Influence of Behaviour of Youth with Mental Health Challenges in a Secure Care Facility on Staff Members and Fellow Residents

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Abstract

When the youth, regardless of their mental status or age, face mental health challenges and engage in criminal activities, they are placed in child and youth care centres (CYCC) in a secure care programme across the country. Unfortunately, these secure care facilities lack proper systems to meet the needs and ensure the safety of mentally ill youth. There is evidence that the rate of mental health disorders is higher among youth in the juvenile justice system than in the general population, and these CYCCs are not adequately equipped to address the challenges presented by mentally ill youth. This article presents a greater understanding of the views and perceptions of staff members and fellow residents (peer counsellors) working with youth with mental health challenges in six provinces, namely: Eastern Cape, Gauteng, Limpopo, Northern Cape, North West, and Western Cape. In this qualitative study, a total of twelve participants were interviewed through semi-structured interviews. These participants, who make up the multidisciplinary team at the facilities, include social workers, psychologists, child and youth care workers, occupational therapists, nurses, educators, and instructors. The findings highlight a significant gap in knowledge about mental health challenges among youth, which can result in the mismanagement of those affected. This research offers valuable insights into the behaviours of these young individuals, enhancing our understanding of their experiences. Understanding their views and perceptions provides vital information to develop social work practices on these grounds. This study resulted in the development of guidelines for the behaviour management and care of youth living with mental health challenges. The findings and recommendations will be implemented in state-run CYCCs, as confirmed by the national Department of Social Development.

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Introduction

Youth crime is a global issue, with around 410,000 children detained annually (Sloth-Nielsen and Mutsavara 2020). In South Africa, the child justice system faces significant challenges in managing both sentenced and remand juveniles, as evidenced by 2019–2020 data showing 2,058 sentenced juveniles and 3,724 juveniles on remand (Judicial Inspectorate of Correctional Services 2021).

Despite social and economic progress in South Africa, factors such as unemployment, parental alcoholism, poverty, family breakdown, violence, and HIV/AIDS continue to drive youth crime (Bezuidenhout et al. 2008). Additionally, the democratic transformation has introduced new challenges, particularly for youth with mental health issues (Jacobs and George 2021). This issue is often overlooked, even in developed countries (Hovey et al. 2017).

The World Health Organization defines mental health as overall well-being and the ability to handle life's challenges (WHO 2014). Incarceration-related stress can exacerbate mental health issues, especially for youth with pre-existing conditions (Underwood and Washington 2016). In South African child and youth care centres (CYCC), there is a pressing need for specialised care for mentally ill youth (Bezuidenhout 2018). The secure care programme, which addresses youth in conflict with the law, often lacks adequate mental health resources, leading to misinterpretation of behaviours and inappropriate admissions (Office of Juvenile Justice and Delinquency Prevention 2017).

CYCC caregivers encounter various mental health symptoms, such as mood swings and aggression, which are best understood within the ecological systems perspective, considering the individual's family and community context (Minimum Standards of the Child and Youth Care System 1998). However, despite the recognised need for mental health support, practical strategies and policies are often inadequate (WHO 2013). The Children's Amendment Act No. 41 of 2007 defines CYCCs as residential care facilities, where mental health challenges among youth are reportedly increasing (Trustmaster System 2019).

This article explores the behavioural patterns of youth with mental health challenges in a secure care centre within CYCCs environment and their impact on staff and peers.

Problem Statement

The juvenile justice system struggles to refer youth with mental health issues to secure care programmes that require specialised care, as outlined in the Blueprint, which

emphasises the child's physical, social, and emotional safety (Blueprint 2010). Despite reforms to the child and youth care system since 1996 and the 1998 Interim Policy on Minimum Standards, the specific needs of mentally ill youth remained unaddressed (Blueprint 2010). Youth development centres were established to provide safer spaces for youth awaiting trial, but agreements between private CYCCs and provincial departments often lack provisions for managing mental health challenges (Blueprint 2010). Although the 2010 Blueprint acknowledges psychological issues in children, it fails to provide clear care guidelines for secure care centres, leaving the multidisciplinary team (MDT) and caregivers without proper intervention strategies.

This article examines the experiences of MDT and caregivers in managing young people with mental health issues, focusing on:

- What behavioural patterns do youth awaiting trial with mental health challenges display in a secure care centre within the CYCCs environment?
- What are the influences of these behavioural patterns on staff members and fellow residents?

The theoretical framework, research methodology, and participant responses will be discussed in the following sections.

Theoretical Framework

This paper is grounded in ecological systems theory, which examines how individual, microsystem, mesosystem, exosystem, and macrosystem factors shape the behavioural patterns of youth with mental health challenges in CYCCs. As highlighted by Analisah and Indartono (2019), this theory emphasises the complex relationship between individuals and their social environments. According to Beck et al. (2018), it is particularly significant in understanding circumstances that negatively impact youth. The theory addresses social issues arising from factors affecting youth functioning, well-being, and behaviour, making it a crucial framework for social work interventions (Leung et al. 2019, 2). Bronfenbrenner's (1989) ecological systems theory includes four interconnected systems: the microsystem, mesosystem, exosystem, and macrosystem (Ettekal and Mahoney 2017).

The bio-ecological theory provides a perspective on understanding the behavioural patterns of youth with mental health challenges and their effects on staff and peers This approach is based on the idea that individuals do not exist in isolation but continually influence each other through interactions and the environment (Oosthuizen-Erasmus and Adlem 2022, 312). When two or more microsystems, such as the family and school, connect and interact, they influence behaviour. In this framework, there is continuous interaction between the young person's family (microsystem), school (microsystem), and CYCC (exosystem). The relationship between parents and social workers is crucial for the youth's well-being and the development of their care plan. This article considers caregiver challenges in the context of youth behaviour patterns within a CYCC setting.

In this framework, there is continuous interaction between the young person's family (microsystem), school (microsystem), and CYCC (exosystem).

Methodology

This study employed a qualitative approach, utilising explorative, descriptive, and contextual research designs to address the research problem (Strydom 2021). The qualitative research approach aligned with the research questions, focusing on the experiences of staff and fellow residents in CYCCs (Hunter et al. 2019, 2), observed within their natural environment (Hamilton and Finley 2020, 3; McGrath et al. 2019, 1003).

This research was conducted in secure care programmes at CYCCs across six provinces in South Africa. As previously stated, secure care is a programme for youth in conflict with the law within the child and youth care system (Social Department 2010, 47). The target population comprised youth living with mental health challenges in these facilities. Cases were purposively selected using the purposive sampling method, choosing units based on their perceived utility and ability to provide comprehensive information about the phenomenon under investigation (Strydom 2021, 382). The focus centred on the management and care of youth with mental health challenges in CYCCs, emphasising the early identification of signs and symptoms of mental illness of detained youth.

A population is the entire group that you want to draw conclusions about (Strydom 2021). In the CYCC, participants, specifically MDT members and peer councillors, were selected based on their active involvement in the daily operations of the facility. They experienced the challenges presented by youth with mental health issues. The staff members are rendering services to the youth in the facility, and among them are young people with mental health challenges. Notably, the study was conducted in CYCCs managed by the employer, which could introduce a potential bias. To mitigate this, the author engaged in frequent debriefing sessions with a supervisor, and the paper underwent peer scrutiny (Nowell et al. 2017, 4).

Data Collection

Data collection for this study employed a comprehensive approach, incorporating face-to-face semi-structured interviews. The participants were strategically chosen for their ability to contribute valuable insights into the research question and meeting sample frame criteria and comprised MDT members and peer counsellors who had firsthand experience with challenges related to youth mental health issues. A total of twelve semi-structured interviews were conducted, allowing for open-ended exploration and the emergence of concepts and theories, fostering flexibility in addressing areas of interest (Bryman 2016, 12).

These semi-structured interviews were designed to gain a detailed understanding of the participants' beliefs, perceptions, and personal accounts of youth living with mental health challenges, guided by an interview guide. Various communication skills, such as listening, reflecting, probing, and clarifying, were applied to encourage active participant engagement (Last et al. 2022). This multifaceted data collection approach aimed to provide a comprehensive and nuanced exploration of the experiences and perspectives of those involved in the day-to-day operations of CYCCs.

Data Analysis

Data analysis began immediately after each semi-structured interview. Files were sorted, labelled, and stored in boxes marked by participants' identification. Interviews with MDT members and peer counsellors were transcribed verbatim.

Following transcription, an independent analysis was conducted to achieve data saturation (Creswell and Creswell 2018, 193–198; Saunders et al. 2018, 1893). The analysis followed Tesch's eight-step framework (cited in Creswell and Creswell 2018, 193–198), revealing themes that shaped the paper. Data were constantly compared across various dimensions, such as MDTs, peer counsellors, and urban vs. rural settings, to evaluate consistency and differences (De Vos et al. 2021, 399). Additionally, audio recordings were reviewed multiple times to identify overarching trends and patterns.

Data Verification

The data verification involved aligning the collected data with the research topic and ensuring reliability for consistent results across different populations. The four-part Guba (1994) model was used to assess the effectiveness of the qualitative inquiry and verify the data. The four constructs necessary for validity and reliability were applied as follows: *Credibility* was ensured by recognising participating staff and residents with shared CYCC experiences as experts (Bryman 2016); *transferability* was addressed by providing detailed context and noting limitations like participant number, data collection methods, session lengths, and timeframe (Adams and Blackman 2017); *dependability* was achieved by documenting the research plan, methods, and participant experiences, as per Bryman (2016) and Korstjens and Moser (2018); and *confirmability* was supported by showing that an independent researcher following the same procedures would obtain similar results (Korstjens and Moser 2018; Moon et al. 2016).

Ethical Clearance and Considerations

The Research Ethics Committee of the Department of Social Work at Unisa approved this research (Ethical Clearance Number: 2015_004). Ethics involve conducting research with integrity and honesty (Flemming 2018). This paper adhered to ethical considerations including informed consent, avoiding harm, debriefing, voluntary participation, confidentiality, anonymity, privacy, and competent management of information.

Biographical Profile of Participants

This section provides an overview of the twelve participants from CYCCs, detailing their gender, age distribution, educational levels, and years of experience. Qualified personnel, following a developmental approach, were assigned to provide child-centric services with a 60:40 male-to-female ratio across CYCC facilities.

Facilities like Mogale in Gauteng and Horizon in the Western Cape serve only male residents, while others are mixed, with females being a minority. Secure care centres generally house more male offenders due to cautious placement of girls by juvenile court judges.

Participants' ages ranged from 26 to 52, and their educational backgrounds included honours degrees, degrees, diplomas, and certificates. Experience varied from less than five years to over twenty years. All staff, including sessional and contractual workers, were trained in the fundamental requirements of secure care, with experience in CYCCs ranging from less than five years to 28 years.

Findings and Discussions

The data analysis, along with the consensus discussions between the independent coder, the author, and the supervisor, guided the development of themes and subthemes. These are elaborated on in the discussion section, focusing on the MDT and peer counsellors. The MDT and peer counsellors provided narrative accounts that reflect their personal experiences with youth facing mental health challenges.

The author detailed the findings from the data selection process, utilising specific codes to identify both secure care facilities and members of the MDT involved in the study. The secure care facilities are represented by the following codes: Burgersdorp (BG), Clanwilliam (CLAN), De Aar (DA), Mafikeng (MAF), Mavembe (MAV), Mogale (MOG), Polokwane (POL), and Rustenburg (RUS). Each facility is a designated secure care centre. In addition, the codes for MDT members and peer counsellors (PC) are included to denote their professional roles: child and youth care workers (CW), educators (ED), nurses (N), psychologists (PSY), occupational therapists (OT), and social workers (SW). This coding framework ensures clarity in the data analysis by distinguishing between different facilities and the roles of care providers involved in the secure care system.

Table 1: Theme descriptions of behavioural patterns

Theme	Subthemes
Participants' descriptions of behavioural patterns displayed by youth with mental health challenges (MDT) Peer counsellors' descriptions of incidents with youth with mental health challenges	A wide range of behavioural patterns: Aggression Depressive behaviours Learning challenges Sexual behaviours Isolated behaviour Triggered by substance abuse

In the following section, we will explore the themes and subthemes emerging from the data analysis, focusing on the behavioural patterns of youth with mental health challenges, as described by participants. These patterns, which range from aggression and depressive behaviours to learning challenges, sexual behaviours, and social isolation, will be substantiated with narratives from the study. They will also be compared with existing literature within the adopted theoretical framework, with a focus on how substance abuse triggers these patterns. Underwood and Washington (2016) highlight that while some symptoms may resemble typical adolescent behaviour, they become concerning when they significantly disrupt daily life. This section will also incorporate Bronfenbrenner's (1979) ecological systems theory, which posits that youth behaviour and well-being are shaped by their social environments, providing a comprehensive understanding of the various behavioural patterns observed in this population (Sheerin et al. 2023).

Aggression

Aggression is a prevalent and complex behaviour observed in youth with mental health challenges at CYCCs. This behaviour manifests in various forms, including physical confrontations and verbal outbursts, often triggered by minor events or interpersonal conflicts. Such aggression disrupts the CYCC environment and poses significant challenges to effective care. Youth displaying these aggressive tendencies often exhibit irritability, anger outbursts, physical altercations, property vandalism, and manipulative behaviours such as lying and swearing. The narratives from staff and peer counsellors provide insights into managing and understanding these behaviours, highlighting the impulsivity and unpredictability that characterise their interactions:

> Some of the behaviours that I've observed from young people with mental health challenges is the fact that their speech is forceful and unpredictable. They answer questions out of context, they get irritated fast, [are] temperamental and react angrily; have anger outburst; act provocative and start fights; are uncontrollable and impulsive

> even in minor/petty instances. They display aggressive, violent, and distractive behaviour, and they vandalise property. They do not want to listen to anyone, and after some time they realise that there was no logical explanation for what they did. (DA 111-114)

Another trait that is concerning is the following:

> They are very rebellious, lying, and very forgetful. By lying, I mean they can be very manipulative and are able to turn any situation to favour them through lies and manipulations. (DA 111-114 P1)

The following participants also agree with the previous statement and provide specific details about a particular individual where intervention was necessary:

> One youth is extremely aggressive and always involved in arguments and fighting, and I have to talk to him as a peer counsellor. (BG 56-57 P1)

This highlights the constant need for reporting by peer counsellors and for immediate intervention and conflict resolution by staff members. Another incident emphasises how minor actions can escalate aggression:

> One day I did the same throwing a tennis ball at one of the boys, and he then became very aggressive, and I apologized even though I was not wrong. … One boy wanted to play with me, and I was busy with something, and he became very angry and started fighting [with] me saying I am ignoring him. (DA 117-119 P3)

This example illustrates the unpredictability of aggressive responses and the delicate balance staff must maintain in their interactions. Furthermore, a participant recounts an instance of correction leading to aggression:

> One of the incidents is when I tried to correct him as he was doing something bad and he started accusing me of controlling him, and he wanted to fight me. … One last thing about young people with mental health challenges, hey! They can swear jealous down! When they start swearing, it's non-stop, and they can pronounce all the difficult swear words/vulgar language without any shame or decency to check the people around. (DA 120-122 P4)

Such episodes reflect the complex dynamics of managing aggression, where attempts at discipline or guidance can be misinterpreted and escalate into confrontations.

> I was once insulted very badly as we were playing board games, and I was trying to show him how he should play. He went ballistic and [was] very angry about it, so for peace's sake, I apologised, but after some time he became well again and played with me as if nothing happened. (POL 118-121 P4)

> When you do something small that irritates that child, he will explode and swear at my mother, for instance. (POL 111-112 P1).

> [It] reminds me they deny a lot [and] just five minutes after doing something they would deny and become forceful about it; not only that they don't show remorse, but young people with mental health challenges don't also know right from wrong, so correcting them is wasting time, and their emotions are not stable, they act out anyhow, and they are unpredictable. (BG ED 373-375), (DA SW 405-408) and (DA CW 424-429)

The participants have shared insights that have shown their knowledge of the problem in their environment. They have since resolved that it is a waste of time to correct these individuals, showing dejection, as they revolve around the same issues:

> Most of the young people with these challenges react badly to situations and tend to threaten other people. They are of the opinion that everyone is against them, and they feel a need to protect themselves in fear of others striking first; they provoke and start fights, and they are very difficult to calm down. (BG ED 373-375)

The above statement indicates an awareness and understanding of behaviours associated with mental health challenges.

The experiences shared by the participants aligns with the literature, particularly the work of Ramakulukusha et al. (2021, 571–581) and the Illinois Criminal Justice Information Authority Centre for Justice Research and Evaluation (2019, 1–12), which highlight that aggression, criminal behaviour, and violence among juveniles are complex behaviours influenced by multiple factors. However, it is crucial to note that not all juvenile offenders necessarily have brain trauma leading to antisocial behaviour.

Masinga (2016, 103) suggests that juveniles exhibiting these behavioural patterns may lack socioemotional skills, contributing to negative interactions. The MDTs' descriptions align with socially deviant, aggressive, rebellious, and violent tendencies in affected youth, emphasising their difficulty in calming down and a propensity to react violently to minor issues.

Depressive Behaviour Patterns

The MDT narratives shared their understanding of depressive behaviour patterns in the following section. The CYCCs echoed these sentiments, emphasising the diverse nature of depressive symptoms in youth with mental health challenges**.**

DA CW 440-446, BG SW 301-308, and MAF CW 338-340 expressed that young people with mental health challenges differ in their behaviour; some display depressive symptoms while others display disruptive behaviours. Even those that have the condition of major mental health challenges still do not react the same way—some are aloof and sad, and others express hallucinations and fluctuating moods:

> They display symptoms of schizophrenia and stress, isolating themselves and have suicidal tendencies, always worried and depressed, … the young person does not show any sign of violence; however, he/she does not show any sign of responsiveness as well, they have repetitive and incoherent speech. This implies that these young people might hear a caretaker when an instruction is given; however, they cannot respond to it, they simply ignore [it] without any shame. They are also untidy/unkept/hate bathing. They have difficulty in sleeping and [are] walking around.

The MDTs' understanding of the complexities of depressive behaviours are viewed and the participants give accounts of observed similarities and differences. CLAN N 395-403 mentioned that young people with mental health challenges also have difficulty sleeping, as highlighted in the following quote: "It is hard for them to sleep."

> Even when one is not sure of the challenge with the young person, in most cases sleeping difficulty is manifested earlier than the other symptoms; some of the young people would talk on their own, some would walk around the room. They hallucinate and see things that are not real. It's like they have imaginary episodes where they interact with their mind, and if there is anything fun that they grasp in their imaginary minds, then they just laugh regardless of who is laughing or looking. (BG SW 261–268)

The participants raise issues regarding the identification of certain behaviours. MOG ED 96-107 and CLAN PSY 291-294 also explained that when it comes to distressed youth, one can easily identify them as they isolate themselves, they have fluctuating moods (mania), and they tend to display antisocial behaviour, mostly sadness and depression, accompanied by feelings of guilt and rejection, which may lead to suicidal thoughts with the likelihood of hurting themselves.

The literature below reflects and supports the lived experiences of the MDTs; although the common presentation of depression does not necessarily suggest depression as a situational precursor to antisocial behaviour, depression and aggression share similar neurobiological substrates (Huesmann et al. 2019). Further, it should be noted that anxiety and depression are thought to have overlapping aetiologies, given the similarity in some of their manifest symptoms and frequent diagnostic comorbidity (Huesmann et al. 2019). Jolliffe et al. (2019, 42–49) suggest a connection between offending and outcomes such as depression and anxiety. Effective interventions to reduce offending could potentially alleviate depression and anxiety, yet specific interventions for depression remain crucial.

The shared experiences of youth with mental health challenges align with Patel's opinion (Ridley et al. 2020, 12). He identifies family conflicts, academic difficulties, and relationship problems as common triggers for depression. The engagement in risky behaviours such as smoking, alcohol consumption, and drug use, particularly cannabis, is noted as potential contributors to mental health challenges, emphasising the need for comprehensive interventions (Kugbey 2023).

Learning Challenges

This section outlines the challenges the youth face, supported by real-life examples and relevant literature. As noted by BG 239-244 and BG SW 261-268:

> Young people with MHC [mental health challenges] are restless, they do not participate in classroom activities and have difficulty in understanding the content of the discussions. They also have difficulty learning, articulating proper speech, and logical thinking, have difficulty understanding or grasping information, and tend to have unrealistic explanations for some of the things they do.

Despite high crime rates and overrepresentation in the criminal justice system in South Africa, literature on learning disabilities among young offenders is limited. Research shows that learning disabilities are more prevalent among young offenders compared to the general population. Studies indicate that those with mild learning disabilities are more likely to offend than those with severe disabilities or no disabilities. Additionally, young offenders with IQs below 70 tend to commit their first offense at a younger age. Recent research links language deficits to difficulties in social communication, nonverbal cognition, and a higher risk of self-harm and substance abuse among young offenders (Nkoana 2019).

The frustrations expressed by participants reflect the complex educational challenges faced by these youth. Hovey et al. (2017) support these observations, highlighting the multifaceted nature of educational, behavioural, and mental health challenges in correctional settings. Understanding the unique needs of youth with mental health issues and learning difficulties is crucial in order for educators and caregivers to support these individuals effectively.

Traits Associated with Sexual Behaviour

In this section, participants provided insights into behaviours associated with sexual activities among youth with mental health challenges. DA CW 405-408, SP 455-457, RUS SW 395-402, and MAV CW 94-98 observed that:

> Young people with mental health challenges are very sexually active. Most of them are so fond of the female staff if they are boys to the extent that they make inappropriate sexual comments. The language of these young people revolves around sexuality, as confirmed by most of the cases.

Exploring the behavioural patterns of youth with mental health challenges encompasses various aspects, including their engagement in riskier sexual behaviours. Studies have suggested a link between drug addiction, mental health disorders, and the propensity for offending, contributing to increased sexual risk behaviours among juvenile detainees compared to the general population (Yap et al. 2020). Problematic or non-normative childhood sexual behaviour is understood as behaviour that is not considered developmentally adequate, too frequent (e.g., to the exclusion of other activities or

leading to social isolation), considered unacceptable by society, which causes harm or other negative consequences to self or others, or which does not respond to parenting (Krause et al. 2022, 4047–4061).

Heyns (2015, 48) underscores that children residing in unstable and unpredictable environments often undergo rapid shifts in physiological arousal and experience varied emotions. The author notes that sexual dysfunctions manifest as disruptions in sexual desire and psycho-physiological changes within the sexual response cycle, leading to marked distress and interpersonal difficulties. Moreover, certain experiences can derail normal sexual development, culminating in deviant sexual behaviour (Heyns 2015, 48).

The insights from Heyns (2015, 48) align with the observations of MDT participants in the CYCCs. These participants highlighted similar behaviours among youth with mental health challenges, emphasising instances of heightened sexual activity and language revolving around sexuality.

Isolated Behaviour

Participants highlight isolated behaviours such as bedwetting and defecation among youth with mental health challenges. These behaviours often stem from a desire for attention and can manifest as irritability, bedwetting (enuresis), and, in some cases, defecation (encopresis). When attention is not given, these individuals may become agitated, feeling ignored or uncared for, as illustrated in the following account:

> They act in an irritable manner, and they bed wet, and some go to the extent of defecating themselves. They enjoy attention whilst they are engaging in the above irritating behaviour. If you don't give them the attention, they will get agitated because … they will think that you don't care for them, or you just ignore them. They will even say it that "you don't care about me anymore." (MAV CW 94-98)

Shaffer and Kipp (2010, 49) warn that although the discussion is about behavioural patterns of youth with mental health challenges, we should also consider the individual's biological characteristics that affect or influence how they interact with other people. Furthermore, Sadock et al. (2015, 1214–1216) confirm the MDTs' observations by stating that bedwetting is a significant emotional and societal difficulty for these children. This includes poor self-image, decreased self-esteem, social embarrassment, restriction, and intrafamilial conflict. Some of these children also suffer emotional abuse, which is a pattern of humiliating a child and can include name-calling and repeatedly threatening to cause harm to the child. Sadock et al. (2015, 1212–1216) add that defecating is diagnosed when faeces are passed into inappropriate places regularly, as observed by the MDTs, for various emotional reasons. Reports have suggested that, occasionally, it is attributable to an expression of anger or rage in a child whose parents have been punitive or hostile. When a child develops this inappropriate negative behaviour eliciting negative attention, it is difficult to break the cycle of continuous negative attention: it can happen during times of stress.

The accounts provided by the MDT participants highlight instances where individuals exhibit irritable behaviour, engage in bedwetting, and, in some cases, defecate themselves. The desire for attention is stressed as a driving factor behind these behaviours, with individuals becoming agitated when they perceive a lack of care or attention.

Triggered by Substance Abuse

Participants' views further affirm the connection between substance abuse and mental health challenges, as presented in the following report:

> It is so difficult to deal with young people who have substance-induced mental health challenges; they are the kind of young people we work with every day. Most of the young people we receive in our care come to us with mental health challenges not inherited but triggered by the substances they used in the past. This is seen by the fact that after some time, these young people will begin to behave normally without any sign of mental health challenges. (CLAN CW 226-232)

The participant noted that substance abuse influences behaviours linked to mental health challenges. MOG N 160-162 opined that "once you start taking drugs, that's a trigger; the drugs will trigger something that was there, but now at that time it was not so obvious, but because the mind is weak the person will have a mental illness because you are taking drugs."

The Child Crime Prevention & Safety Center (Kraut 2023) highlights that 80 per cent of minors in state juvenile justice systems exhibit some connection to drugs or alcohol when committing crimes. They may test positive for drugs, be arrested for substance-related offenses, admit to substance abuse or addiction problems, or have a combination of these characteristics. These substance-related behaviours often accompany factors such as low IQ, poor school performance, antisocial behaviour, physical violence, poor parenting skills, abusive parents, broken homes, poverty, and gang membership.

Surekha (2021, 26–28) agrees with these findings, reporting that substance abuse is widespread among youth involved with juvenile justice, with almost half of them suffering from substance abuse, often alongside co-occurring mental health disorders. Furthermore, Apollis (2016, 25) supports the MDTs' findings and outlines the consequences of drug addiction on adolescents, including impaired normal developmental experiences, loss of potential, tolerance to substances, interpersonal problems, and impaired decision-making ability. Additionally, in a report on the effects of drugs on the brain, Doran (2023) highlights the impact of drugs on neurotransmitters, influencing how nerve cells send, receive, and process information. Surekha (2019, 9; 16) contributes further insights into the interaction between mental health and substance-use disorders, affirming that alcohol and drug use can trigger the emergence of a mental health disorder in youth who are biologically/genetically predisposed to mental illness.

Limitations

The study was confined to secure CYCCs exclusively. This focus limited the breadth of the research, as it did not include the broader spectrum of CYCCs, which encompasses government-run places of safety, children's homes, and secure care facilities. Including these diverse types of CYCCs could have provided a more comprehensive understanding of the behavioural patterns and challenges faced by youth with mental health issues across different institutional settings.

Conclusions

The study highlights the complex behavioural issues faced by youth with mental health challenges in secure care centres, focusing on aggression, depressive behaviours, learning difficulties, sexual behaviours, isolated behaviours, and substance abuse. The research, limited to secure care centres, suggests a need for broader studies across various facilities to gain a more comprehensive understanding. Findings align with existing literature (e.g., Heyns 2015; Hovey et al. 2017; Jolliffe et al. 2019; Ramakulukusha et al. 2021) and underscore the link between mental health and substance use. Future research should address these limitations to improve interventions and support systems for this vulnerable population.

Recommendations

To address the challenges identified, the following recommendations are proposed to improve operational efficiency, staff support, and overall youth well-being in the facilities:

1. Standardise procedures: Implement consistent operational protocols and behaviour management guidelines to enhance efficiency and staff support.
2. Promote awareness: Develop peer awareness and suicide prevention programmes to educate youth on recognising and addressing suicidal tendencies.
3. Increase staff training: Provide training on effective behaviour management and mental health issues to better equip staff in handling challenging behaviours.
4. Establish specialised facilities: Set up padded rooms and mini-psychiatric units and collaborate with psychiatric hospitals for immediate interventions.
5. Improve education support: Advocate for additional teacher support, including remedial teachers, to address educational needs.
6. Create an information system: Develop a comprehensive system to track and analyse abnormal behaviours and identify patterns and triggers.
7. Focus on infrastructure: Invest in necessary infrastructure and resources to support both physical and psychological needs.

A holistic approach involving standardised procedures, awareness programmes, staff training, specialised facilities, educational support, and effective information

management is essential to addressing the multifaceted challenges of youth mental health.

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