8} showed that up to the age of 32, over one third were convicted of criminal offences. The peak age for the number of offenders and the number of offences was 17, but approximately equal numbers of offences were committed by males as juveniles (age 10-16), as young adults (age 17-20), and as adults (21-32). The men who were first convicted at the earliest ages tended to become the most persistent offenders and committed large numbers of offences at high rates over long time periods. Despite this, earlier work by West, showed that only about one quarter of adolescent offenders continued to offend into their twenties.⁷

Much less research has been carried out on females but figures quoted by Farrington suggested that the ratio of males to females acquiring a criminal record was approximately 3.5-4.5:1.⁹

Implications for management

It is clear from this research that a certain amount of law breaking is the norm, particularly for males, and does not necessarily imply any significant degree of personal maladjustment. Many youths only appear in court once and only a small proportion show a persistent pattern of delinquency. While it may seem appropriate to

intervene as early as possible in the lives of delinquents research suggests otherwise.

The dangers of intervention

THE JUDICIAL PROCESS

There are differing theories about the judicial response to delinquency. The work of Farrington *et al* has shown that the first appearance in court tends to be followed by an increase in delinquent activities, as well as increases in hostile attitudes towards the police, aggressive attitudes and behaviour.¹⁰ This study suggests that a first court appearance (and public labelling) has a deleterious effect, and probably more so if the consequences are trivial. A study by McCord suggests otherwise, however.¹¹

In Britain we lock up a higher proportion of our population than most other Western European countries. At one time it was hoped that institutional treatments would be therapeutic and reformatory in their effects. Unfortunately this has not proved to be so and some studies from America show that non-custodial approaches do better than institutional ones.^{12 13} McCord, in the study referred to above, showed that incarcerated boys do not do better with respect to recidivism than those receiving more lenient sentences.¹¹ In England there is no evidence that the borstal (now renamed the young offender) system is effective in influencing long term recidivism. Sixty four per cent of trainees released in 1972 were reconvicted within two years; the figure for boys under the age of 17 years was even higher, at 79%.¹⁴

It seems unlikely that institutional treatment, retraining, and punishment are effective in decreasing delinquency. It is even possible that there is a harmful effect because of the alienation, stigmatisation, and 'contamination' suffered by those who are incarcerated together with other offenders.

COMMUNITY BASED PROGRAMMES

Similar results would not have been anticipated from community based, non-punitive programmes. Unfortunately this is not so and one study by O'Donnell *et al* showed that non-delinquents had a worse outcome than controls, possibly because of delinquent peer group contamination.¹⁵ An important study by McCord looked at the long term effects of a treatment programme for boys and their families based on a 30 year follow up of over 500 men, one half of whom had been randomly assigned to a treatment programme at the age of 5-13 years, for an

Children and Adolescent's Department,
The Maudsley Hospital,
Denmark Hill,
London SE5 8AZ

Correspondence to:
Dr Sheldrick.

average of five years.¹⁶ Treatment consisted of counselling for the boy and his family, introduction to community programmes and summer camps, provision of medical and psychiatric assistance as well as tutoring in academic subjects. The treated group actually fared worse than the control group on such measures as criminal behaviour, death at a young age, stress related disease, alcoholism, serious mental illness, occupational status, and job satisfaction.

There have been more successful community based programmes developed, mostly in North America, and reviewed by Stumphauzer,¹⁷ however.

Attempts at diversion

THE COURTS

It is clear from this research that diversion of young people from certain interventions, particularly those of the courts and the prison system, is desirable.

In Britain the Children and Young Persons Act 1969 was introduced in order to prevent children coming to court for criminal proceedings.¹⁸ Before 1971 children could be given a warning if apprehended while committing an offence. This was an informal procedure, conducted at the discretion of the police officer and not recorded officially. The 1969 act gave statutory sanction for police cautioning as a means of diverting children from the courts. The caution is usually administered, with the consent of the child, parents and victim, in a formal way to emphasise the gravity of the situation. Sometimes the police undertake follow up supervision and guidance, or they may refer the child to the social service department on a voluntary basis.

In 1979, the year when the legislation was fully implemented, it was found that cautioning increased,¹⁹ which led Farrington and Bennett to believe that this had produced a widening of the net, so that official cautions had tended to replace informal, unrecorded warnings, rather than being used in place of court appearances.²⁰

The situation since then appears to have changed for the better, however. Richardson and Tutt,²¹ using data from the Home Office,²² point out there has been a 23.2% decrease in the number of 10–16 year olds in the population in England and Wales over the 10 years 1979–88. It has been found that over 55% fewer juveniles entered the formal court system during 1988 than did in 1979, a very dramatic diversion of young people away from the courts.

THE USE OF COURTS FOR CARE PROCEEDINGS AND INTERVENTION IN THE COMMUNITY

In England courts have basically two types of case to hear: care proceedings and criminal proceedings. Under the age of 10 years a child cannot be found guilty of a crime (except homicide) and between 10 and 14 years should not be prosecuted for a crime. This means that all those under the age of 14 years should come before the courts for care proceedings only. An additional safeguard is that the 1969 act,¹⁸ replaced by the Children Act 1989,²³ sets out

criteria for taking out care proceedings. Under the terms of the Children Act 1989, a care order may no longer be imposed as a sentence in criminal proceedings. However the fact that a child had committed an offence may indicate that he or she is suffering, or likely to suffer, significant harm, so that the local authority may apply for a care order in respect of that child.

THE USE OF SUPERVISION ORDERS

These orders were originally introduced in the Children and Young Persons Act 1969¹⁸ as a means of dealing with offenders through an intermediate treatment programme (see below). They can now be linked to a number of disposals (Children Act²³ and Criminal Justice Act²⁴). Supervision orders may still be made criminal proceedings, the statutory responsibility lying with the local social services or, in the case of older juveniles, with the probation service. The primary consideration is to 'advise, assist and befriend', and not to protect the public, though the supervisor can return the young person to court if the terms of the order are breached.

SUPERVISION ORDERS WITH A SUPERVISED ACTIVITY REQUIREMENT

The supervised activity requirement can be made by magistrates and social services have to accept it. Placements are usually drawn from the intermediate treatment scheme.

Intermediate treatment has been adopted since the white paper *Children in Trouble* was published by the Home Office.²⁵ The aim is to fill the gap between simple supervision and removal from home. It is designed to allow the child to remain in his home, but bring him into contact with a different environment, interests, and experiences that may be beneficial to him and enable him to share them with other children who have not been before the courts. Although intermediate treatment is usually community based, it can be provided in a residential facility for up to 90 days. As Cawson points out, the end of the 1970s saw two major developments in practice: 'intensive intermediate treatment' to provide a real alternative to removal from home, and the introduction of new methods for working with groups.²⁶ Nevertheless there is still substantial disagreement within social work as to the desirability of programmes that are an alternative to custody programmes, and many intermediate treatment programmes are still focused on non-offenders, or even exclude serious delinquents.

CUSTODIAL SENTENCING

We have a history, in Britain, of locking up large numbers of young people. The numbers dealt with in this way escalated dramatically during the 1960s and 1970s,²⁷ and particularly so immediately after the introduction of the Criminal Justice Act 1982.²⁸ These trends were seen for girls as well as boys.

The situation during the 1980s has changed for the better however. As has already been noted there has been a large increase in the

numbers of young people diverted from the courts in Britain from 1979–89. The same trend has been mirrored by the numbers of young people receiving custodial sentences—that is, 7097 in 1979 and 2176 in 1988.²²

It is of interest to note that similar changes have occurred within the child care system, a great increase in the provision of secure accommodation having occurred in the 1970s, with a decline in its provision during the last decade.²⁹

Is treatment of delinquency possible?

CAUSES OF OFFENDING

Numerous studies have shown that delinquency tends to be much more frequent in adolescents coming from certain kinds of family and social backgrounds. The most important variables associated with juvenile delinquency are: large family size, poverty, parental criminality, marital conflict, poor parental supervision, cruel, passive or neglecting attitudes, and erratic or harsh discipline.^{4 30 31} Farrington has shown that the childhood predictors of conviction up to the age of 32 can be grouped into six major conceptual categories: socioeconomic deprivation, poor parental child rearing, family deviance, school problems, hyperactivity-impulsivity-attention deficit, and antisocial child behaviour. He suggests that the link between antisocial child behaviour⁵ and offending probably reflects an underlying construct of antisocial personality, and goes on to suggest that the other five constructs are possible causes of offending.

IMPLICATIONS FOR TREATMENT

The implications for planning treatment from these considerations are considerable. Whatever the theoretical starting point it is generally agreed that there is no single cause of delinquency; the factors initiating delinquency are probably not the same as those maintaining it. It is unclear how the various factors interact, and most of those identified tend to be inter-related anyway. As discussed by Rutter and Giller it is difficult to know which possible cause to treat, particularly bearing in mind the gap between identifying a damaging influence and knowing how to mitigate or eliminate it.³²

The work of Farrington suggests that potential offenders can be identified at an early age with a reasonable degree of accuracy and that, on the basis of current empirical evidence, the most helpful methods of reducing juvenile offending are through parental training and educational programmes.⁵ Other possible interventions include giving more economic resources to poor families, providing juveniles with socially approved opportunities for excitement and risk taking, deterring offending through an increased probability and level of penalty (although this also has dangers), increasing the physical security or surveillance of potential targets, and encouraging resistance to antisocial peer pressures.

Who to target?

THE INDIVIDUAL AND THE FAMILY

A medical model of delinquency has been in

vogue for many years. Within this model the major determinants of delinquent behaviour are regarded as being located within the individual, the maladjusted personality being the result of genetic inheritance or the product of early experiences and relationships, especially from within the family (see Bowlby³³). While such a model might suggest a psychotherapeutic approach to the treatment of delinquents it has been found to be of value with only a relatively small number of anxious, introverted young people who are aware of their personal problems and who want help for them. In the past 20 years there has been a considerable increase in the application of behavioural treatment programmes for antisocial and aggressive behaviour. Yule has reviewed the most important of these techniques.³⁴

The most extensive behavioural family intervention studies have been those undertaken by Patterson and his colleagues at the Oregon social learning centre.^{35–37} Both aggressive children and delinquents have been treated using a behaviourally orientated parent training programme. Parents are helped to use positive, non-coercive methods of control; to interact more positively as a family; to monitor their children's activities better and to deal more decisively with deviant behaviour; to negotiate behavioural contracts with their children; and to develop improved social problem solving skills. The findings have shown that both aggression and stealing can be markedly reduced by this approach, but that the benefits are much shorter lived with the latter group. While this approach offers great promise, the published studies so far have been flawed by methodological difficulties. Kazdin *et al* are researching further the possible benefits of parent management training and cognitive-behavioural problem solving skills.^{38 39}

An important development has been the establishment of residential group homes, closely integrated with the community and run on behavioural lines. The best example of this approach is provided by the achievement place studies.^{40–44} The model provides a community based, family style, group home treatment programme for six to eight youths aged 12–15 years who are in danger of being institutionalised. The programme is administered by a couple referred to as teaching parents, who have had a year's professional training. The goal of the programme is to establish through reinforcement, modelling, and instruction the skills needed in the social, self care, academic, and prevocational areas that the youths have not acquired. There appears to be a significant reduction in offending during treatment, but no advantages at one year follow up.⁴⁵

As Farrington states that if low intelligence and school problems are causes of offending, then any programme that leads to an increase in school success should lead to a decrease in offending.⁵ He quotes the Perry preschool project carried out in Michigan by Schweinhart and Weikart.⁴⁶ This 'Head Start' programme and a later follow up study of this group by Berrueta-Clement *et al*⁴⁷ suggest great promise but requires replication.

THE RESIDENTIAL ESTABLISHMENT

Delinquent children who repeatedly come to the attention of the authorities tend, in this country at least, to end up in some form of residential care and much Home Office research has been directed towards evaluating and comparing such institutions.

Cross institutional designs have been used to look at the large differences that exist between institutions in the behaviour shown by similar types of residents while they are in their care. The first Home Office cross institutional study was designed and carried out by Sinclair.^{48 49} The study was concerned to examine the probation hostel system, where it was found that the proportions of boys leaving the hostels prematurely as a result of absconding or further offending ranged from 14% to 78%. Sinclair found that certain qualities of the staff, in particular the wardens, were important. By using the Jesness staff attitudes questionnaires it was found that wardens with the lowest rate of premature leaving were those who ran a strictly disciplined hostel, but who also expressed warmth towards the boys and were in agreement with their wives about how the hostel should be run.⁵⁰ Those who were harsh, emotionally distant, lax, permissive, or who disagreed with their wives about hostel policy tended to have high drop-out rates from their hostels.

Many young people are placed in community homes with education on the premises (CH(E)s). (Before the 1969 Children and Young Persons Act¹⁸ these were known as approved schools.) Studies by Millham *et al*⁵¹ and Sinclair and Clarke⁵² have shown that successful schools are dependent on qualities of staff and combine a harmonious atmosphere, good staff-pupil relationships, kindness, consistency, firmness, with high expectations, a high level of activities, and vocational training. Dunlop's more detailed study of eight CH(E)s, catering for boys aged 13–15 on admission, showed that schools that appeared to lay emphasis on trade training and on mature and responsible behaviour had lower rates of both absconding and other forms of misbehaviour during admission as well as having marginally, though significantly, better reconviction rates.⁵³

In their comparison of 12 inner London secondary schools Rutter *et al* showed that delinquency rates were probably affected by school factors such as appropriately high expectations, good group management, effective feedback to the children with ample use of praise, the setting of good models of behaviour by teachers, pleasant working conditions, and giving pupils positions of trust and responsibility.⁵⁴

THE THERAPIST

Research into institutions and the use of specific techniques has led to an increasing awareness of the importance of therapist qualities. As early as 1967, Truax and Carkhuff's work with adults being treated with Rogerian counselling emphasised that effective counsellors were characterised by genuineness, empathy, and

non-possessive warmth.⁵⁵ Subsequent work has shown a great deal of inconsistency in the effects of these therapist variables (see Mitchell *et al*⁵⁶) and other studies have suggested that different qualities are important. Alexander *et al* examined therapist variables in relation to interventions with families of delinquents.⁵⁷ They found that 60% of the outcome variance in treated cases was accounted for by structuring and relationship skills (these latter being composed of several behaviourally defined categories including affection, warmth and humour). Kolvin *et al* found substantial differences between therapists in their effectiveness in treating children, but that the important qualities were extroversion, assertiveness, and openness.⁵⁸ Clearly, research indicates that therapist qualities are important, but further studies are required in order to establish which are the most important ones and whether or not they can be taught.

Is there a medical role in the treatment of delinquency?

ASSESSMENT OF DELINQUENTS

While delinquents have many features in common, it has often been observed that some patterns of delinquency overlap with aggression, emotional disturbance, poor peer relationships, hyperactivity, and attentional deficits. These problems may well require assessment and treatment in their own right, which can best be provided by a multidisciplinary team based in a child psychiatry department or child guidance clinic. These teams are usually headed by a medically qualified practitioner, but the medical role in the assessment and treatment of delinquency is probably a limited one.

Counselling and psychotherapy, based on the establishment of a personal relationship, have rarely proved successful except for a small minority of rather anxious, introverted young people who are aware of their personal problems and want help with them. Overt neurological disorder or severe psychiatric abnormality are met with only occasionally in adolescent offenders. Those with hyperactivity and attentional deficits may benefit from medication and those with emotional disturbance from individual or family psychotherapy. However, the numbers that can be helped in these ways are few. For the majority, treatment aims are probably best directed towards improving the educational, vocational, practical, and social skills of the individual and a problem oriented approach to assessment and treatment of young offenders promises to be the most effective. Such an approach has been described by Stumphauzer.¹⁷

REQUESTS FOR PSYCHIATRIC COURT REPORTS

Despite the fact that the medical role in the assessment and treatment of delinquency is limited, psychiatrists are often asked to prepare reports on young offenders for the court. There are a number of different issues on which they are asked to advise. The first, and most obvious, is to comment on the presence (or absence) of mental illness. Signs which might suggest these

are reports of self damage, extreme changes of mood, and recent changes in personality. A history of solvent or drug abuse may also give cause for concern. Aspects of the background history, in the absence of any obvious symptoms, such as a previous history of mental illness in the family, may also lead to the request for a psychiatric opinion. A psychiatrist may also be involved in the assessment and management of some developmental delays, physical conditions and illnesses, especially if there is an emotional component. The investigations for speech disorder, enuresis, and epilepsy provide examples: the hyperkinetic syndrome of childhood deserves special investigation and treatment. A request may be made for an adolescent to be seen alone, or with his family, and in this context it may be possible for a psychiatrist to express a view on the personality and emotional development of the young person, other members of the family, or on the functioning of the family as a whole.

Other indications for assessment are unusual or bizarre behaviour either reported in the past, possibly at the time of an offence, or even witnessed in court during a hearing. Inexplicable, repetitive offending, sexual deviancy and dangerous behaviour, such as fire setting and serious assault against another person may lead to a psychiatric referral.

As with adults, a specific request for assessment of dangerousness, fitness to plead, diminished responsibility, and treatability within the resources of the health service may be requested of psychiatrists. In addition they are often asked to advise on, or support recommendations for, placements within the child care system, and often have an important role in consulting to establishments within that system.

Summary

The medical role in the treatment of delinquency is a limited one. There is conflicting evidence as to whether treatment aims should be directed towards the individual, to the family, the institution, or the therapist. Nevertheless there seems to be a consensus of opinion that short term, focused therapies aimed at improving educational, vocational and social skills, possibly from a preschool age, are the most effective. Any treatment gains achieved while in residential care appear to be short lived. It therefore seems that this should be reserved for those individuals who commit repeated, violent crimes and for those from very damaging family backgrounds who repeatedly abscond or absent themselves from community based programmes.

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