MHYO

MENTAL HEALTH RESOURCES FOR YOUNG OFFENDERS

EUROPEAN COMPARATIVE ANALYSIS AND TRANSFER OF KNOWLEDGE

VOLUME II

MHYO MANUAL FOR IMPROVING PROFESSIONAL KNOWLEDGE, SKILLS AND DEVELOPING ADVOCACY PROGRAMME

INTERNATIONAL JUVENILE JUSTICE OBSERVATORY

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JLS/2008/CFP/DAP/2008-1

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© IJJO November 2011
Published by the International Juvenile Justice Observatory (IJJO),
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This publication has been produced with the financial support of the Daphne III programme of the European Commission. The contents of this publicationare the sole responsibility of the International Juvenile Justice Observatory and can in no way be taken to reflect the views of the European Commission.

MENTAL HEALTH RESOURCES FOR YOUNG OFFENDERS

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MHYO VOLUME II

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Preface

by Prof. Dr. Thomas Grisso
University of Massachusetts Medical School

There is growing evidence – from scientific research and juvenile justice professionals — that many young offenders in juvenile justice systems throughout the world have symptoms of mental disorders and serious drug use problems. Reliable research in several countries has found that one-half to two-thirds of youth entering pre-trial detention centres meet the criteria for one or more mental disorders. Indeed, this is a significant problem, even more so if these needs remain unidentified and unaddressed, with significant long-term effects on their life chances and physical and mental health and well-being. These young people are therefore among the most disadvantaged in society.

Many countries are now in the process of developing policies and standards that will establish obligations of the juvenile justice system for addressing youths' mental health needs when they are in the system's care. Careful consideration must be given to these obligations. Juvenile justice systems are not mental health systems, yet certain responsibilities should be accepted by juvenile justice programs. For example, there would seem to be a fundamental obligation to identify youths' mental health needs when they enter juvenile justice programs. Thus screening and assessment methods would seem to be a basic requirement. Standards also ought to consider whether treatment obligations should focus broadly on all youth who meet psychiatric diagnostic criteria, or whether scarce treatment resources should focus particularly on youth with the most severe forms of mental health and substance use problems.

Child psychiatry and child psychology have developed a significant array of psychological, pharmacological, and family or social interventions for responding to youths' mental health needs. But the question must be addressed with two primary considerations in mind. One is the importance of identifying whether a treatment is "evidence-based." Is there solid, research based evidence for its effectiveness? If not, using it may involve a waste of resources and a failure to do anything for youth that is of value. The second consideration pertains to the value of mental health treatments in the context of juvenile justice. Many treatment methods may or may not be possible to implement in secure (locked) juvenile facilities. Others may require medical and psychological specialists that the juvenile justice system cannot afford to

employ. We must have clinically effective methods, but they must also be feasible for implementation in juvenile justice settings.

It is unlikely that our juvenile justice systems will ever be able to meet all of the needs of all of the youth who enter their programs. Thus, the juvenile justice system must work in collaboration with, and have the cooperation of our communities' broader mental health agencies. Too often youth are identified as "belonging" to the juvenile justice system or to the community's mental health system, when their delinquency and their mental disorders require the services of both of these types of agencies working collaboratively.

As evidence mounts regarding the relatively high prevalence of mental health problems among youth offenders and the apparent inefficiency and lack of coordination/ cooperation between juvenile justice and health care systems to deal with them, juvenile justice systems are looking for guidance on how to respond. For this reason, Volume II of the MHYO report has been developed to provide juvenile justice systems – and other stakeholders concerned for that matter – with the necessary guidance on how to deal with this highly vulnerable group. Volume II includes two sections, namely: MHYO Training Tools Manual for improving professional knowledge and skills, and MHYO Advocacy Tools.

Acknowledgements

Cristina Goñi
Secretary General. International Juvenile Justice Observatory

The many European partners who have supported the DAPHNE III Program 'European comparative analysis and knowledge transfer on mental-health resources for young offenders', in various ways, include The European Commission, the external expert reviewers - Ms. Marianne Moore and Mr. Gary O'reilly-, stakeholders in the field, researchers, and the IJJO team.

Moreover, we have received great contributions from representatives of United Nations, EU institutions, national and regional local authorities, university experts and NGOs, which participated in the 9th and 10th November 2010 at the Fourth IJJO International Conference, in Rome (Italy) under the title 'Building Integrated Juvenile Justice systems: Approaches and methodologies regarding mental disorders and drug misuse' achieving a comprehensive understanding of the situation of young offenders with mental disorders.

We do appreciate and thank the special collaboration and contribution of the international experts with all their knowledge, expertise and vocation to improve the situation and treatment of young offenders with mental health issues.

Project overview: Objective and methods

by Cédric Foussard. Director

Agustina Ramos. MHYO Project Coordinator

International Juvenile Justice Observatory

The European Comparative Analysis and Transfer of Knowledge on Mental Health Resources for Young Offenders, hereafter referred to as MHYO project, is an innovative project which has been developed in cooperation with eight different European countries throughout the last 2 years. The Project aimed to share knowledge and expertise concerning young offenders with mental health (MH) issues, meaning children and youngsters, who are at the same time offenders and victims of their own mental health. The MHYO project paid special attention to young offenders with mental health issues who are in contact, on the one hand, with the judicial system which considers them only as an offender, and on the other hand, the health system which recognises the same child as a victim of a mental disorder.

European Union Member States have to face similar problems in terms of developing an effective way to enhance the collaboration of health, social, and justice institutions dealing with children in conflict with the law. In this context, the MHYO Project's aim was to study the different national mechanisms to promote the necessary changes both in policy and practice, as well as to agree on minimum standards concerning the functioning of institutions dealing with young offenders, including judicial services, across the EU. As a result of this research, the lack of specific mental health programmes within juvenile justice systems in the different countries has become evident. In this context, it has been a priority of the MHYO Project to focus on the identification of practices which have improved the MH services for young offenders, as well as, fostering the cooperation between different entities in charge.

Young offenders with mental health issues: a common European problem to be addressed.

Throughout the last decade, a lack of adequate treatment as well as accurate strategies and policies to deal with young offenders with mental health issues has been identified across Europe. According to several national studies (see bibliography), children and

young people in detention are struggling with a high risk of mental pathologies or disorders, a situation that has not been sufficiently taken into account. These young people are at risk of even a greater prevalence of poor mental health than adults, facing at least one mental health problem. Moreover, they often lack proper assistance which leads them to mental breakdown or finding suicide the best solution for their current situation.

In conclusion, the most crucial task for the EU as well as national entities is the recognition of the needs of young offenders with mental health problems, illnesses or disorders, when designing the policies and strategies in the fields of justice, health or children's rights.

European as well as national entities dealing with young offenders with mental health issues need to address the set of identified issues including: the essential need for early screening and assessing of mental health problems, illnesses or disorders among children and young people which might prevent them from entering the justice system; appropriate placement within facilities suitable for the effective treatment of their mental health issues; improvement of training standards of personnel who work with young offenders with mental health issues; application of multi-disciplinary and multi-agency approaches enhancing the communication and collaboration, aimed at safeguarding the wellbeing of children and young people with mental health issues, illnesses and disorders.

As a result, a prevailing objective for European countries, instead of institutionalising mental health illnesses through prisons, juvenile justice or health, should be facilitating the provision of individual, adapted to particular needs of children and young offenders with mental health issues - resources, through for example creation of specific units or community therapy.

An effective liaison between judicial and mental health professionals would develop a multidisciplinary common framework of intervention to prevent recidivism.

The Project´s global strategy focused on the analysis of the national health and judicial systems for young offenders with mental health disorders aged between 10 and 21 years old. The basis of the present study is the research findings on the comparative analysis of the national legal frameworks, as well as European good practices. The research has identified the current treatment strategies for young offenders with mental health issues in order to promote practical tools and adequate policies that involve children's mental health and the juvenile justice systems.

Within the Framework of the MHYO European research project representatives of

UN, EU institutions, national and regional authorities, university experts and NGOs, gathered on the 9th and 10th November 2010 in Rome (Italy) to participate in the Fourth IJJO International Conference, entitled: ´Building Integrated Juvenile Justice systems: Approaches and methodologies regarding mental disorders and drug misuse'.

The main objective of the above mentioned conference was to investigate how the needs of young people with mental health problems can be managed in the juvenile justice system through a coordinated, integrated multi-agency response, identifying the support required for such an approach and for achieving successful cooperation. To achieve this goal the Conference programme was divided into two main themes.

First, it concentrated on mental health disorders and drug misuse amongst minors in conflict with the law. It included conducting the study on the situation of young offenders with mental disorders or disorders related to drug misuse, in order to identify appropriate interventions on the basis of the young offender's profile in the psychosocial context. The analysis also highlighted that the establishment of accurate definitions on integrative interventions for young offenders with mental disorders and with addictive behaviour were of great importance.

The second theme concentrated on the juvenile justice and health systems necessary to enhance their multidisciplinary and integrative collaboration. In this field the conference called for: more effective and coordinated communication between sectors, development of common intervention tools, and promotion and establishment of common links between the different systems.

Altogether, more than 350 representatives from 50 countries coming from Europe, America, Africa, Asia Pacific also debated juvenile justice issues more broadly, including: the study of the situation of minor offenders suffering from mental health disorders or drug misuse; the juvenile justice systems´ responses to the offences committed by minors or young people that suffer from mental disorders; the profile of the minor offender and the analysis of resources employed towards his/her social integration and the ethical aspects of the treatment of health disorders.

The conference emphasised the need to achieve a comprehensive understanding of the situation of young offenders with mental disorders referring to their individual social, familiar and personal circumstances, improving an integrative and multidisciplinary coordination and collaboration between all the stakeholders and agencies involved in the field. The IJJO's main focus for 2010-2012 is to take forward the concrete recommendations of the Scientific Committee of the Fourth International Conference, on the promotion in the international and European agenda of an improvement of health resources for young offenders on prevention and intervention policies, to provide

an effective response for minors.

To conclude, the current project delivered strongly against its expected results. The Observatory is pleased to present two volumes of MHYO Publications which document these results - firstly Volume I 'Mental Health Resources and Young Offenders: State of art, challenges and good practices', and secondly Volume II 'MHYO Manual for improving professional knowledge, skills, and developing advocacy programmes. The first section of this Manual sets out MHYO training tools for improving professional knowledge and skills, and the second section includes recommendations and an advocacy programme.

Volume I ('Mental Health Resources and Young Offenders') contains an analysis of the current status of mental health of young people in conflict with the law, conducted in different European countries such as: Belgium, France, Italy, the Netherlands, Poland, Portugal, Spain and the UK. Each national report gave an insight into the problems of serious mental health issues that young people, involved in criminal behaviour, struggle with. Each country described its legal framework for juvenile offenders and principles of the access to appropriate services. Therefore, the main emphasis in Volume I, has been put on the mentally ill juvenile offender's profile, the specific legal framework concerning penal and child care and the role of professionals and development of their skills. In addition, Volume I also explores the effectiveness of applied intervention approaches in European countries as well as recommendations and concrete proposals for good practices. It also includes the contributions of Brazil and the continent of Africa which allow us to gain an understanding and comparative insight about the situation of children in conflict in the law with mental health issues.

The International Juvenile Justice Observatory's Mental Health and Young offenders Manual Volume II is aimed at improving professional knowledge and skills. This is a global manual for all of the stakeholders in contact with young offenders with mental health problems. Thus, the international partners of the MHYO project have contributed their knowledge and expertise in the preparation of this second Volume. The first section, the **MHYO Training Tools for improving professional knowledge and skills** has been designed to guide the reader through the pathway of young offenders with mental issues through the criminal justice system. Each point of contact of the young people with health and justice agencies or professionals is described to allow the reader to consider the different difficulties and problems a young person can face. Each chapter can be read in chronological order or separately. The second section is a toolkit for advocacy, **MHYO Advocacy Tools**. It aims to help national stakeholders and experts to develop an advocacy and evaluation program to improve the provision for young offenders with mental health problems, illness and disorders.Therefore, three tools have been developed to allow the development of national advocacy programmes

thanks to, firstly the MHYO Recommendations (as a result of the 4th IJJO International Conference together with its Scientific Committee and the MHYO project partners) in order to bring this problem to the national agenda, then, secondly, an evaluation toolkit to evaluate national specific programs and resources for MHYO target group, and finally a 'Charter for the rights of children deprived of liberty with mental health issues' in order to foster the cooperation between professionals and to set up standards at national level.

The IJJO would like to thank the MHYO partners, external experts' reviewers, the Fourth IJJO Scientific Committee, the European Commission and the intercontinental contributors, without all of whom the development of this ambitious, challenging and important project, would not have been possible.

Special gratitude is extended to all those who have been surveyed or who have responded to the questionnaire. These responses were the basis for drafting each national report and outline of good practices.

Finally, the IJJO would like to express its gratitude for the support and contribution of the African and Brazilian perspective that broadened our knowledge, enhanced our understanding, and allowed us to place relevant results of European study on children and young offenders with mental health issues, in the global context.

Introduction

by Marianne Moore
Freelance Consultant and Director Justice Studio Ltd

The International Juvenile Justice Observatory's Mental Health and Young offenders Manual Volume II is aimed at improving professional knowledge and skills. This is a global manual for all of the stakeholders in contact with young offenders with mental health problems.

People in the criminal justice system are three times more likely to suffer from a mental health problem compared to the general population.[1] This is particularly true for young people. For example in 2005, Harrington and Bailey interviewed 300 people in the juvenile justice system in the UK and found that:

> *'a third of young people had mental health needs, a fifth with depression, a tenth reporting self-harm in the past month and a tenth suffering anxiety and post-traumatic stress symptoms. Hyperactivity was reported in 7 per cent of the young people and psychotic like symptoms in 5 per cent. Almost a quarter had learning difficulties and a further third had borderline learning difficulties'.*[2]

In turn, reports of the American Academy of Child and Adolescent Psychiatry indicate that 40% to 70% of young people in the juvenile justice system have some kind of mental disorder compared to 20% of young people in the general community.[3]

Indeed, Volume One ('Mental Health Resources and Young Offenders') gave many examples of serious mental health issues that young people, involved in criminal behaviour, struggle with in countries such as: France, Italy, the Netherlands, Poland, Portugal, Spain and the UK. It is clear that young people in the youth justice system have high levels of mental and physical health needs and vulnerabilities. Indeed, it is a significant problem that 'For many, these needs remain unidentified and unaddressed, with significant long-term effects on their life chances and physical and mental

1 Hagell 2002 quoted in Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

2 Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

3 Arroyo W., Buzogany W., & Hansen G. (2001) ***Task Force on Juvenile Justice Reforms: Recommendations for Juvenile Justice Reform.*** Washington, DC: American Academy of Child and Adolescent Psychiatry (AACAP).

health and well-being. These young people are among the most disadvantaged in society'.[4]

Link between offending and mental health

The link between young people with mental health problems and offending is not clear cut. However it can be broadly stated that there a different ways that the two might be formed in relation to each other:

- **Where offending is directly related to or driven by aspects of mental disorder.** In this case, effective treatment of the mental disorder would be likely to reduce the risk of further anti-social behaviour.
- **Where offending is indirectly related to mental disorder.** Treatment would be likely to make a contribution to a reduction in offending but would not be sufficient in itself to tackle offending behaviour.
- **Where offending and the mental disorder are related by some common antecedent, for example childhood abuse.** Treatment of the mental disorder in itself would not be sufficient to tackle re-offending.
- **Where offending and the mental disorder are coincidental.**
- **Where the mental behavior is at least partly secondary to the offending behaviour.**

Forensic Faculty, Royal College of Psychiatrists, 6 March 2008 quoted in Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

4 Lorraine Khan and Jane Wilson, (2010)You just get on and do it: healthcare provision in Youth Offending Team.s Centre for Mental Health.

Part I
MHYO Training Tools Manual for improving professional knowledge and skills

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INTRODUCTION

The International Juvenile Justice Observatory's Mental Health and Young offenders Manual Volume II, Section I is aimed at improving professional knowledge and skills. It has been designed for all those who work with young offenders or with young people who suffer from mental health problems issues or disorders. It provides the reader with clear and concise information on mental health issues in the context of the youth criminal justice system.

This training manual has been designed to take the reader through the pathway of a young person as they move through the criminal justice system. Each point of contact with certain agencies and professionals is broken down and the reader is shown the important points to consider at each time.

How to use the training tools manual

Volume II, Section I can be used as a reference booklet or as a training tool to expand the knowledge of the professionals that work with young offenders. Each chapter contains:

- Information on what to do at critical points in the young offenders' journey and how certain issues may be addressed
- Definition boxes on key issues
- Best practice examples from across the world

- What the young person's needs are at each stage of the process
- Reminders of what you can do for a young person at each stage
- Questions and exercises for discussion or self reflection

Definitions of mental health problems, illnesses and disorders

The definitions of mental health problems, illnesses and disorders are not universal among the health sector, and are even less so in other sectors. Different services have their own conceptual framework for understanding mental health problems. Indeed, they may talk in different ways about the same child. For example, a youth probation officer may talk about a child's antisocial behaviour, a teacher about their poor concentration and aggressive behaviour and a social worker about their neediness and anxiety.[5] We must remember, therefore, that different agencies will see different aspects of a child. None of them are wrong – however none give the full picture. The most effective way of working with a young person requires all agencies to work together and offer thier different viewpoints.

MULTI-DISCIPLINARY WORKING

Working effectively with other agencies is crucial in the detection and treatment of mental health problems. The Mental Health Foundation found that there were certain barriers to effective working across agencies:

- The fragmentation of services, within and between agencies
- The lack of priority accorded to children's mental health services in health
- Different approaches and lines of accountability across disciplines
- Different conceptual frameworks and language
- Issues of status, salary and training

In order to mitigate these issues, it is recommended that agencies move towards:

- Multidisciplinary training
- Multiagency screening and assessment tools
- Clear, demarcated lines of responsibility
- Clear working definitions for multiagency use
- Multi-agency working at strategy and delivery

5 Walker 2003 in Stephenson et al (2011) Effective Practice in Youth Justice: Second edition. Routledge. New York

In this manual we talk of mental health problems, illnesses and disorders. Broad definitions for these three concepts, taken from Effective Practice in Youth Justice are below:

- Mental health problem: A range of emotional or behavioural difficulties that may cause concern to parents and carers and / or distress to the young person. These difficulties may be short or long term. Although they affect a young person's day to day life, they may not be diagnosable as a mental disorder.
- Mental disorder: those problems which meet the requirements of ICD-10 International statistical Classification of Disease and Related Health Problems 10thRevision6. These problems are associated with considerable distress and substantial interference in a young person's everyday life. It tends to be more severe and persistent than a 'problem'.
- Mental illness: Used in the mental health sector to refer to the most severe types of disorder.[7]

Mental health problems

Mental health problems are common and can affect the way people think, feel or behave.[8] They can take many shapes and forms, affecting different people in different ways.[9]

They tend to be classified into various categories, or diagnoses. Diagnosing a mental health problem allows the doctor to know what action to take and for the patient to have a clear idea of what is wrong with them. However, the process of diagnosis is subjective and different doctors are liable to come to different conclusions regarding a person's mental health[10]. In turn, if a diagnosis becomes a label, it can be very damaging, especially for a young person who is also an offender. Along with offending, it can become a difficult part of their personal identity.

It must be remembered therefore that it is possible to recover completely from mental health problems and many do.[11] It is almost impossible to tell what the result will be for each young person. As such, it is important never to tell a young person that

6 World Health Organisation (1994) ICD-10 International statistical Classification of Disease and Related Health Problems 10th Revision

7 Stephenson et al (2011) Effective Practice in Youth Justice: Second edition. Routledge. New York

8 Mind (2007) Understanding mental illness

9 Mind (2007) Understanding mental illness

10 Mind (2007) Understanding mental illness

11 Mind (2007) Understanding mental illness

they won't recover as such statements can become self-fulfilling because they add to existing feelings of hopelessness.[12] The following definitions, taken from the document Understanding Mental Illness by Mind, give a simple definition of commonly diagnosed forms of mental health problems:

Depression

Depression lowers a person's mood, and can make them feel hopeless, worthless, unmotivated and exhausted. It can affect sleep, appetite and self-esteem, and interfere with daily activities. It may even affect their physical health. This may set off a vicious cycle, because the worse they feel, the more depressed they are likely to get. Depression often goes hand in hand with anxiety.[13]

Anxiety

Anxiety can mean constant and unrealistic worry about any aspect of daily life. It may cause restlessness, sleeping problems and possibly physical symptoms; for example, an increased heartbeat, stomach upset, muscle tension or feeling shaky. Someone who is highly anxious may also develop related problems, such as panic attacks, a phobia or obsessive compulsive disorder.[14]

Panic attacks

These are sudden, unexpected bouts of intense terror. A person experiencing an attack may find it hard to breathe, and feel their heart beating hard. They may have a choking sensation and a pain in the chest, begin to tremble or feel faint. It's easy to mistake these for the signs of a heart attack or another serious problem. Panic attacks can occur at any time, and this is what distinguishes them from a natural response to real danger.[15]

Phobias

A phobia is an unreasonable fear of a particular situation or object. It may cause major disruption to life because it imposes such restrictions on the way people live. Agoraphobia can cause such paralysing fear that a person may remain isolated in their own home, afraid to go out. Other common phobias include fear of animals, heights, flying and enclosed spaces.[16]

Obsessive-compulsive disorder

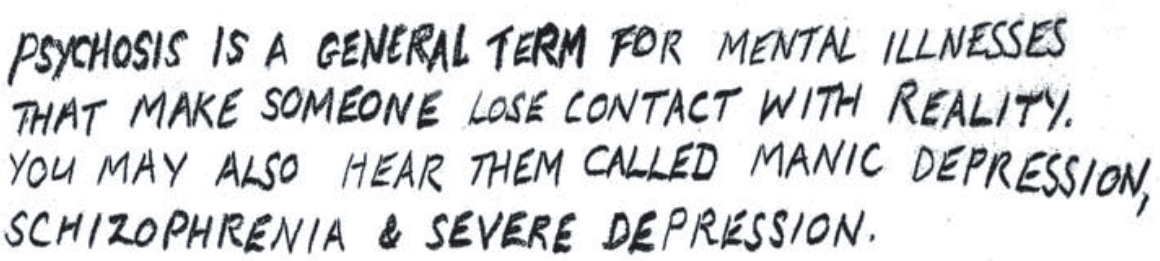
Someone with an obsessive-compulsive disorder feels they have no control over certain thoughts or ideas that are highly disturbing to them, but which seem to force

12 Mind (2007) Understanding mental illness
13 Mind (2007) Understanding mental illness
14 Mind (2007) Understanding mental illness
15 Mind (2007) Understanding mental illness
16 Mind (2007) Understanding mental illness

themselves into consciousness. These thoughts, or obsessions, create unbearable anxiety, which can only be relieved by performing a particular ritual to neutralise them. This could be something like repeatedly opening and closing a door, washing hands, or counting.[17]

Mental illness

Young people are particularly prone to suffering from a mental illness called Psychosis[18]:



Bipolar disorder (manic depression)

Bipolar disorder is a mood disorder. During 'manic' episodes, people tend to be hyperactive, uninhibited, reckless, full of grandiose schemes and scattered ideas. At other times, they may go through long periods of being very depressed. Not everyone experiences both these extremes.[19]

Schizophrenia

Schizophrenia is one of the most debilitating of all mental illnesses and can severely interfere with someone's ability to perform everyday tasks and activities. Symptoms may include hearing voices and seeing things that other people can't. Someone with these problems may become confused and withdrawn.[20]

Personality disorders

Ones 'personality' is their pattern of thoughts, feelings and behaviour. We do not always think, feel and behave in exactly the same way, as it depends on the situation we are in, who we are with and other factors. However, the majority of people tend to behave in fairly predictable ways. They may be 'shy' or 'outgoing' for example.[21] Personalities can mature as we go through different experiences in life. However, if

17 Mind (2007) Understanding mental illness
18 Emily Wilcox (2007) My name is Pete. Mind
19 Mind (2007) Understanding mental illness
20 Mind (2007) Understanding mental illness
21 Mind (2007) Understanding personality disorder

you have a personality disorder, your patterns of thinking, feeling and behaving are more difficult to change and you will have a more limited range of emotions, attitudes and behaviours with which to cope with everyday life.[22]

There is a severe reluctance by health professionals to diagnose children and young people as having a personality disorder. Under current diagnostic systems, anti-social personality disorder, for example, is not formally diagnosed before the age of 18. However, the features of the disorder are recognised as conduct disorder.[23] Indeed, personality disorders usually become noticeable in adolescence or early adulthood, and can start in earlier childhood.[24] It can be scary, isolating and lonely to have a personality disorder.[25]

Personality disorder can show itself in different ways, however, the diagnosis only applies if the personality difficulties affect all aspects of ones life, all the time. It does not include personality changes caused by a life event such as a traumatic incident, or physical injury.[26]The 10 different types of personality disorder can be grouped into three categories[27]:

Suspicious	Emotional and impulsive	Anxious
paranoid	borderline	avoidant
schizoid	histrionic	dependent
schizotypal	narcissistic	obsessive compulsive
antisocial		

22 Mind (2007) Understanding personality disorder

23 National Institute for health and Clinical Excellence (2009) Anti-social personality disorder: Treatment, management and prevention. NICE clinical guideline 77

24 Mind (2007) Understanding personality disorder

25 Mind (2007) Understanding personality disorder

26 Mind (2007) Understanding personality disorder

27 Mind (2007) Understanding personality disorder

Avoidant and dependent personality disorder are very similar, as are schizoid and schizotypal, and histrionic and narcissistic personality disorders. In turn, one person may meet the criteria for several different disorders, while a wide range of people may fit different criteria for the same disorder, despite having very different personalities.[28]The definitions below, taken from Understanding Personality Disorder by Mind, give an overview of the different types of personality disorder:

Suspicious: Paranoid personality disorder

You are likely to feel very wary of others, imagining they have hidden motives, will use you, or take advantage of you, if you don't stay vigilant. As a result, you will find it very difficult to trust other people. You will be suspicious and always on your guard, even with your friends, and you may feel that it's not safe to confide in them. You may watch others closely, looking for signs of betrayal or hostility and you will read threats and menace – which others don't see – into everyday situations. Others may complain that you are far too mistrustful.[29]

Suspicious: Schizoid personality disorder

Having a schizoid personality disorder means that you aren't really interested in forming close relationships with other people. You feel that relationships interfere with your freedom and tend to cause problems. You prefer to be solitary and inward looking, and choose to live your life without interference from others. Other people will see you as a loner. Few things in life give you pleasure, and you may have little interest in sex or intimacy.[30]

Suspicious: Schizotypal personality disorder

Making close relationships will be extremely difficult for you. People may describe you as eccentric, and you will find that you think differently to others. You might believe that you can read minds or that you have special powers and you may feel anxious and tense with others who do not share these beliefs.[31]

Suspicious: Antisocial personality disorder (ASPD)

This is closely linked with criminal behaviour, heavy drinking or drug-using. You are very easily bored and you may find it difficult to hold down a job for long or stay in a long-term relationship. You will tend to act impulsively and recklessly, often without considering the consequences for yourself or for other people. You may do things – even though they may hurt people – to get what you want, putting your needs above theirs. You believe that only the strongest survive and that you must do whatever it takes to lead a successful life, because if you don't grab opportunities, others will. You

28 Mind (2007) Understanding personality disorder
29 Mind (2007) Understanding personality disorder
30 Mind (2007) Understanding personality disorder
31 Mind (2007) Understanding personality disorder

may be regarded as being selfish and hard. You will have had a diagnosis of conduct disorder before the age of 15. This diagnosis includes 'psychopathy'. This term is no longer used in the Mental Health Act, but a 'psychopathy checklist' questionnaire may be used in your assessment.[32]

Emotional and Impulsive: Borderline personality disorder (BPD)

BPD may cause a number of problems in different areas of your life. You may feel that you don't have a strong sense of who you really are, and others may describe you as very changeable. You will suffer from mood swings, switching from one intense emotion to another very quickly, often with angry outbursts, and you may have brief psychotic episodes when you hear voices or see things that others can't. You may end up doing things on impulse, which you later regret. You may have episodes of harming yourself, and think about taking your own life. You will probably also have a history of stormy or broken relationships, and you will have a tendency to cling on to very damaging relationships, because you are terrified of being alone.[33]

Emotional and impulsive: Histrionic personality disorder

Being ignored is probably very uncomfortable for you, and you feel much more at ease as the 'life and soul of the party'. But you may also feel that you have to entertain people and that you are dependent on their approval. You may flirt or behave provocatively to ensure that you remain the centre of attention, or find that other people influence you too easily. You may earn a reputation for being dramatic and overemotional. Because you love excitement and don't tolerate boredom, you may behave recklessly or impulsively at times.[34]

Emotional and impulsive: Narcissistic personality disorder

You may believe that there are special reasons that make you different, better or more deserving than others, but because your self-esteem is rather fragile, you rely on others to recognise your worth and your needs. However, other people often ignore your special needs and don't give you what you feel you deserve, so that you then feel upset, and resent other people's successes. Because of this, you put your own needs above other people's, and demand they do too. People are likely to see you as selfish and 'above yourself'.[35]

Anxious: Avoidant personality disorder

Feeling inadequate or inferior to other people, and avoiding work or other social activities, is one sign of avoidant personality disorder. You expect disapproval and criticism, and you worry constantly about being 'found out' and rejected. You may be

32 Mind (2007) Understanding personality disorder
33 Mind (2007) Understanding personality disorder
34 Mind (2007) Understanding personality disorder
35 Mind (2007) Understanding personality disorder

particularly worried about being ridiculed or shamed by others, so you avoid social relationships, friendships and intimacy. However, you feel lonely and isolated, and long to have the very relationships you avoid. It's hard for others to understand the extent of your worries and not to believe you're exaggerating your fear of ordinary social situations. They will see you as a loner.[36]

Anxious: Dependent personality disorder

You are likely to feel needy, weak and unable to make decisions or function properly without help or support. You allow others to assume responsibility for many areas of your life, finding it hard to say when you disagree with them because you fear losing their support. You could find yourself agreeing to things you feel are wrong, and put up with other people's unreasonable behaviour to avoid being alone. Your self-confidence will be low, and you see other people as being much more capable than you are. Others may describe you as much too submissive and passive.[37]

Obsessive-compulsive personality disorder (OCPD)

If you are very concerned to keep everything in order and under control this can be a sign of OCPD. You are likely to set unrealistically high standards for yourself and others, and you generally think yours is the best way of making things happen, so you end up feeling responsible for everything. You worry when you or others make mistakes, and expect catastrophes if things aren't perfect. OCPD is separate from obsessive compulsive disorder (OCD), which describes a form of behaviour rather than a type of personality.[38]

Dissociative disorders

In addition to personality disorders, there are the lesser known dissociative disorders. These disorders are related to a person's sense of identity, reality and continuity. If your feelings, thoughts, sensations, perceptions and memories become 'disconnected' from each other, or don't register in your conscious mind, it changes your sense of who you are and the way you see things around you. This is what happens during dissociation.[39]

Dissociative disorders occur when people have persistent and repeated episodes of dissociation. These usually cause distressing internal chaos, and may interfere with work, school, social, or home life. However, some people apparently function well which hides their distress. The five dissociative disorders can be arranged, in order of complexity, along a 'dissociative disorder continuum'. A person's position on the continuum will

36 Mind (2007) Understanding personality disorder
37 Mind (2007) Understanding personality disorder
38 Mind (2007) Understanding personality disorder
39 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

depend on the severity and mix of the types of dissociation they experience.[40] The following definitions as laid out on the dissociation continuum have been taken from Understanding Dissociative Disorder by Mind:

Depersonalisation disorder

This features strong feelings of detachment from a person's own body, or that their body is unreal. A person may also experience mild to moderate derealisation and mild identity confusion.[41]

Dissociative amnesia

An inability to remember significant personal information or particular periods of time, which can't be explained by ordinary forgetfulness. People may also experience mild to moderate depersonalisation, derealisation and identity confusion.[42]

Dissociative fugue

A person travels to a new location during a temporary loss of identity. He or she may assume a different identity and a new life. There is severe amnesia, with moderate to severe identity confusion and often identity alteration.[43]

Dissociative disorder not otherwise specified (DDNOS)

Each of the five types of dissociative response may occur, but the pattern of mix and severity does not fit any of the other dissociative disorders.[44]

Dissociative identity disorder (DID)

The most complex dissociative disorder. It's also known as multiple personality disorder (MPD) according to the ICD-10. This has given rise to the idea that this is a personality disorder, although it is not. Its defining feature is severe identity alteration. Someone with DID experiences these shifts of identity as separate personalities. Each identity may assume control of behaviour and thoughts at different times. Each has a distinctive pattern of thinking and relating to the world. Severe amnesia means that one identity may have no awareness of what happens when another identity is in control. The amnesia can be one-way or two-way. Identity confusion is usually moderate to severe. It also includes severe depersonalisation and derealisation.[45]

People may have other problems too such as depression, mood swings, anxiety and panic attacks, suicidal tendencies, self-harm, headaches, hearing voices, sleep disorders, phobias, alcohol and drug abuse, eating disorders, obsessive-compulsive behaviour and various physical health problems. These may be directly connected

40 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind
41 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind
42 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind
43 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind
44 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind
45 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

with the dissociative problem, or could mean the person also has a non-dissociative disorder.

Many mental health problems, such as schizophrenia, bipolar disorder and borderline personality disorder, also have dissociative features.[46]

Behaviour

Although it is important to have a theoretical understanding of a mental health problem, illness or disorder, it is the behaviour of the young person that is most immediately apparent to a professional. Although there are many different types of mental health problem, it is how these problems manifest themselves in a young person's behaviour that is noticed first.

In order to understand the way a young person's behaviour demonstrates their mental health problem, a distinction has been made between the way each problem may be displayed. For example, a distinction is made between 'internalising' problems such as anxiety or depression and 'externalising' problems such as hyperactivity and antisocial behaviour.[47] Assessing whether a young person is displaying internal or external behaviour can help to understand what type of problem they may have. Nevertheless, it is important to remember that some young people will have such complex needs that they may display both types of behaviour and may oscillate between 'externalising' or acting out and 'internalising' and turning their behaviour in on themselves.

Dual Diagnosis

The majority of young people use substances as a normal part of their lives, and the most frequent age of onset is between 10 and 15 years.[48] Young people get positive effects from substance use, which is why many do, and will, experiment with substances. The task for the practitioner is to establish what is 'normal' experimentation and what is substance misuse that is particularly harmful for the young person.

Continuous and excessive substance use, or substance misuse is of most concern in relation to young people with mental health problems. The risk factors for young people who are likely to misuse substances are those:

- Not attending school

46 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

47 Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge

48 Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge

- At risk of offending and reoffending
- Who are homeless or runaways
- Living in drug-using families
- Who are in the care of government
- In commercial sex work or sexual exploitation
- With behavioural, mental or social problems[49]

If young people who have a mental health problem, illness or disorder also have a substance misuse problem, this is termed 'dual diagnosis'. Substances in this case can sometimes be used by the young person as a type of self-medication to mask the symptoms of the mental health problem. For example research by the Youth Justice Board of England and Wales into the substance misuse of young people in custody found that:

- 30% said they had taken drugs not to get high but just to feel 'normal'
- 30% had taken drugs 'to forget everything'
- 56% were eligible for a mental health screening.[50]

In turn, Hagell reported high incidences of mental health problems among young people referred from court for possible alcohol and drug issues:

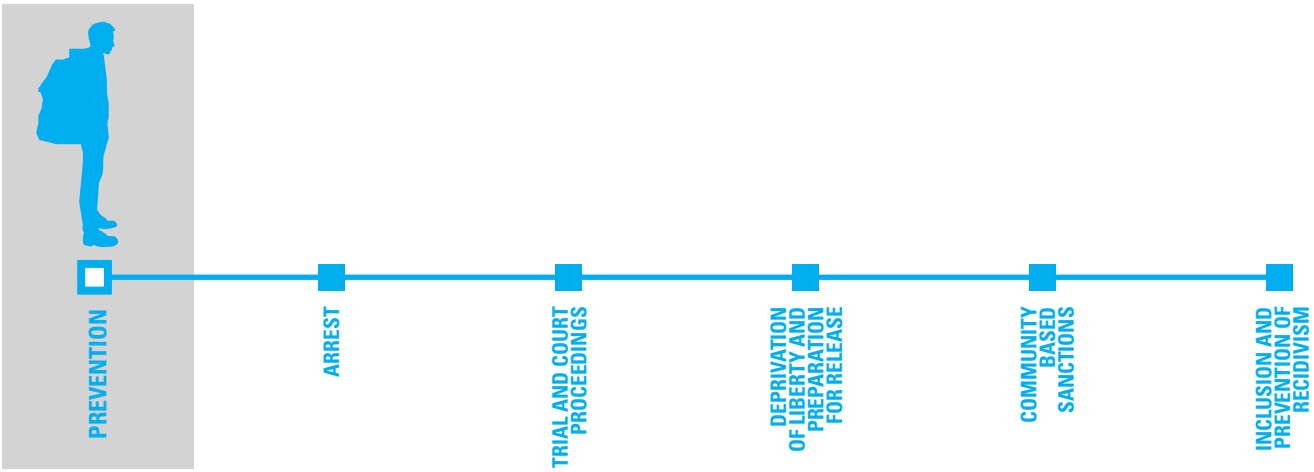
- 91% were shown also to have conduct disorder
- 58% oppositional disorder
- 33% aggressive conduct disorder
- 32% depression
- 23% attention deficit disorder[51]

Dual diagnosis is common and practitioners must be alert at all stages to detecting not just a mental health problem, but a substance misuse problem.

49 Citied in Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

50 Galahad SMS 2004 quoted in Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

51 Hagell 2002 quoted in Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.


PREVENTION
ARREST
TRIAL AND COURT PROCEEDINGS
DEPRIVATION OF LIBERTY AND PREPARATION FOR RELEASE
COMMUNITY BASED SANCTIONS
INCLUSION AND PREVENTION OF RECIDIVISM

PREVENTION

What are the causes of crime?

Risk and protective factors

Children who are at risk of coming into conflict with the law tend to display certain traits, termed 'risk factors' that lead professionals to believe that they may commit crimes in the future. The majority of these risk factors can be countered by fostering more positive traits, or 'protective factors'. At the basis of prevention is the attempt to tackle risk factors by fostering protective factors in the children's lives. The table below gives examples of common risk and protective factors:

RISK FACTORS	PROTECTIVE FACTORS
FAMILY FACTORS	
• Low family socio-economic status • Parents, siblings or other family members with offending and anti-social behaviour • Harsh and inconsistent parenting • Poor parent-child relationships • Early victimisation (physical, sexual and other abuse) • Violence in the home • Passive or condoning attitudes to anti-social and criminal behaviour	• High socio-economic status • Parents who provide pro-social role models • Consistent parental support and supervision • Strong bonds to parents • No early trauma or abuse • Safe home • Clear moral guidance from parents regarding anti-social and criminal behaviour
SCHOOL FACTORS	
• Weak attachment to school/not attending school • Low educational achievement • Organisational weakness in the school • Aggressive behaviour and bullying	• Strong bonds to teachers • Strong educational attainment • Well functioning school • Good relationships with classmates

COMMUNITY FACTORS

- Lack of attachment to the local community
- Ready availability of drugs
- Disadvantaged area
- High turnover of the population
- Gangs operating in the area
- High community involvement
- Drug free neighbourhood
- High socio-economic area
- Stable population
- No gang networks operating

INDIVIDUAL/PEER FACTORS

- Association with delinquent peers
- Substance abuse
- Aggression and impulsivity
- Attitudes sympathetic to offending
- Pro-social peers
- Social skills
- Self-control
- Attitudes against offending

Studies show that children with exposure to 5 or more risk factors by the age of ten are seven times more likely to commit violent acts at age 18, with the odds increasing to ten times more likely at age 14 and 11 times more likely at age 16.[52]

Abuse and neglect

The majority of children at risk of committing crime will have experienced chaotic and abusive backgrounds. Such abuse could include neglect, physical abuse, psychological/emotional abuse and sexual abuse or witnessing violence in the home. It is important to remember the different types of abuse that affect children in order to understand their circumstances. The WHO Child Abuse definitions are shown below:

Neglect

Neglect is the inattention or omission on the part of the care-giver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development.

52 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

This includes the failure to properly supervise and protect children from harm as much as is feasible.[53]

Physical Abuse

Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents.[54]

Sexual abuse

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is (WHO, 1999) in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials.[55]

Emotional abuse

Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potential, and in the context of the society in which the child dwells. There may also be acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, 'scapegoating', threatening, scaring, discriminating, ridiculing, or other non-physical forms of hostile or rejecting treatment.[56]

53 WHO (1999) World Health Organisation on Child Abuse
54 WHO (1999) World Health Organisation on Child Abuse
55 WHO (1999) World Health Organisation on Child Abuse
56 WHO (1999) World Health Organisation on Child Abuse

RISK FACTORS FOR SUBSTANCE MISUSE

The risk factors associated with substance misuse among young people are similar to those for offending and mental health problems. They include:

- Disrupted and or abusive family backgrounds
- Poor supervision or weak parental attitude towards negative behaviour
- Delinquent peer groups
- Poor social skills
- Low psychological well being
- Non-attendance at school
- Having been in the care of institutions/government

As such it is important to treat psychiatric problems and substance misuse together not just in isolation. For example drugs workers and mental health practitioners could work together to ensure the appropriate sequencing of their respective service inputs. The earlier young people begin using substances the greater the negative effects are likely to be.

Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford: Routledge.

Physical and sexual abuse have been shown to significantly increase the risk of conduct disorder in children and to be a predictive of later antisocial personality disorder and the development of psychopathy. In turn, witnessing violence in the home has been proven to increase later anti-social behaviour. A risk that appears to be greatest for boys and younger children.[57]

What are the causes of mental health problems, illness and disorders?

Mental health problems and criminal behaviour have similar causes. The commonly accepted reasons for developing a mental health problem, illness or disorder include:

- Difficult family background
- Trauma
- Genetics and inheritance[58]

57 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

58 Mind (2007) Understanding mental illness

Indeed, it could be said that all of the risk and protective factors that are listed in 2.1.1 could also have an impact on the development or prevention of mental health problems, illnesses and disorders.

Difficult family background

In the same way that having a difficult family background can be a risk factor for committing crimes, it can also lead to mental health problems, illness or disorders.

Mental health problems can emerge from growing up feeling uncared-for, scared of a parent, or having been sexually abused. This can make people highly insecure and more vulnerable to mental distress. On the other hand, being much too overprotected as a child can also put one at risk.[59] Some people may have been discouraged from expressing their feelings from a very early age. As a child, they may even have been punished for getting angry, crying or laughing too loudly. Feelings that are held back, and which are not expressed, can then affect physical and mental health.[60]

Extremely difficult family circumstances can make one vulnerable to personality disorders. Anti-social Personality Disorder (ASPD) (see above) has been linked to antisocial behaviour in childhood, which could be the result of high levels of stress and family problems. These might include parents not giving enough warmth, intimacy, consistency or appropriate discipline and supervision. If ones' parents have ASPD or abuse drugs or alcohol this could also be a factor. In particular, many people diagnosed with Borderline Personality Disorder report having been neglected, or physically or sexually abused as children.[61]

Trauma

Trauma can bring on mental health problems, illness and disorders. The type of mental health issue that is brought on is usually dependent on the type of the trauma, how early in one's life it was experienced, and how prolonged the experience of the trauma. Stressful life events might bring on a mental health problem. This could be traumatic events, such as the death of someone close, or longer-term struggles, such as being the victim of some form of harassment or oppression.[62]

Repeated childhood traumas may lead to a personality disorder. Although not everyone who experiences a traumatic situation will develop these problems, it has been suggested that early and severe trauma, in particular, can cause personality difficulties. The way the person and others around them react and dealt with it, and the support

59 Mind (2007) Understanding mental illness
60 Mind (2007) Understanding mental illness
61 Mind (2007) Understanding personality disorder
62 Mind (2007) Understanding mental illness

and care you received, will make a difference to the outcome, however.[63]

Although the causes of dissociative disorders are complex, studies show that a history of trauma, usually abuse in childhood, is almost universal for people who have moderate to severe dissociative symptoms.[64] It is also linked to children's early attachment to primary caregivers. A number of experts agree that the following factors have to be present for a person to develop the most complex dissociative disorders:

- abuse begins before the age of five
- abuse is severe and repeated over an extended period
- the abused child has an enhanced natural ability to dissociate easily
- there is no adult to provide comfort; the child had to be emotionally self-sufficient.[65]

Attachment

A child's secure attachment to a positive caregiver in infancy has shown to greatly affect their ability to regulate their emotions and operate in socially appropriate ways. Insecure attachment, where a child does not have the necessary nurture form primary care givers means that the child is deprived of the opportunity to experience emotions in a safe and secure manner and to learn how to control their emotional experiences.[66] There have been three general patterns of secure attachment defined:

Avoidant attachment patterns

This is observed in children whose caregiver is observed to be rejecting in response to the infant's expressions of distress. In response to rejection, these infants will minimise their distress in order to maintain proximity to the caregiver. Children with avoidant attachment style have been found to be more overtly angry late in development, are more apt to displace frustration and anger to other people, and have been found to be more aggressive, hostile, and impulsive in school settings.[67]

Anxious/resistant attachment patterns

Infants who are anxious/resistant in their attachment style have caregivers who are inconsistent in their response to expressions of distress. These infants tend to demonstrate exaggerated dependence on the caregiver and, it is thought, fail to

63 Mind (2007) Understanding personality disorder

64 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

65 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

66 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

67 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

relax and be soothed for fear of losing contact with the caregiver. Children with this attachment pattern have also been found to be more overtly angry and cry more frequently. They are also more likely to exhibit passive withdrawal and to become the victims of children with avoidant attachment patterns.[68]

Disorganised/disorientated attachment patterns

These children have been shown to exhibit controlling behaviour, bossiness and parentification.[69] If a child with a disorganised attachment style suffers abuse they are more likely (than children with other attachment styles) to respond to it by using dissociation as a defence.[70]

Genetics and inheritance

Genetics and chemistry can influence your mind. For example, if you are frightened, it triggers the body's 'fight or flight' response to produce a hormone called adrenalin. If physical activity doesn't use up all the adrenalin, the body remains tense and the mind stays over-active. This could lead to the development of mental health problems, illnesses or disorders. There is also the possibility that your genes can affect your propensity towards developing a mental health problem as it is possible that your genes can affect your personality. There are genes that cause physical illnesses, so there may be genes that predispose a person towards mental illness. There is some scientific evidence to support the idea that one person may be more likely than another to develop a particular problem, such as bipolar disorder or schizophrenia.[71]

As some elements of our personality are inherited, this may also link with personality disorders. People are born with different temperaments; for example, babies vary in how sociable they are, in the intensity of their reactions, and in the length of their attention span. Some experts believe that inheritance may play a relatively big part in the development of OCPD and ASPD (see above), and that there may also be a genetic link between personality disorders.[72]

68 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

69 Pope et al (2007)'The etiology of antisocial behavior: biopsychosocial risk factors across development in Kessler & Kraus (eds) 'The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

70 Kathyrn Livingston (2009) Understanding Dissociative disorder. Mind

71 Mind (2007) Understanding mental illness

72 Mind (2007) Understanding personality disorder

WHAT WORKS TO PREVENT MENTAL HEALTH PROBLEMS?

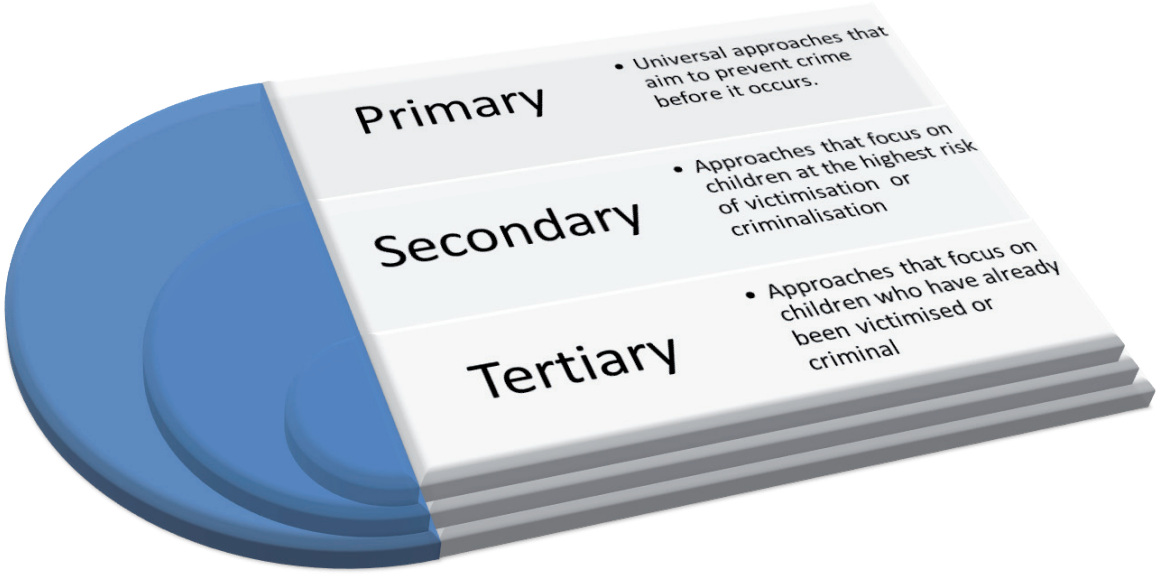
Although there has been limited research into what works to help young people with mental health problems some common features have been found. These include:

- The importance of early intervention
- The need to use a range of methods, and combinations of methods, within individual treatment plans
- The key role of the relationship between therapist and client in treatments
- The importance of the family context, both in the assessment process and in supporting or thwarting treatment efforts.

Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

What is crime prevention?

Crime prevention is the work undertaken by professionals to stop children and young people from committing crimes. Preventing crime is beneficial to children, their families, their communities and society as a whole. It can be interpreted in different ways, however, interventions are usually structured across three tiers. Each tier delineates the level of intervention and the target audience. The diagram below shows the three categories of crime prevention:



Primary

The primary, or universal, level describes activities that are aimed at preventing crime amongst all children. They are based on universal strategies, and are aimed at developing personal and social competences that will enable all young people to cope with problems in a constructive way. Agencies may provide information, education and social support to all children through forums such as schools, youth clubs, churches, social workers, public institutions and NGOs. It can also include the press and other media. Those targeted in these actions are those who are likely not to have any criminal record.

In terms of promoting mental health, prevention on a universal level is intended either to avoid the emergence of mental health illnesses associated with criminal and antisocial behaviour, or to minimise or mitigate signs or indications of disorders and problems of this nature. It should be focused either on developing pro-social skills, or reducing the development of mental health problems through ensuring good outreach and social services and mental health provision to the parents of children.

GOOD PRACTICE PORTUGAL:

PROJECT APAV 4D – PREVENÇÃO INTEGRADA EM CONTEXTO ESCOLAR

This is a Portuguese version of the Canadian programme 'The Fourth R'[6], developed by the Portuguese Association for Victim Support, in cooperation with the University of Minho. It is a comprehensive universal prevention school-based programme. It is implemented by teachers throughout 28 sessions and aimed at reducing violence and risky behaviours, by providing information to young people that will enable them to make good decisions. There are 4 main dimensions to the programme: 1) Violence in dating relationships and between peers, 2) Risky sexual behaviour, 3) Substance use and abuse and 4) gender issues.

Information on this program available in the Internet at:
http://www.psp.pt/Pages/programasespeciais/escolasegura.aspx?menu=4

Secondary

Secondary prevention is aimed at selected children and young people who are displaying risk factors towards committing crime. These could be, for example a subgroup of the population whereby the risk of developing criminal behaviour is significantly higher than average such as children from disadvantaged neighbourhoods, children of very

young single mothers, children and adolescents lacking parental control, or with disruptive behaviour problems, from families in social exclusion, students that have more than one disciplinary referrals, or truants. The types of actions, at this level, have also informative and educative character but with more of a practical nature, with more direct and active contact with the children. Secondary prevention measures in mental health are aimed at people displaying any kind of dysfunction or who are at risk of suffering from a mental health problem, illness or disorder.

GOOD PRACTICE. PREVENTION ENGLAND AND WALES

The Youth Justice Board of England and Wales introduced Youth Inclusion Programmes (YIPs) in 2000. They aim to reduce youth crime and anti-social behaviour in the neighbourhoods in which they work by offering tailor-made programmes for 8 to 17-year-olds who are at high risk of involvement in crime or anti-social behaviour. YIPs target young people in a neighbourhood who are considered to be most at risk of offending, but are also open to other young people in the local area. Young people on the YIP are identified through a number of different agencies, including the Youth Offending Team, police, children and family services, local education authorities or schools, neighbourhood wardens and anti-social behaviour teams.The programme gives young people somewhere safe to go where they can learn new skills, take part in activities with others and get support with their education and careers guidance. Positive role models, the workers and volunteer mentors in the schemes, help to change young people's attitudes to crime and anti-social behaviour, and address those factors that put young people at risk of involvement in offending or anti-social behaviour.

Tertiary

Tertiary prevention is directed at young people who have already committed a crime. It is targeted to promote reintegration and prevent recidivism. Tertiary actions are aimed at social integration and countering the deepening of a young person's criminal career. In terms of mental health, the action could be targeted encouragement and one to one work with young people seeking to avoid relapses and fostering reintegration and rehabilitation into the community. The types of intervention could include focusing on skill development, problem solving, on-going assessment throughout the programme to monitor progress, a component that requires the young person to do work outside of sessions and engagement between the therapist or youth justice worker and young person.

GOOD PRACTICE NETHERLANDS:

DIVERSION/PREVENTION FOR CHILDREN YOUNGER THAN 12 YEARS OLD.

Until 2010, all children younger than 12 years old with a first police contact were offered a so-called STOP response. It was a free offer to support parents with the correcting of their children when they have committed an offense. STOP consisted of "an activity of an educational purpose" for up to 10 hours. Evaluation showed, however, that the approach was insufficiently effective and did not have a clear theoretical basis. It has therefore been replaced by a "robust approach" for children below twelve. In the new, comprehensive approach, the police talk with the parents and – where necessary - lead them to the Youth Care Agency. The Youth Care Agency screens for underlying problems, and - if necessary - directs the parent and child to person-oriented, adequate aid. Either light or intensive interventions are advised. A multiagency Preventive Case Consultation Youth (PCO) (made up of representatives from the police, municipality, Youth Care Agency) examine which approach is the most suitable.

Key professionals involved in prevention

Since the prevention of crime and mental health problems is strongly related to other social problems, it is a shared responsibility between many professionals. These include:

- Social workers, community support workers and other professionals from social services and care agencies
- Outreach workers, health visitors or other home visiting professionals
- Representatives from charities and non-government organisations
- Mental health professionals including psychiatrists
- Medical practitioners such as general practitioners, accident and emergency doctors and pediatricians
- Police officers
- Teachers, educators, and school support staff
- Psychologists, psychotherapists and counselors
- Probation officers, prison staff and correctional staff
- Youth workers
- Staff from sporting or cultural organisations
- National and local government representatives
- Public housing associations

What you can do

1
Practice 'pro-social' attitudes and beliefs – behave as you would like the child and young person to behave

2
Communicate openly with the child in a way they can understand but be yourself

3
Be honest and consistent in order to form a trusting relationship with the child

4
Maintain a 'can-do' attitude in the face of challenge and recognise that small changes to you are big changes for the child

5
Empathise with the children and young people – think about how you would feel in their position

Key points to consider

As there are many agencies and professionals in the prevention of crime and mental health problems, it is important for all agencies to consider how they may best work with each other to achieve their goals. Both when designing prevention programmes and on a day-to-day basis, it is necessary to take into account the motivation and expectations of the recipients, so that they can be used as catalysts in the process. It is important to be:

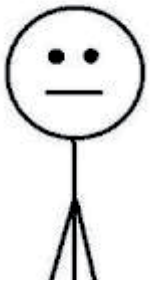
- **Systematic:** A systemic perspective, which fosters working in the community and with the community, working with it and not for it, playing an active part and serving as a force of change of the system itself. Aim to develop non-vertical programmes, based in the community and with the community.

- **Strategic:** Strategic thinking, promoting concrete and defined objectives which facilitate their own measurement and redefinition, as well as gauging the intervention process underway.

- **Well-co-ordinated:** There needs to be coordination between different team members as well as with the other working teams who are part of the same network, to avoid doubling up on prevention methods, optimise resources and function efficiently. A general and widespread lack of coordination between generic services for children and young people (including mental health services)

and those designated for young offenders may mean that particular children are not properly assessed and subsequently unable to access appropriate services for treatment. It is extremely important to coordinate different resources which come together in the prevention programme. This requires continual communication and common and coherent criteria, so that interventions neither overlap nor, conversely, leave some objectives unmet.

- **Creative and flexible:** As there are many actors involved, it is important to be creative and flexible to be able to make creative changes and optimise existing resources. Furthermore, the importance of a human perspective is paramount, bearing cultural and social characteristics in mind, when designing the prevention programme. It is also important to ensure balanced prevention, as excessive intervention can be as ineffective as the absence of any at all.



The child's needs at this time

During the prevention stage professionals need to be aware of the fact that a child may have a lack of attachment to adults which can lead to feelings of anger, fear, shame, humiliation, or terror. As such they may be wary of working with adults or be unsure of how to act appropriately.

The child needs to feel understood, listened to, loved and respected in a secure and safe environment. Further they need to experience positive life experiences to break down boredom, burn energy and have an active and fulfilled leisure time.

Crucial intervention points

Early intervention

It is sometimes difficult to distinguish between preventative and early intervention approaches. Early intervention is defined as intervening as soon as possible to tackle problems that have already emerged for children and young people. This implies a targeting at an early stage of children and families who are exhibiting a range of worrying behaviours.

While at school

Schools can be a major focus of government policy for crime prevention. They often concentrate on improving behaviour and attendance, both of which factors have been identified as contributing to antisocial or offending behaviour by young people.

Teachers are key partners in recognising the difficulties experienced by children such as abuse in the home, development of anti-social behaviour or the development of other disturbing behaviour. They are the key referring agents to social workers or mental health teams for assessment and treatment. Recognising and targeting children and young people showing early signs of antisocial behaviour is critical in preventing later onset of more serious criminal behaviours.

Service entry point

One of the difficulties for young people with mental health problems is that they may only receive appropriate help and support too late. This suggests that in earlier years their difficulties were not fully recognised and treated. There may be several contributing factors to this failure: the difficulty of diagnosing mental illness in children and young people; the masking of mental health problems by other behaviours which become the focus of intervention, especially in school; the presenting behaviour may be withdrawal or social isolation rather than extreme acting out behaviours, which can be overlooked or ignored. Nevertheless, the point at which a young person enters a service, be that the criminal justice system or a mental health service, is the point at which all partners need to get involved if they have not done so already.

Specific exercises/discussion points for training

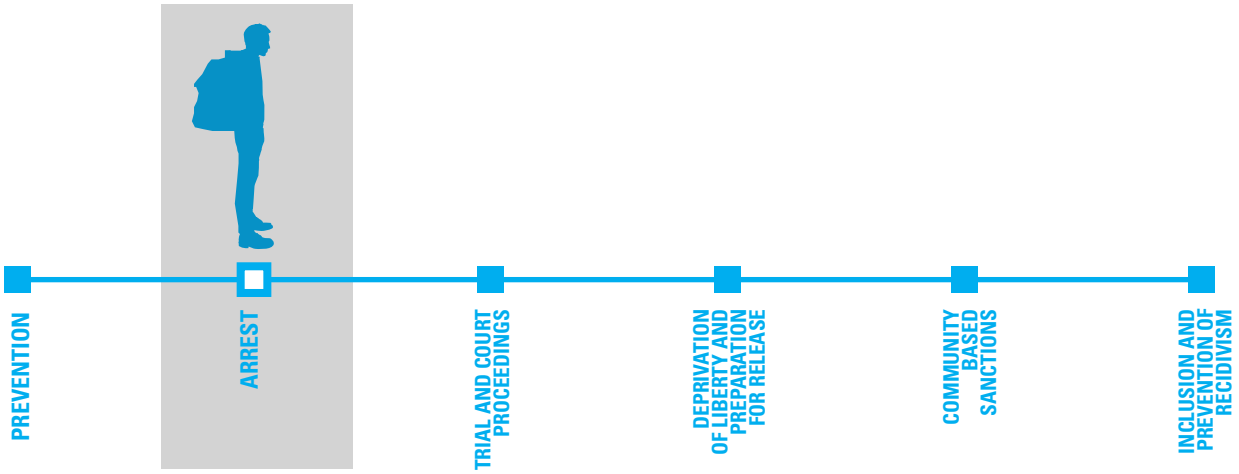
Questions

- Why is prevention important?
- What characteristics do young people with mental health problems and substance misuse have in common with young people who offend?
- Some prevention programmes concentrate on the individual child, some on the parents, and some on the whole family. Which do you think is most affective? What are the pros and cons of the different methods for young people with mental health problems?

Exercise

Look at the list of professionals who are involved in prevention. How many professionals do you know from this list?

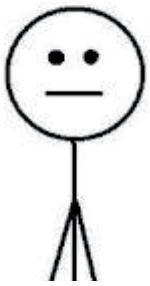
Make a plan of how you will talk to all of the professionals on the list of people to see what work they are doing to prevent crime or look after children and young people at risk of mental health problems.


PREVENTION
ARREST
TRIAL AND COURT PROCEEDINGS
DEPRIVATION OF LIBERTY AND PREPARATION FOR RELEASE
COMMUNITY BASED SANCTIONS
INCLUSION AND PREVENTION OF RECIDIVISM

ARREST

What happens when a child is arrested?

If a child is of the age of criminal responsibility and has committed a criminal act then they can be arrested by the police. The circumstances of arrest are different for each country, however, the arresting agent is usually the police. Apprehension by the police is often the first contact children have with the criminal justice system. Therefore it is of crucial importance that this is undertaken in such a way that they cause as little damage as possible to the child, and in fact, to ensure their protection.



The child's needs at this time

During the stage of arrest the child is likely to be scared, disorientated and overwhelmed. The position of being arrested can lead to anxiety, and fear about what will happen to them. They need:

- **To be told why they have been arrested in a language they understand**
- **To be continuously well informed, at every stage of procedure, on his/her rights and obligations, on the future steps**
- **To have a parent/guardian or family member with them**
- **To have a professional on their side such as a probation officer or social worker**
- **To have a lawyer who will inform them of their legal rights in a manner they understand**
- **To be talked to in a 'child friendly' environment**
- **To have access to a psychologist for assessment to ensure that they are capable of understanding the process**

Key professionals involved in arrest

Although the main professional responsible for the child at this stage is the police officer, there are a number of other partners who are also integral to this stage in the process:

- Social Worker/probation worker
- Appropriate adult/early help employee / Child Protection Board representative
- Judicial and juvenile justice system authorities e.g. Judicial Case Consultation (Youth Care Agency, school attendance services, public prosecutor).
- Judges of family court
- Police, educators, or employees of youth services
- Psychologists, medical experts
- Interpreters or speech and language therapists
- Lawyer representing the child

In some countries special solicitors have been trained to have a particular knowledge of mental health issues. These solicitors have been found to help increase the number of diversions for people with mental health problems and are better able to put their clients at ease.[73]

What you can do

1
At the outset of your conversation put the child or young person at ease

2
Offer clear information to the child at the relevant points in time about their rights

3
Be open to any questions the child has

4
Ensure the presence of their parent, guardian or other familiar or related person

5
Ensure all contact is delivered in a 'child friendly' environment

6
Always bear in mind how harmful and damaging contact with justice system and the label of 'criminal' is for the child's future development

7
Ensure that they are screened for any mental health problems that need to be addressed

8
Ensure good articulation and cooperation between other professionals involved in this process – share the relevant information with each other

9
Keep motivated,try not to get frustrated as the child will pick up on and be affected by negative emotions and behaviours

10
Empathise with the child – think about how you would feel in their position

73 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

Crucial points in the process

The appropriate response

The first consideration for the police when dealing with a suspect with a suspected mental health problem, illness or disorder is to establish whether the situation requires:

- A criminal justice response alone
- A social care or healthcare response alone
- A combination of responses[74]

Arrest

When a child is arrested, they are in a vulnerable position and must be treated with respect by police officers. Following arrest the police officer is obligated to immediately:

- Inform the child of the reason of the arrest in a language they can understand
- Inform the child of his/her rights and obligations
- Notify the child's parents or legal guardians
- Facilitate the child's access to a lawyer and/or legal aid

It is thus important to use simple and clear language, adapted to the age and circumstances of the child and giving understanding to the existence of mental health problems, illnesses or disorders. Special attention should be paid to any interventions with linguistic or ethnic minorities and with children with a foreign nationality.

On arrest the child parents or guardians should be informed and brought to the police station. If a parent or guardian is not available then an Appropriate Adult may be contacted instead to act as a safeguard to the child's rights. They will be present during any questioning or other procedures, i.e. finger printing, photographing or taking a urine or DNA sample. Their role is to assist and advise the young person who should be allowed to consult privately with the adult at any time. The role is not simply that of an observer but to advise the young person throughout the proceedings and to observe that relevant protocols are being followed at all times.

74 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

Detecting a mental health problem

It is not expected that police officers or other un-trained professionals should be able to diagnose a mental health problem, illness or disorder. However, being able to recognise the signs of mental ill health is crucial. The below warning signs could be noticed at any point in the proceedings and should always be taken seriously:

- Irrational conversation and behaviour
- Talking about seeing things or hearing voices which cannot be seen or heard by others
- Removing clothing for no apparent reason
- Confusion and disorientation
- Paranoid beliefs or delusions
- Self-neglect
- Hopelessness
- Impulsiveness
- Inappropriate or bizarre behaviour
- Obsessional thoughts or compulsive behaviour
- Inappropriate responses to questioning
- Apparent suggestibility
- Poor understanding of simple questions
- Confused response to questions
- Speech difficulties (e.g. poor enunciation, slurring words or difficulty with pronunciation)
- Difficulty reading and writing
- Unclear concepts of times and places
- Problems remembering personal details or events
- Any suggestion or indication that a person is in touch with mental health services (e.g. psychiatric medication or appointment card)
- Poor ability to cope with interruptions
- Poor handwriting that is difficult for others to read
- Difficulty with filling out forms
- Inability to take down correct information or follow instructions correctly
- Talking continuously, or slowly and ponderously
- Repeating him or herself [75]

75 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

Some signs of personality disorder

If a young person has repeatedly self-harmed or shown persistent risk-taking behaviour or marked emotional instability, consider referring them to community mental health services for assessment for borderline personality disorder.

When providing psychological treatment to people with borderline personality disorder, monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm and depression.

National Institute for Health and Clinical Excellence (2009) Borderline personality disorder treatment and management. NICE guidelines 78.

People who have Autism or Asperger syndrome are often highly sensitive to their environment and, for example, loud noises or bright lights.[76]

Interrogation

The methods and processes used in police interrogation can be problematic in two ways: because of the child's age when they are being interrogated, and because of any mental health problems, illnesses or disorders that they may posses.[77] Therefore, police interrogators need to be aware of the fact that the signs that they may ordinarily assume to be associated with guilt, such as the suspects posture, poor eye contact, word choice and other non-verbal cues may also be signs of stress, and are likely to appear more frequently in children and those with mental health problems, illnesses or disorders.[78] Because interrogations presume guilt, and can involve elements of deception where police may pretend that they already have evidence against the suspect, studies have found that children are much more likely to falsely confess than adults, and when impairments in mental functioning are added to this, the likelihood of falsely confessing is even greater.[79]This must be kept in mind for all professionals undertaking interrogations. Indeed 'the techniques found to be dangerous with child victims/witnesses (in terms of generating false reports) can also be dangerous with child suspects.'[80] Further, it must be

76 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

77 Redlich et al (2007) 'Police interrogation of youth' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

78 Redlich et al (2007) 'Police interrogation of youth' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

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80 Redlich et al (2007) 'Police interrogation of youth' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

ensured that police do not undertake interrogation when the child is intoxicated in any way, as this places the child in a more vulnerable position.[81]

Given the high level of speech and language needs among young people it is worth considering having available a speech and language therapist to aid with communication in police custody. Also, where translation services are required, preferably these should be people trained in mental health issues. It may also be necessary to have medical or psychological assistance to the young person during or after the interview process. Similarly, if the child is seriously affected by the consumption of alcohol or narcotics, or affected by any kind of mental disorder, including transitory ones, they should be transferred to a medical centre as a matter of urgency. Police forces should ensure that local protocols make it clear that it is the role and function of health professionals in the custody environment to assist the police in accessing relevant healthcare facilities when required.[82]

Diversion

Diversion away from the criminal justice system is particularly desirable in the case of children with mental health problems, illnesses or disorders. Different countries have different mechanisms for diversion. In the UK the police have the discretion to take no further action, reprimand the child, or give a final warning to the child. In Portugal the police and public prosecution services make early referrals for young offenders with mental health problems. These are met by swift responses by hospital psychiatric emergency units, who promptly diagnose psychiatric disorders and recommend treatment, in a child friendly environment.

Diversion could take the form of:

- Removing the young person from police custody to a place of safety
- Arranging for a psychiatric assessment to be carried out
- Referring them to health services
- Facilitating the young person's voluntary admission into hospital.[83]

Police and prosecutors are also able to divert young people from the criminal justice system through using cautions or in discontinuing criminal proceedings where the public interest does not require a prosecution.[84] They must strike the balance between

81 Redlich et al (2007) 'Police interrogation of youth' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

82 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

83 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

84 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

the public good in convicting a young person with a significant mental illness and protecting the public from harm.

GOOD PRACTICE ENGLAND AND WALES: THE TRIAGE MODEL

The Triage model brings YOT expertise into police charging centres to assist with decision making. Triage takes place at the point that a young person enters police custody following arrest. The concept, taken from the hospital triage model, seeks to act as a 'gateway' whereby all young people entering custody can be rapidly assessed to ensure that they are dealt with swiftly and effectively. This model is built upon practice developed in other areas. These include Mental Health Triagewhich is a clinical function conducted at point of entry to health services that aims to assess and categorise the urgency of mental health related problems.

Investigation and charge

If a young person is suspected of having a mental health problem, the investigation should usually still continue and be coordinated with the healthcare assessment. Although it is important to obtain as much information as possible from the young person, it must be recognised that this information can be limited, especially in cases of diversion.[85]

GOOD PRACTICE POLAND: BLUE ROOMS

The room is designed like a child's room: the walls are painted blue, with lots of toys, and coloured furniture creating a friendly and safe environment. The Blue Rooms are used for hearing children at the police station, not only in cases when underage person is suspected for committing a criminal act but in all cases when the child is in contact with the police as a witness. While the child is speaking a psychologist is obligated to be present in the room. The special rooms function at most of the police stations. If there is no such facility at the station, then the police are obliged to interview the child in the closest blue room in area. In some small towns, when the police station is not able to dedicate a special space, a blue room is arranged in other public facilities, i.e. welfare centre or local centre for supporting families.
https://woc.uc.pt/fpce/class/searchmaterial.do

85 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

After arrest and investigation, a decision must be made as to whether or not the young person is to be charged with an offence. Officers should be aware that young people with mental health problems may need more time to understand the charge they have been given.

Police custody

The police officer must establish whether the young person is fit to be detained. In doing so they should:

- Make an assessment of illness, injuries and drug and alcohol problem
- Take advice from other professionals
- Take provision of necessary medication
- Consider the possibility of referral to hospital
- Be aware of mental health legislation[86]

Remand to police custody should always be a last resort and only in exceptional circumstances. It is not advised for a child with a mental health problem, illness or disorder. When it occurs, police custody of the child cannot last longer than strictly necessary in order to carry out the checks needed to establish the facts and, in all cases, it must fall within the maximum time period set out by legislation. When this time is completed, the young person must be either freed or charged and sent before a judge or the competent authority.

During their time in police custody, the young person should receive the care, protection and social, psychological and physical care that they require, given their state, age, gender and individual characteristics. The right to be seen by a medical expert may be sought by the young person themselves, their lawyer, their parents or their legal guardian.

Professionals should take care to notice any signs that the young person is a danger to themselves or others. Behaviour that would indicate this includes:

- Putting themselves in danger (e.g. walking into the path of moving traffic or on railway lines)
- Asking for help with their mental health
- Engaging in threatening behaviour towards others for no obvious reason
- Threatening or engaging in self-harm
- Attempting or threatening suicide (e.g. expressing ideas, intentions or plans relating to suicide)

86 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties

- A high level of volatility
- Being unresponsive to others
- A tendency to trip, fall over or bump into things
- Hyperventilating (over-breathing)
- Showing physical signs of severe malnourishment and self-neglect[87]

Management of crisis

If a young person suffers a mental health crisis:

- Maintain a calm and non-threatening attitude
- Try to understand the crisis from the young person's point of view
- Explore the young person's reasons for distress
- Use empathetic open questioning, including validating statements to identify the onset ad course of the current problems
- Seek to stimulate reflection about solutions
- Avoid minimising the young persons' stated reasons for the crisis
- Refrain from offering solutions before receiving full clarification of the problems
- Offer appropriate follow-up within a time frame agreed with the young person

National Institute for Health and Clinical Excellence (2009) Borderline personality disorder treatment and management. NICE guidelines 78.

Specific exercises/discussion points for training

Questions

- In what ways might interrogating a young person with a mental health problem illicit a false confession? How can this be mitigated against?

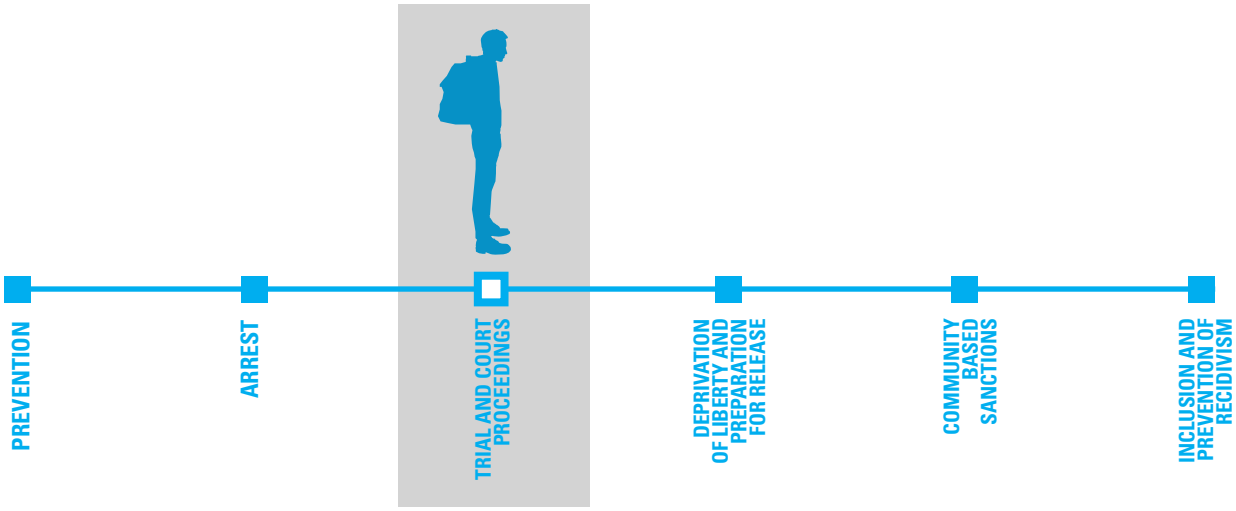
- How would you keep a young person suspected of having a mental health problem calm during their time in police custody?

- How can police best reassure a young person who has been arrested that they are safe?

Exercise

Look at the list of symptoms that indicate a young person may be suffering from a mental health problem. Have you ever encountered a person displaying these characteristics? What did you do? After reading this chapter do you think you would behave in the same way again or in a different way? Why?

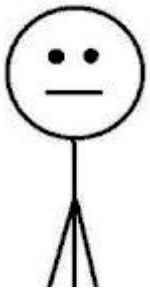
87 Association of Chief Police Officers, National Policing Improvement agency, Department of Health (2010) Guidance on responding to people with mental health or learning difficulties



TRIAL AND COURT PROCEEDINGS

Trial and the judicial process

The trial of a young person must be undertaken with consideration for the young persons' understanding and their age. It is crucial that during this process a child friendly environment is created in order to establish the circumstances of the case, the role of the practitioners, and the determination of the penal responsibility. Most countries hold children's cases within a youth or juvenile court so that the young person is at ease. Professional communication between psychologists, judges and lawyers is crucial at this stage.



The child's needs at this time

Trial proceedings are intimidating for adults, and a child is more likely to feel intimidated by the process. If they have a mental health problem, illness or disorder then it can be even more frightening.In order to reassure the child at this time they need:

- **To understand the whole procedure and what is expected of them at each point in time. Even simple things such as where to stand, when to speak, and who they should address will need to be explained to the child.**
- **To have a lawyer who will inform them of their legal rights in a manner they understand and of the measures that the court can apply**
- **For all parties to listen to them and treat them with fairness and seriousness**
- **To have a parent or guardian and other family members with them**
- **To have the trial conducted in a child friendly and non-intimidating atmosphere**
- **To be continuously well informed, at every stage of procedure, on his/her rights and obligations, and on the next steps of the proceedings**
- **To have a professional on their side such as a probation officer or social worker**

Key professionals involved in trial and court proceedings

The trial and court proceeding stage involves a wide variety of professionals, including:

- Police officer
- Lawyer representing the child
- Social worker/appropriate adult/early help employee/Child Protection Board representative/youth offending team representative
- Judges and prosecutors, the Crown prosecution service
- Medical or psychological experts
- Interpreters
- Forensic child and youth psychologists or psychiatrists

GOOD PRACTICE: USA MENTAL HEALTH COURTS

Mental health courts provide enhanced psychiatric support at court so that offenders with mental health problems are identified and appropriately assessed. They help to give increased interaction between criminal justice agencies and health providers and benefit form a judiciary trained in mental health issues. Pilots suggest the system is producing some good results, however there are concerns regarding stigmatisation and social exclusion resulting in attending the court and that specialist courts might detract from ensuring that all courts have some expertise and resources to handle mental health cases. Juvenile drug courts have also been piloted.

Kessler, C (2007) 'Innovative problem-solving court models for justice-involved youth' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

What you can do

1
Familiarise yourself with the Council of Europe's guidelines on Child Friendly Justice

2
Ensure that you are versed in the child's needs, how to listen to the child, how to prepare him or her for hearings and how to conduct the hearing with respect for the best interests of a child

3
Bear in mind how harmful and damaging contact with justice system and labeling the child as a 'criminal' can be for the child

4
Be aware of the child's conduct, personality and psychiatric problems, which will allow them to see if the child is ok or if they need to be taken out of the court proceedings and referred elsewhere.

5
Ensure coordination with all other professionals

6
All information about the child's physical, psychological, mental and social development, as well as the specific needs of the most vulnerable children, such as children with disabilities need to be continuously shared between professionals

Crucial intervention points

Fitness to plead

Studies have found that a substantial percentage of children who are tried in juvenile court may not be competent to stand trial according to the competency standards applied to adults.[88] In order to stage a trial, before appearing at court, it must be established:

- If the young person is fit to plead.
- If they are not, whether a transfer to a hospital is necessary, or whether they will need support during he court proceedings
- If they are, they should be remanded to custody, bailed or sent to hospital

88 Geraghty et al (2007) 'Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

- What information will be vital to inform any decision that the judge might make in relation to sentencing options.[89]

Any individual standing trial "must be capable of contributing to the whole process of his or her trial, starting with entering a plea"[90]. The main criteria to determine fitness to pleas is:

- Capacity to plead with understanding
- Ability to follow the proceedings
- Knowing that a juror can be challenged
- Ability to question evidence
- Ability to instruct counsel[91]

It is also important to assess if the child understands the mechanics of the proceedings. For example:

> 'Does the child understand that there could be/will be appearances before the judge for status, for pre-trial hearings, and eventually for a trial? Does the child understand that a trial consists of the calling of witnesses and the introduction of evidence? Does the child understand the concepts of the burden of proof, and proof beyond a reasonable doubt? Does the child understand the various roles of the actors during trial? Does he know what the role of the judge will be? Does he understand the role of the prosecutor? Does he understand that evidence will be presented through the testimony of witnesses and the submission of documentary and physical evidence? Does he understand that witnesses will be examined and cross-examined?[92]

It is important to judge the young person not only on their capacity to understand owing to their age, but also their capacity to understand taking into consideration their mental health problems. A child who suffers from a mental health problem may have symptoms that impair his/her ability to understand the proceedings and or cooperate with their lawyer.[93] Indeed, in one study, one third of children who have been through

89 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

90 British Psychological society feb 2008 quoted in Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

91 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

92 Geraghty et al (2007) 'Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

93 Geraghty et al (2007) 'Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

the court process said they did not understand why a lawyer would want them to tell them the truth. Also, a significant number misinterpreted the right to silence, thinking that the judge could waiver that right, and felt that the warning "anything you say can and will be used against you in court" referred to swearing or critising the judge.[94]It must also be noted that young people with learning difficulties may have particular issues in understanding the workings of a courtroom, especially in terms of understanding questions and when asked specific leading questions. These problems may not mean they cannot stand trial, but that they need extra support to understand the proceedings.[95]

Social enquiry or pre-sentence report

Prior to the trial, an investigation into the child's home circumstances and the extent of their mental health problem, illness or disorder needs to be explored. This report will then be used to present to the judge to be taken into consideration at sentencing.

A social enquiry or pre-sentence report is usually written by a social worker, however, each country will do this report slightly differently. The report should include relevant information on the kind of crime committed by the young person and on the criminal charges laid against them. These reports are essential for the competent authority to be accurately informed of the child's social and family history, their schooling, and their educational background so that they can make the most appropriate ruling. It should also include information and recommendations on what sentence would be the most appropriate for the child and why. It should be objective and impartial but analytical.

94 Geraghty et al (2007) 'Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

95 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

GOOD PRACTICE UK: MENTAL HEALTH SCREENING TOOL

In the UK, it is the responsibility of the Youth Offending Team staff to complete an assessment which then forms the basis of all further reports on the child. The assessment, called 'Asset' is a standard assessment of the factors contributing to a young person's offending. The outcome of the assessment informs the reports and the identification of any necessary treatment order to be included as part of the disposal. In addition to the routine Asset documentation there is a further screening tools to be used for young people with mental health difficulties. The completion of the Asset Mental Health Screening Tool is triggered by a response to the scoring of section 8 in the Asset core profile. The Asset Mental Health Screening Tool consists of:

- SQIFA - The Mental Health Screening Questionnaire Interview for Adolescents (SQIFA) is a short screening tool attached to Asset to be completed by all YOT staff.
- SIFA - The Mental Health Screening Interview for Adolescents (SIFA) is a detailed interview to be completed by YOT health staff.

It is extremely important to compile information on the clinical, social, educational history of a child to facilitate assessment and diagnosis. Also important is information on which lines of intervention have previously been tried, which strategies have worked, which have not, and why not, so as not to repeat unsuitable models. It is possible however that some tools used in the past which did not work at the time could be effective for the young person at the current time.

For young people with mental health problems, illnesses or disorders, a pre-sentence report should address the following issues:

- **Culpability:** how does the mental health problem bear upon the young person's personal responsibility for their conduct?
- **Risk:** does the mental health problem make further offending more likely? Does it increase any risk to self or others? What can be done to minimise any risk identified?
- **Feasibility:** does the mental health problem make it unlikely that the young person would be able to comply with the requirements of a community order? What would be the implications of a custodial sentence?
- **Supervision:** what work would be undertaken in the course of a community order? Is the young person able to participate in an accredited programme? Would the psychiatric services be involved? Can the order be supervised by probation?[96]

96 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

Assessing substance misuse

Many young people will use substances without it constituting substance misuse. Therefore a useful definition for substance abuse is 'continued use despite negative consequences, and dependency as continued use despite adverse consequences, loss of control, and preoccupation with using substances'.

A way of describing the stages from non-use to abuse is as follows:

- Primary abstinence – never used
- Experimentation – use with peers in a social context usually out of curiosity, due to peer pressure and to 'fit in'
- Regular use or social use – usually in the context of peer acceptance and on a regular basis in social situations
- Problem use, misuse or instrumental use – either compensatory use – use to relieve a negative mood, affect or disposition, such as shyness or sadness, or Hedonistic use – use to discover new ways to feel good or to experience something new
- Abuse – continued use despite negative consequences. The young person may unable to feel 'normal' when not using and have a daily dependence on it. This could include substance use leading to vehicle accidents, unprotected sex, deteriorating grades at school, fights or arrest.

Simkin, D (2007) 'Substance abuse in youth offenders' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

Expert assessment

When a mental health problem is identified, a judge or lawyer can request expert opinions to gather more information. It is necessary to realise that there are many different experts that can be called on for a competency evaluation and it is important to call the right one. For example:

> 'Should the referral be made to a psychiatrist with the expectation that the psychiatrist will associate with a psychologist? If educational deficits are identified, will a specialist in special education need to be retained? If a physical disability is the cause of the perceived incompetence, will a physician who specialises in the impact of disabilities be made part of the team?[97]

It is crucial that the expert chosen is a specialist in child and adolescent psychology and has knowledge of the latest developments in the field and the legal setting. If a

97 Geraghty et al (2007) 'Assessing children's competence to stand trial and to waive Miranda rights: new directions for legal and medical decision-making in juvenile courts' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

custodial sentence is being considered, the court should specifically ask the expert to address the impact of any custodial sentence on the young person's problem or disorder and any available treatments. A psychiatric assessment should also be undertaken before a community order with mental health treatment requirements can be given.[98] Psychiatric and other expert reports can take a long time to prepare. Ideally they need to be prepared with timeliness, quality and appropriateness. It is advisable that Courts, health services, the probation service and the prosecution service work together to agree local service level agreements for the provision of psychiatric reports and advise to the courts.[99]

In many cases a psychiatric report may be required by the court or as part of the pre-trial reports. The psychiatric-psychological examination pays attention to physical, psychological, social and community factors:

- Physical needs: Everything which demonstrates a good state of physical health is assessed, that is, a good diet, sleep quality and conditions, vitamin deficiencies, excess weight, prevention and/or caring for lesions from chronic illnesses, sufficient sensory stimulation, body development, physical exercise, awareness about the need to take care of oneself (knowledge of the evolutionary stages of development, committing to keeping sufficiently healthy, brushing one's teeth, attending check-ups).

- On a psychological level: All psychological variables which could increase vulnerability to developing mental health problems are taken into account in order to mitigate them. This will have an impact on intellectual stimulation, the development of pro-social attitudes, beliefs and values, self-esteem, care and the emotional and affective development of the child, both in their personal relationships and in their relationship with their family, and in those with equals and in other contexts the young person finds themselves in, implementing coping and conflict resolution skills.

- On a social level: A social structure fostering protection from mental health illnesses and antisocial behaviour should be encouraged, fostering and promoting a situation where the young person can participate in healthy and positive social networks and contexts, both through leisure services and through training or through services in any other area.

98 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

99 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government.

Ethical issues

A forensic evaluation of a child for court purposes is different from that in a treatment setting. Therefore, at the outset of the interview the evaluator should ensure that the child understands the purpose and process of the evaluation. Informed consent to this should be obtained before proceeding. The child should also have had the opportunity to consult with a lawyer before being interviewed. Generally, clinical practitioners will uphold confidentially unless a patient is:

- Self injurious or suicidal
- Assaultive or homicidal
- Presents a clear and present risk of escape or the creation of disorder

In an evaluative situation, there are less guards on confidentiality as the client is not the patient but the law enforcement agency. Therefore, when the expert is interviewing the young person it is essential that the non-confidential nature of the interview is understood properly by the young person.[100]

Trial

Free legal and judicial assistance are necessary to guarantee the young person's defence. It must be recognised that young people with mental health problems are less likely to understand that they have a right to a lawyer, or to be able to instruct the lawyer. Therefore the lawyer should explain to the child their rights, and make sure they understand them.

GOOD PRACTICE NETHERLANDS: WEBSITE FOR CHILDREN

This website for young people by the Public Prosecution **www.vetverkeerd.nl** contains information on the judicial procedure for young suspects.

The young person should be informed immediately, in a language they understand and in a detailed way, of the nature and causes of the charges brought against them, without being obliged to say anything or admit their guilt.

100 Romero-Bosch, L et al (2007) 'Ethical issues of youthful offenders: confidentiality; right to receive and to refuse treatment; seclusion and restraint' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

The young person has the right to be heard directly. This right should be fully respected at every stage of the proceedings, from when they are charged, when the child has the right both to remain silent and to be listened to by police as well as by the judicial authorities or other competent authorities, to when they are tried, until sentencing is passed and the imposed measures are executed. In communication, preference should be given to the use of spoken communication over written. When written communication is used it should be in easy-reading formats with appropriate language so that young people with difficulty understanding can comprehend everything that is said to them.

Sentencing

In order to make an appropriate decision regarding the young person, judges need to have both information on the young person's background, and knowledge of the available local services. They require:

- Early information regarding a young person's mental health
- Proportionate and timely psychiatric reports
- Access to information and advice about local mental health services in order to make good use of community disposals
- Links to diversion services where they are available.

When the trial or hearing is over, the judge or competent authority must pass a 'not-guilty' or 'guilty' sentence. The dominant opinion is that the capacity for guilt should be excluded when the disturbances caused by a mental illness or addiction are of a considerable intensity. The severity of a guilty sentence should be proportionate to the crime. It should also take age, physical and mental welfare, development, abilities and personal circumstances into account. It must be explained to the young person that they have the right to appeal before a higher authority against the ruling finding them guilty of the charges laid against them and against the measures resulting from the guilty verdict.

Specific exercises/discussion points for training

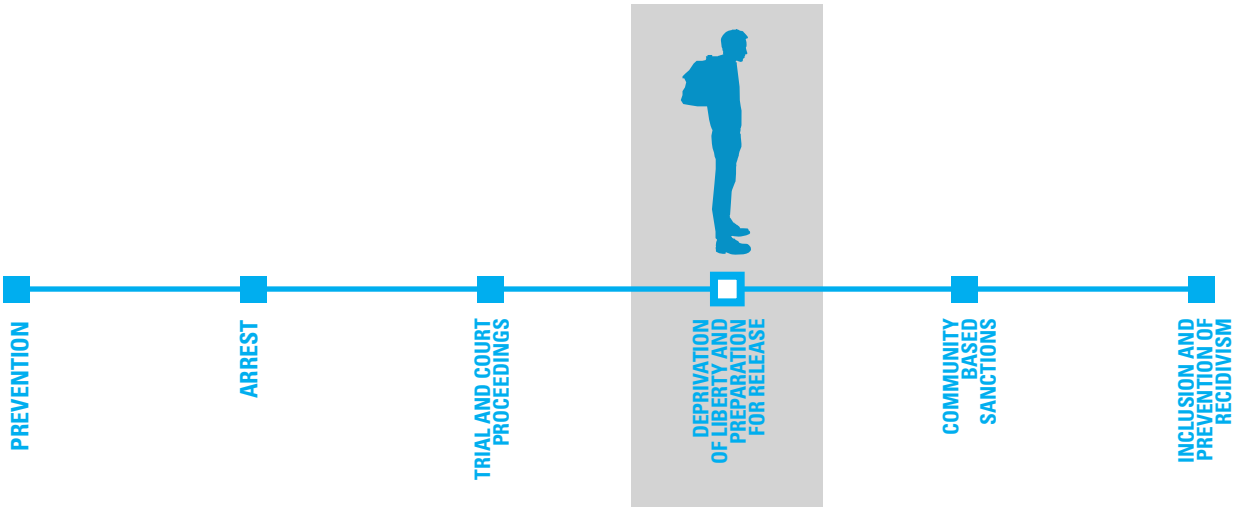
Questions

- How can the concepts of serious, appropriate, and fair consequences for criminal behaviour by young people be balanced with their mental health problem?

- How should young people with a mental health problem be made accountable for their actions?

Exercise

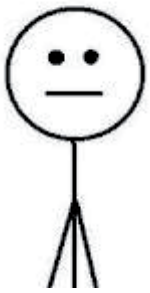
If you were a lawyer representing a child who you believed to have a mental illness and who also displayed signs of co-morbidity, what steps would you take to ensure that his rights were properly upheld in court?



DEPRIVATION OF LIBERTY AND PREPARATION FOR RELEASE

Deprivation of Liberty and preparation for release

Deprivation of liberty is used as a punishment and as a way of rehabilitating young people who have committed crimes. Depriving a child of their liberty is psychologically and physically harmful to the child. For young people with a mental health problem, illness or disorder, being deprived of their liberty can be even more dangerous for them and those around them. The prevalence of psychiatric disorders is very high in young people in detention with 95% suffering from a mental disorder or substance misuse problems in the UK.[101] A study from the US shows that nearly two-thirds of males and nearly three quarters of females met the diagnostic criteria for a mental disorder and 92% of all participants in the study reported having experienced at least one trauma. There were also significant levels of depression among this group.[102]



The child's needs at this time

The child in detention needs a clear, defined and coherent structure. This entails a strict yet flexible framework, and being mindful of their personal, social, physical, relational, psychological and psychiatric characteristics. They need:

- **To be informed, of his or her rights and obligations.**
- **To be listened to, to be treated seriously and fairly, and to be able to express his or her opinion.**
- **To be able to play an active role in the workings of the establishment and to be able to make choices about his or her environment and sentence plan.**
- **Close and frequent contacts with parents, or guardians, or with chosen relatives.**
- **To have treatment for any mental health problems, illnesses or disorders that they may be suffering from.**
- **To be able to develop healthy personal and social relationships with staff and other young people.**
- **To be kept safe and have any risky behaviour (substance use, inappropriate sexual behaviour, violent behaviour) worked through.**
- **To have their ability for self-sufficiency developed such as dealing responsibly with money.**

101 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government

102 Teplin, L et al (2007) 'Psychiatric disorders of youth in detention' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

Key professionals involved during deprivation of liberty and preparation for release

The prison establishment staff is the most prevalent professionals at this time of the young person's pathway. However, other important professionals also work with the young people at this stage:

- Detention centre staff/ security officers/prison wardens
- Schools, educators, teachers
- Employers, vocational workers
- Employees of juvenile shelters/hostels
- Therapists, psychologists, psychiatrists, forensic psychologists, Neuropaediatricians, health care staff, doctors, counsellors and occupational psychologists
- Probation officers/social workers
- Public prosecutor, Judge
- Defence lawyer
- Chaplain, vicar, priest, mullah, other religious representative

What you can do

Staff working in detention facilities is most likely to observe changes in the condition of a young person signalling the onset of possible mental health problems. It is also the case that the social environment of a unit or a wing affects the emotional state of the young people and has an enormous impact on the overall quality of the custodial experience. The ability to observe young people is essential to assist other staff to make proper assessments or diagnoses of mental health. To help the young person you need to:

1
Be trained in children's needs, how to listen to a child, how to develop a close relationships based on trust and respect

2
Bear in mind how harmful and damaging staying in isolation or in an unfriendly environmentcan be for the future development of the child

3
Understand the evolutional development of young people and be able to detect mental health issues

4
Remember that the child is an adolescent, they are still growing, and may be displaying normal adolescent characteristics such as egocentrism, narcissism, emotional immaturity rather than an particular mental health problem

5
Keep highly motivated

6
Be tolerant, try not to get frustrated, be creative and emotionally stable

Crucial intervention points

Remand

Deprivation of liberty prior to trial must be avoided unless the young person is considered a danger to the public. The transitory nature of being on remand, and the uncertainty as to the length of remand makes it difficult for the young person to undertake any medical treatment and/or engage in vocational and educational activities in any structured or meaningful way. It is therefore likely to be harmful to the young person.

Transfer and admission

By the time a young person comes into the reception at a secure establishment, they should already have been assessed for mental health problems at least once by the police or the courts. They may also have had previous contact with health services outside. If so, it is important that all the information from these previous assessments is obtained by the custodial setting. If they are, they can be used to inform the assessments and work undertaken by the custodial establishment itself.

It is extremely important to ensure that the child knows why they have been detained and about the measure imposed. Furthermore, they should be told in a clear and comprehensible way about their rights, responsibilities and the characteristics of the detention centre they are in. For young people with mental health problems, illnesses or disorders the adaptation process can be slower than for other young people. It may be that owing to their characteristics they may find themselves out of touch with the reality around them, lost in thought, absent. If this is the case, it is better to give them crucial information in small chunks in order to facilitate their understanding. When communicating with a young person, it is important to do so in a language which is understandable to the child and with due consideration given to their state and situation.

GOOD PRACTICE NETHERLANDS:
DESTINATION TREATMENT FACILITY

Psycho Medical Consultation (PMO) is care consultation that coordinates the individual's care, and takes account of multidisciplinary needs assessments and diagnosis. It is conducted by the facility physician, nurse, child and youth psychiatrist and a psychologist (and sometimes pedagogue) as part of a multi-disciplinary team. The psychologist functions as chairman and it focuses on young people who require special care, to support the treatment team.

The first night and week after admission

The first night in custody is the most crucial point in a child's detention as it is at this time that they are most likely to self-harm or commit suicide. Among all children, those incarcerated are at the highest risk of suicide attempts. In the USA, most suicide victims are young white males arrested for non-violent offenses who were found to be intoxicated at the time of arrest.[103] Indeed, studies show that completed suicide among children aged 10-18 was almost 5 times more likely to occur if the child had been drinking.[104] These young people are typically found dead within 24 hours of arrival usually hanging by bedding or clothing.[105] Other studies show that following the first 24 hours, the first week is a high risk period of suicide attempts. A study identified that slightly over half of prison suicide victims committed suicide within the first 6 days of being admitted to custody, proving that assessment of children within the first 24 hours, and subsequently within the first week has been proven to reduce their likelihood of self harm and suicide attempts.[106]

It is crucial that children receive a mental health screening within 24 hours of admission to a facility. This screening should address acute mental health problems including psychosis, risk for suicide and self-harm, psychiatric medications, substance abuse and risk for assaultive behaviour.[107] It is also advised that all facilities have a written suicide prevention policy that all staff understands. It has been proven that facilities that have suicide prevention programs have documented a reduction in the number of suicide attempts. Staff should be trained to detect mental disorders that are overlooked at intake or are likely to arise during incarceration such as depression.[108]

Children with a history of sexual abuse, affective disorders or borderline personality disorders are at high risk of attempting suicide.[109] Suicidal children are more likely to feel isolated, receive fewer visits, write few letters and miss loved ones more than non-suicidal children.[110]

103 Smajkic et al (2007) 'Suicide and delinquent adolescents' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

104 Simkin, D (2007) 'Substance abuse in youth offenders' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

105 Smajkic et al (2007) 'Suicide and delinquent adolescents' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

106 Smajkic et al (2007) 'Suicide and delinquent adolescents' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

107 Teplin, L et al (2007) 'Psychiatric disorders of youth in detention' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

108 Teplin, L et al (2007) 'Psychiatric disorders of youth in detention' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

109 Smajkic et al (2007) 'Suicide and delinquent adolescents' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

110 Smajkic et al (2007) 'Suicide and delinquent adolescents' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. Cambridge.

Planning interventions

From the moment the young person is detained, an intervention plan should be designed to foster their progress, with an ultimate goal that, when the moment comes for them to be released, they can re-join society in an autonomous and participative way.

It must be remembered that progress towards goals with young people can be slow and this can be especially true if the young person has a mental health problem, illness or disorder. It is therefore important to have realistic expectations that are in line with the child's situation, since it may be the case that, in spite of the advances they make, they will still require continual monitoring and oversight on every level.

Care planning

Teams working with young people who have conduct disorder, developing other personality disorders or those who display a multitude of complex needs can benefit from a care plan. The care plan should:

- Identify clearly the roles and responsibilities of all health and social care professionals involved.
- Identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them.
- Identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term aims.
- Develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of hours teams and crisis team) when self-management strategies alone are not enough.
- Be shared with the general practitioner/doctor.

National Institute for Health and Clinical Excellence (2009) Borderline personality disorder treatment and management. NICE guidelines 78.

The designing of the intervention programme should be undertaken by setting objectives in:

- Psychiatric or psychological improvements
- Educational attainment
- Vocational and skill based attainment
- Pro-social behaviour

The plans for interventions should be adapted to each young person's characteristics, situation and mental health problem, illness or disorder. It should incorporate the different activities that structure their day-to-day life, which in turn should be designed in order to help the young person acquire skills and strategies for coping.

The involvement of the child's family is of great importance. From the moment the child arrives, there should be a parallel intervention with their family, ensuring they are aware of the characteristics of the centre where their child has been detained, promoting a participatory and involved role, generating a relationship of trust and highlighting the role of the family in providing support and setting a regulatory and emotional example for the child. It is crucial that within this, family relationships are to be strengthened through family therapy if relevant.

In planning interventions, it is important to have a holistic approach to mental and emotional health. In custodial establishments this means having a range of non-health activities such as reading, painting, going to the gym and receiving support from others available. It is important to aim for the whole custodial setting to be set up to support emotional wellbeing.[111] In addition, staff members should be aware that with such high levels of trauma in their backgrounds, common practices such as using handcuffs, searches, or locking the children in their cells can bring back traumatic feelings and trigger post traumatic stress symptoms.[112] The environment should be designed to be a safe and secure environment for these young people.

111 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government

112 Teplin, L et al (2007) 'Psychiatric disorders of youth in detention' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

GOOD PRACTICE PORTUGAL: DESTINATION TREATMENT FACILITY

In Portugal, interventions are developed in a four phased strategy. Each phase allows for both progression and regression, depending on the level of accomplishment of the young person in meeting the goals of the intervention plan:

- Reception phase
- Progressive phase 1 (educational intervention is carried out and, in addition to attending training programmes and other activities, the young offender develops interpersonal competence, learns how to cope with negative emotions and how to solve day-to-day problems, the relationship with the family and the various aspects and effects of his or her deviant behaviour are also subject of reflection)
- Progressive phase 2 (consolidation of the progress made during the previous phases, development of autonomy and responsibility, enhancement of change-oriented competence and self-confidence, importance of reparation and strengthening family ties)
- Departure phase (preparation for release)

Treatment

Mental health in-reach teams are an important part of the process where a young person is detained in a normal custodial setting. It is a good way of linking health care and prison services. It is also important to link these services to drug and alcohol services.

Managing insomnia

Secure establishments are daunting and noisy places especially at night time. In addition to shouting that may take place on landings, young people are also likely to suffer from insomnia. If a young person suffers a mental health problem this can be particularly difficult for them. Ensure that all young people have advice about sleep hygiene including having a bedtime routine, avoiding caffeine, reducing activities likely to defer sleep such as watching violent or exciting television and employing activities that may encourage sleep such as reading.

National Institute for Health and Clinical Excellence (2009) Borderline personality disorder treatment and management. NICE guidelines 78.

Treatment should be adapted to the individual. Pharmaceutical prescriptions can be a useful tool in some cases. However, it can be the case that a child may receive as many as three concurrent diagnoses meaning that children can be placed on multiple medications without a clear understanding of their interactions or the functional result in helping the child. There must be vigilance on the part of professionals in secure settings to ensure that this does not happen. In addition, comprehensive physical examinations must be conducted to ensure that there are no harmful side effects for the child from any medication they are taking.[113]

Children must be ensured that they are informed of the medication they are receiving and give their informed consent. Whilst it has historically been un-permitted in hospital settings for a patient to completely refuse treatments, evaluations or interventions, usually patients should be allowed to refuse specific treatments that they disagree with.[114]

Child sex offenders

Child male sex offenders are most likely to be diagnosed with paraphilias or conduct disorder and female sex offenders are most likely to be diagnosed with mood disorders and engage in self-harm. In one study 92% of male sex offenders had conduct disorder, 67% had a narcissistic personality disorder, and 72% had a borderline personality disorder. Child sex offenders have higher rates of schizoid, dependent and avoidant personality disorders.

Recent assessment tools have been developed for child sex offenders (Worling & Curwen 2001)
The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)
ERASOR-2

In terms of treatment cognitive behavioural therapy is considered the most useful therapeutic model if they focus on taking responsibility for behaviour, develop victim empathy and develop skills to prevent reoffending. Those who are unable to admit their crime or show remorse are likely to need more input before they can benefit from therapy.

Belsky, et al (2007) 'Juvenile sex offenders' in Kessler & Kraus (Eds)The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

113 Karnik (2007) 'Psychopharmacology and juvenile delinquency' in Kessler & Kraus (Eds)The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

114 Romero-Bosch, L et al (2007) 'Ethical issues of youthful offenders: confidentiality; right to receive and to refuse treatment; seclusion and restraint' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

It is especially relevant to make the child accountable for their actions, both when it comes to the events which lead to the judicial measures, and in terms of being responsible for themselves in their day-to-day life. This can include things such as taking medication, being aware of their vulnerabilities and risk factors.

Those with substance misuse problems are often excluded from mental health services and those with significant mental health problems from substance misuse treatment. It is important to establish greater links between these services. It is recommended that inter-departmental strategies be developed for certain young people in custody.[115]

GOOD PRACTICE NETHERLANDS: DESTINATION TREATMENT FACILITY

From 2010, all institutions have a destination treatment facility. These are specialist units for young offenders who need treatment which requires specialised knowledge. Within the treatment facility, all young offenders receive intense help and treatment:

- The FOBA (forensic observation and guidance department): for young offenders in a psychological crisis that must be stabilised. For example, people with serious drug dependence and dissociative disorders are often referred to FOBA. They then stay there for several weeks, are set on the right medication and then return back to 'their' JJI.
- The mild mental disabilities (LVG-section): for young offenders with a low IQ (between 55 and 80).
- The Very Intensive Care (VIC-section) for youngsters who need extra assistance because of a psychiatric disorder or personality disorder.
- The ESP-division: for youth who have serious sexual problems.
- The Individual Route Department (ITA): for young offender who seriously disrupt the group process, so that they have a negative impact on their peers. At the ITA they receive individual treatment.

115 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government

Restraints and seclusions

Seclusions and restraints must only be used in emergency situations when the child or other children or staff members are in danger.[116] Seclusions and restraints can only be used in the following circumstances:

- To prevent clear imminent harm to the child or others
- To prevent significant disruption to treatment program or physical surroundings[117]

Restraints should never be used to change or control a child's behaviours.

116 Romero-Bosch, L et al (2007) 'Ethical issues of youthful offenders: confidentiality; right to receive and to refuse treatment; seclusion and restraint' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

117 Romero-Bosch, L et al (2007) 'Ethical issues of youthful offenders: confidentiality; right to receive and to refuse treatment; seclusion and restraint' in Kessler and Kraus eds The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

Specific exercises/discussion points for training

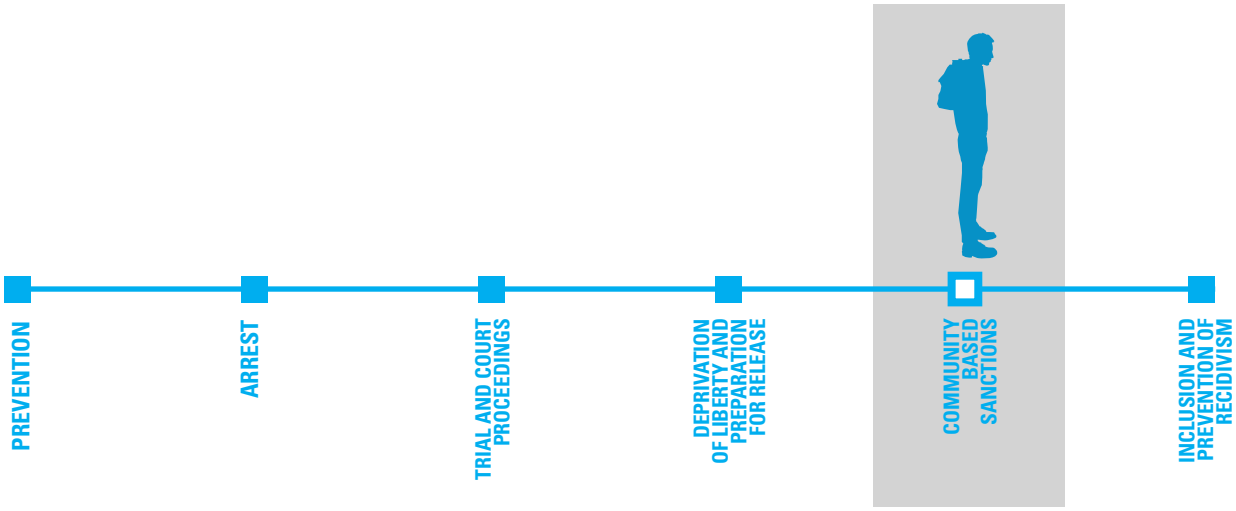
Questions

- Healthcare staff working in the reception area of the secure centre may be the first to notice potential problems with a prisoner's state of mental health. What should they do if so?

- What is the best way to manage bullying among young people in a custodial setting? How could a young person's mental health problem be affected by a bullying culture?

Exercise

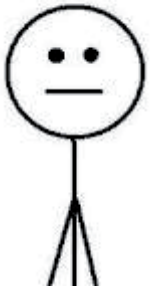
If you were to write a new care plan for a young person on a 6-month sentence who had depression and hyperactivity what professionals would you want to consult with? What sort of interventions would you include in the plan and how would you measure success in treatment of the young person?



COMMUNITY BASED SANCTIONS

Community based sanctions

Community based sanctions are those punishments imposed by a judge for the young person to carry out in the community. They can involve an obligation to behave in a certain way, correct wrongdoings, perform specific work, or participate in educational classes. They usually also require supervision from an appropriate body such as a social worker or probation officer. At every stage of the process, a sufficiently-broad range of community sanctions and measures should be available. These should be adapted to the specific needs of the child.



The child's needs at this time

The child given a community sentence will have to balance their freedom with the responsibilities of sticking to their community programme. They need to be accountable for their actions and aware of the importance of not reoffending. In addition they will need:

- **To be informed, at every phase of the community programme of his or her rights and obligations**
- **To be listened to, to be treated seriously and fairly, and to be able to express his or her opinion**
- **To have treatment for any mental health problems, illnesses or disorders that they may be suffering from**
- **To be helped to develop personally and acquire new skills;**
- **Help to improve their relationship with their parents and/or guardians.**

Key professionals who undertake community based sanctions with young people

In the community there are many actors who are key to a young person successfully completing a community order:

- Police officer
- Juvenile public prosecutor, judge
- Youth probation employee, youth offending team worker, probation officer youth/social/work organisations
- Psychologist, psychiatrist, nurse, doctor therapist
- Teachers
- Agencies in charge of community projects for young people
- Residential and security staff
- Mentors

What you can do

1
Ensure that you are familiar with the facilities in the area

2
Have a clear understanding of the child's personal and social situation

3
Ensure the objectives of alternative measures are in line with the general reintegration programme, reinforcing concrete objectives or implementing certain skills and/or tools

4
Be trained in child's needs, how to listen to a child, how to develop a close relationship based on trust and respect

5
Be tolerant, try not to get frustrated, be creative and emotionally stable

Crucial intervention points

Supervising a community sentence

Supervision of a social worker or probation officer is necessary to ensure that the community sanction is being carried out. Ideally during the period of supervision, the appointed officer should help, not only the child, but also the whole family, to develop socially accepted behaviour, and to reduce negative habits. Probation officers should be an entrusted person who is able to establish a closed relationship with the child.

Attendance and 'drop-out'

Young people in the criminal justice system and young people who have a mental health problem are often poor at attending interventions or appointments. In order to increase their attendance, set up:

- Clearly defined procedures for monitoring attendance and engagement in programme elements
- Tight, but supportive supervision for the young person
- Clear lines of communication between relevant professionals providing the various elements of the intervention
- Support of parents/carers in encouraging the young person to attend and participate
- A focus on attendance and participation in sentence management review meetings.

This might be particularly relevant for young people who 'externalise' their behaviour as they are more likely to 'drop out' of interventions. When this is the case, parental strategies for structuring, monitoring and supervising the young people is even more important.

Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

It is important when supervising a community order to set objectives adapted to the young person's reality and ability. The goals need to be achievable in the medium- to short-term, and realistic in the given environment and timescales.

During the supervision of a child, it is important to develop pro-social attitudes and beliefs in them. This is in order to foster the autonomous and positive integration of the young person into society. Good supervision and community sentences will foster the involvement of the family and social network and encourage the child to desist from criminal activity by engaging in positive activities, education and work. They are most effective when they are designed to directly deal with the circumstances of the offence.

GOOD PRACTICE NETHERLANDS: MULTIDIMENSIONAL TREATMENT

Dimensional Family Therapy (MDFT): Designed for young people between 12 and 18 years old who exhibit serious behavioural problems ranging from excessive alcohol or drug use, truancy, running away and all forms of antisocial and / or criminal behaviour. MDFT focuses on the child, his or her parents, problems at school, work and leisure. Each week, the therapist has two to three personal encounters with the child, the parents or family members together and also third parties such as teachers can be present. Depending on the severity and complexity of the problem, MDFT takes three to nine months.

Multidimensional Treatment Foster Care (MTFC)
Designed for young people aged 12 to 17 years with serious antisocial and / or criminal behaviour and antisocial thinking patterns, an above average or high risk of recidivism and an IQ of at least 70. The child is placed in an educational family where new behaviour is learned. The biological family receives assistance which prepares them for the return of the child. It is the most radical intervention in the immediate surroundings of the child and lasts from 6 to 12 months.

Interventions for mental health that have the most effect are those that are multi-modal, skills based and focused on problem solving with a cognitive behavioural approach.[118] Therapies that have been noted to particularly help children with mental health problems include family integrated therapy and dialectical behaviour therapy, as well as multi-systemic therapy, functional family therapy and multi-dimensional treatment foster care.[119] During any intervention or therapeutic process it is important

118 Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford.

119 Trupin, E (2007) 'Evidence-based treatment for justice-involved youth' in Kessler & Kraus (Eds)The Mental Health Needs of Young Offenders: Forging paths towards Reintegration and Rehabilitation. New York: Cambridge University Press.

to establish a good relationship with the young person, as well as continually monitor them. This helps maintain progress made and meet new goals. Furthermore, once the measure has been completed, it is important to pass on information regarding the goals met and recommendations in order for intervention to continue in other areas.

Non compliance

A key issue for the management of community sentences is setting the threshold at which a breach order is made in the event of non-compliance by the offender. There is sometimes difficulty in engaging with young people, particularly those with mental health problems. If the child does not comply with the conditions and obligations of sanctions or measures applied in the community where they are imposed, liberty should not be automatically withdrawn. Wherever possible, sanctions or measures applied in the community should be replaced by other modified sanctions, measures or others. The failure to comply should not automatically constitute a crime.

GOOD PRACTICE UK AND NETHERLANDS:

MULTI-SYSTEMIC THERAPY

Multi-Systemic Therapy is designed for young people with offending histories, mental health problems and those who are misusing substances. It adopts a social-ecological approach to understanding anti-social behaviour or emotional problems. The underlying premise of MST is that young people's difficulties are multi-causal; therefore, effective interventions would recognise this fact and address the multiple sources of influence. These sources are found not only in the young person (values and attitudes, social skills, biology, etc.) but also in the young person's social ecology: the family, school, peer group and neighbourhood. It is a key premise of MST that community-based treatment informed by an understanding of the young person's ecology will be more effective than costlier residential treatment.

MST involvement can be from two to five months with up to 20 hours of therapy per month. The entire family is involved with MST, in contrast to the many interventions that define the young person as the "identified client." Collaboration with community agencies is also a crucial part of MST. The school is a key player and workers may be in daily contact with teachers and administrators. The MST Team will work closely with youth justice officers, social workers or mental health workers to ensure that MST is implemented to maximum effect in the context of the requirements of the referring agency. While the initial MST involvement may be intensive, perhaps daily, the ultimate goal is to empower the family to take responsibility for making and maintaining gains. *(http://www.brandon-centre.org.uk)*

Specific exercises/discussion points for training

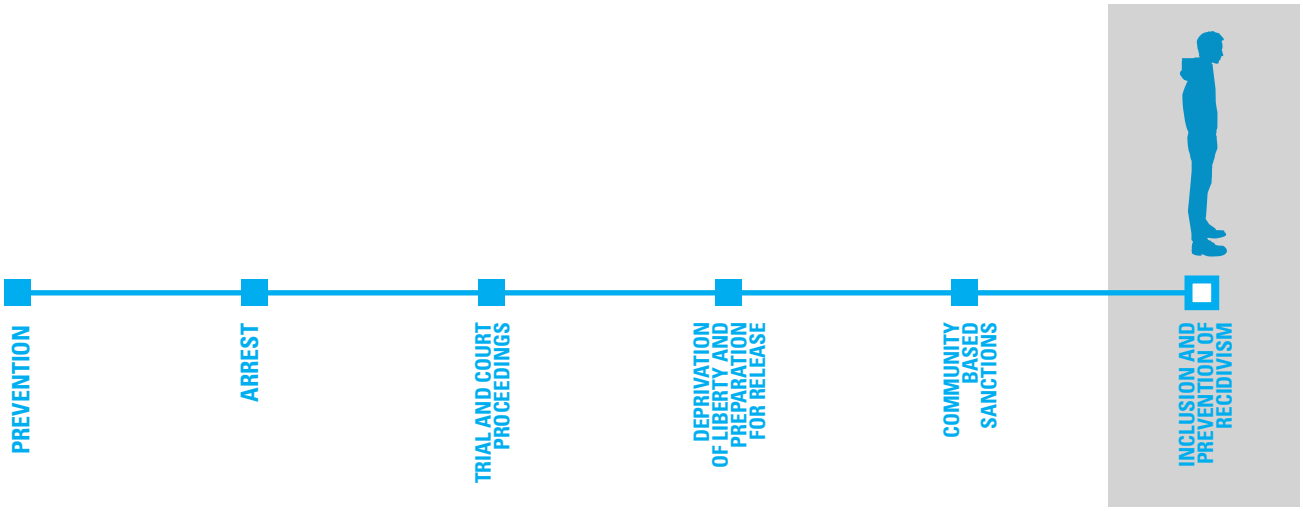
Questions

- How can community sanctions and measures be made as meaningful as possible to the young person?

- What are the best types of community sanction for a young person who has dual-diagnosis?

Exercise

Discuss whether community sanctions can be used for serious or violent offenders. If such children are allowed to participate, who should make the final decision as to a particular child's eligibility? What would be the different points of view of the judge, the prosecutor, the child and the victim?



INCLUSION AND PREVENTION OF RECIDIVISM

Inclusion and prevention of recidivism

The defined purpose of the youth justice system is to prevent and reduce offending by young people. Indeed, inclusion and prevention of recidivism should be the main goals of any measure or intervention in the field of youth justice. The lack of attention to this point is seen in many countries of the world. All components of the system are geared towards these ends although the difficulties in achieving a coordinated approach at both national and local levels remain acute. Many professionals note that for example educational efforts made during the stay of the child in a facility are wasted when the child is released and for instance has no place to live, no entrusted person to turn to when needed, no centre to cooperate with and to receive fundamental help and support necessary to start independent life.

Continuity of care

Difficulties in maintaining continuity of care can arise from:

- Poor information accompanying young people on entry into the secure estate from the community and from the secure estate to the community
- Repeated assessments of the young person as they move through the different settings
- Lack of appropriate services in the community to ensure continuity
- Young people refusing to engage

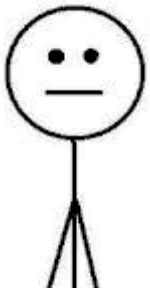
In order to provide a better transition:

- Help the young person plan and practice new behaviours in increasingly challenging and realistic situations before release
- Develop a multidisciplinary transition plan involving the young person, his or her family and relevant service providers
- Monitor and anticipate difficulties that could arise after release
- Provide awareness raising for significant others (e.g. family and friends) and other relevant staff regarding relapse risks and risk situations and training in how to reinforce pro-social behaviours
- Ensure there is a clear chain of command within the transition period to ensure that emergencies are dealt with efficiently
- Make sure professionals know who to contact if they have a concern about a young person's welfare.

Stephenson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

Effective follow up care should be provided for all children leaving educational and correctional centres. Achieving independence is a difficult process. Therefore, the social inclusion of young people should by particularly well organised and developed.

Community services should be made use of, so that the young person can make use of them themselves, in an autonomous and responsible way.



The child's needs at this time

Suddenly being released into the world having previously been sheltered is a disorientating time for the child. They have freedom and may not know how to deal with this. They need to be helped to:

- **Develop skills, abilities and strategies which can help them through their personal, social, psychological and psychiatric vulnerabilities.**
- **Coordinate and organise their time, both when it comes to leisure time and training or work.**
- **Have a clear idea of their new rights and obligations, and the possibilities of independent life**
- **Be helped into vocational training, work or education;**
- **Be helped to make independent decisions**
- **Be empowered to be able to make their own choices about their life**

Key professionals involved in inclusion and prevention of recidivism

Since the prevention of recidivism and mental health problems is strongly related to other social problems, it is a shared responsibility between many professionals. These include:

- Social workers, community support workers and other professionals from social services and care agencies
- Outreach workers, health visitors or other home visiting professionals
- Representatives from charities and non-government organisations
- Mental health professionals including psychiatrists
- Medical practitioners such as general practitioners, accident and emergency doctors and pediatricians
- Police officers
- Teachers, educators, and school support staff
- Psychologists, psychotherapists and counselors
- Probation officers, prison staff and correctional staff
- Youth workers and staff from sporting or cultural organisations
- National and local government representatives
- Public housing associations

What you can do

1
Remember how intimidating the outside world can be if you are not used to it

2
Remember how difficult simple processes to find work, or education can be if you are not used to them

3
Familiarise yourself with all the opportunities that are out there for the child

4
Help the child to set small attainable objectives for themselves

5
Bear in mind the child's mental health problem, illness or disorder and its implications

6
Maintain adequate coordination with different intervening bodies, in order to assess the young person's progress and adjust objectives if necessary

7
Involve the family in the treatment / reintegration program

8
Be trained in child's needs, how to listen to child, how to develop a close relationship based on trust and respect

9
Keep Highly motivated, tolerant, and try not to get frustrated.

Crucial intervention points

Transition

Studies have shown that there are many points when continuity of care for a young person with mental health problems could break down. The consequences of the breakdown in continuity are:

- Increased risk of suicide and self harm incidents for new transfers and receptions into prison
- Reassessment of individuals upon transfer between prison rather than using and building on existing assessments
- Incomplete or inadequate assessments failing to identify an individual's range and complexity of need
- Individuals who were already receiving care prior to reception into prison not

receiving it in prison, thus increasing the likelihood of deteriorating mental health state
- Individuals not being picked up within three months of release from prison resulting in disruption in treatment regimes, re-referral and reassessment by community services, and subsequent deterioration in the person's mental state
- Poor compliance by patients with resettlement and treatment regimes, resulting in possible reoffending
- In some cases, no involvement by patients in their resettlement planning compounding compliance issues and access to appropriate services
- Increased risk to practitioners and the wider community.[120]

Managing endings and transition

Anticipate that withdrawal and ending of treatments or services and transition from one service to another may evoke strong emotions and reactions from young people. Therefore ensure that:

- Any chances are discussed carefully beforehand with the young person and their family
- There is a plan to support effective collaboration between other care providers during endings and transitions and a designated strategy for crisis situations
- Time the transfer to suit the young person
- Be aware of reactions to change such as self-harm

National Institute for Health and Clinical Excellence (2009) Borderline personality disorder treatment and management. NICE guidelines 78.

120 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government

Planning for the end of the order

When planning for the release of a child, the prevention of relapses when the child comes into contact with the outside world is crucial. The release of a child should be gradual and make use of outings and day release. It is important that they gradually get used to the environment, steadily increasing both the frequency and duration of these outings depending on the child's progress.

Any time of temporary release from detention should be based on their integration into external learning situations or their participation in leisure and pastime activities which promote their social integration into their new environment. They should also be based around intervention objectives. These could be educational, family focused or to help the child to understand the outside world. The collaboration and involvement of the family is particularly important in this phase of the process, during which the intervention begins to focus on the outside world. The family and the detention centre should continue to move in the same direction in how they treat the young person, using the same rules in order to minimise conflicts and power struggles.

GOOD PRACTICE POLAND: HOSTELS

Hostels are a facility dedicated to children subjected to custodial measures, who, due to good behaviour, can complete their stay there, rather than custody. Hostels are similar to a non-secure setting. Pupils learn or work, and also have responsibilities associated with living in a hostel. Supervision is exercised by teachers in the centres rather than prison officers. Staying in a hostel aims to help in transition from the correctional facility to the society, and above all, to help students in becoming independent.

Aftercare services

Generally, reintegration services when provided for those released from custody are haphazard and un-co-ordinated. Therefore, it is important that a clear line of responsibility is passed on to the relevant service when a young person leaves custody so that they are engaged well in advance of discharge. A national strategy for rehabilitation services or a resettlement wing will help this.[121] Many young people are not registered with a general practitioner before they enter custody, therefore it is important that this simple procedure is carried out before they leave so that there is a structure in the community waiting for them when they return home. To aid this, joint health care planning should take place between mental health and drug and alcohol services on release.

Any mentoring and supervision carried out with the child should be gradually reduced and should be based on increasing their autonomy in line with the increase in responsibility. It is important to preparing for contact with the outside world, by anticipating conflict and devising strategies to cope with this. Contact should continue as much as possible post release in order to create a gradual transition for the young person.

121 Bradley (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system. HM Government

Specific exercises/discussion points for training

Questions

- What are the issues likely to be the most important for a child immediately after his or her release from custody?
- Consider how community agencies could be involved in helping children to prepare for release? How could they best work together to provide comprehensive support for those leaving detention?

Exercise

What agencies currently operate in your local area that a young person could benefit from being connected to? How many of these agencies are aware of each other's existence and work together? What steps could they take to create more of a coordinated approach to young people leaving custody?

FURTHER RESOURCES/ INFORMATION

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Part II
MHYO Advocacy Tools

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Introduction

The International Juvenile Justice Observatory's (IJJO) Mental Health and Young Offenders Manual Volume II, Section II is a toolkit for advocacy. It is aimed at helping countries to develop an advocacy program to improve the provision for young offenders with mental health problems, illness and disorders.

The IJJO believes that the most effective national advocacy programmes must be multi-agency. Collaboration between the health and the justice sector are crucial in safeguarding young offenders with mental health problems. It is anticipated that NGOs, universities, and the public administration of each country will work together during this process. This is the most important part of any advocacy campaign. It is hoped that through a multi-agency campaign involving all stratas of civil society, a common understanding of the needs of young offenders with mental health problems, illnesses and disorders, will be reached and their rights upheld.

How to use this toolkit for advocacy

Three tools have been developed to aid each country in their advocacy programmes and are contained in 3 chapters:

1. Developing Law reform
2. Charter for the rights of children deprived of liberty with mental health issues
3. Evaluation and assessment

The three tools can be used to develop a country specific programme of action or as tools in themselves depending on each national context.

Guidelines and principles

Relevant standards, guidelines and resources

There is already a wide variety of resources in terms of standards, guidelines and resources that outline the rights of children that are relevant to young offenders with mental health problems, illnesses or disorders. Such as:

- Convention on the Rights of the Child (1989)
- Standard Minimum Rules for the administration of Juvenile Justice (1985) "the Beijing Rules"
- Guidelines for the prevention of Juvenile Delinquency (1990) "the Riyadh Guidelines"
- Rules for the Protection of Children Deprived of their Liberty (1990) "the Havanna guidelines"
- Principles for the protection of Persons with Mental Illness and the improvement of Mental health care (1991)
- European Rules for Juvenile Offenders Subject to Sanctions or Measures
- European guidelines on Child Friendly Justice

Additional useful publications which are relevant to working with young offenders who have mental health problems, illnesses or disordersare:

- The Criminal Justice Assessment toolkit UNODC (2006)
- From coercion to cohesion: Treating drug dependence through healthcare, not punishment, UNODC (2010)
- Handbook for Prisoners with Special Needs, UNODC (2009)
- Handbook on Security Sector Reform, OECD and DAC (2007)
- Health in Prisons: A WHO Guide to the essentials in prison health, WHO, (2007)
- Juvenile Justice Training manual, PRI and UNICEF (2007)
- Manual for the Measurement of Juvenile Justice Indicators, UNODC and UNICEF (2006)
- Prevention of acute drug-related mortality in prison populations during the immediate post-release period Copenhagen, WHO (2010)
- The Madrid Recommendation: Health protection in prisons as an essential part of public health, Copenhagen (2010)
- Trencin Statement on Prisons and Mental health, WHO, (2008)
- UNODC Report: Promoting Health, security and Justice: Cutting the threads of drugs, crime and terrorism, UNODC (2010)
- World Medical association Handbook of Declarations (2006)

International rights and principles

Regarding the fundamental rights of young people with mental health problems, illnesses or disorders in detention, the following existing international principles that can be quoted:

- *The International Covenant on Economic Social and Cultural Rights* (1966) Article 12.1 "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

- The *UN Principles for the protection of persons with Mental illness and the improvement of mental health care*, Adopted by General Assembly resolution 46/119 of 17 December 1991:

  > **Principle 1.1.** All persons have the right to the best available mental health care, which shall be part of the health and social care system.
  >
  > **Principle 2.** Protection of Minors. Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

  The Principles recognise that every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the body of Principles for the Protection of all persons under Any Form of Detention or Imprisonment.

- The *United Nations Convention on the Rights of the Child* (1989) requests in Article 39 '[State Parties] shall take all appropriate measures to promote physical and psychological recovery of a child victim of abuse; torture or any other form of cruel inhumane and degrading treatment'.

- The *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (Havana Rules) Adopted by General Assembly resolution 45/113 of 14 December 1990. Facilities must guarantee meaningful activities to promote health, self respect and sense of responsibility of juveniles. (…) Juvenile justice personnel should receive appropriate training including child welfare and Human Rights.

- The *UN Standard Minimum Rules for the Administration of Juvenile Justice* (Beijing Rules) GA resolution 40/33 of 29 Nov 1985, declares:

> 13.5 While in custody, juveniles shall receive care, protection and all necessary individual assistance-social, educational, vocational, psychological, medical and physical-that they may require in view of their age, sex and personality;

- The World Health Organization (WHO) in its '*Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*' signed by the Euro Ministerial Conference in Helsinki and endorsed by the Ministers of Health of the European Region, states:

> 10. We, the Ministers of Health of the Member States in the WHO European Region, commit ourselves to supporting the implementation of the following measures, in accordance with each country's constitutional structures and policies and national and sub national needs, circumstances and resources:
>
> xv. encourage the development of specialized expertise within the mental health workforce, to address the specific needs of groups such as children, young people, older people and those with long-term and severe mental health problems;

European rights and principles

Regarding the fundamental rights of young offenders with mental health problems, illnesses or disorders in detention, the following existing European principles can be quoted:

- The 2006 European Parliament resolution on improving the mental health of the population, towards a strategy on mental health for the European Union (2006/2058(INI)), Article 35.1. warns all member states that: "*Where exceptionally children under the age of 18 years are detained in a prison for adults the authorities shall ensure that, in addition to the services available to all prisoners, prisoners who are children have access to the social, psychological and educational services, religious care and recreational programmes or equivalents to them that are available to children in the community.*"

- the committee of Ministers of the Council of Europe in its 2008 Recommendation CM/Rec(2008)11 to member states on the European Rules for juvenile offenders subject to sanctions or measure, Article 28 *"The rights of juveniles to benefits in respect of education, vocational training, physical and mental health care, safety and social security shall not be limited by the imposition or implementation of community sanctions or measures."* and Article 117 *"Juvenile offenders in mental health institutions shall receive the same general treatment as other juveniles in such institutions and the same regime activities as other juveniles deprived of their liberty."*

Early assessment of mental health problems, illnesses or disorders, is called for by:

- the committee of Ministers of the Council of Europe, in the 2004 Recommendation Rec(2004)10 to member states concerning the protection of the human rights and dignity of persons with mental disorder, Article 5 – Promotion of mental health: "*Member states should promote mental health by encouraging the development of programmes to improve the awareness of the public about the prevention, recognition and treatment of mental disorders.*"

- the European Parliament, in its 2009 Resolution on Mental Health (2008/2209(INI)), Article 5: *"Calls on the Commission to propose common indicators to improve the comparability of data and facilitate the exchange of best practices and cooperation between the Member States to promote mental health."* and Article 28 *"Stresses the need for the early detection and treatment of mental health problems in vulnerable groups, with particular reference to minors."*

The appropriate placement of young people with mental health problems, illness and disorders is called for by:

- the committee of Ministers of the Council of Europe, in the 2004 Recommendation Rec(2004)10 to member states concerning the protection of the human rights and dignity of persons with mental disorder, Article 10 declares that *"Member states should takes measures to ensure sufficient provision of hospital facilities with appropriate levels of security and of community-based services to meet the health needs of persons with mental disorder involved with the criminal justice system."*

- the 2006 European Parliament resolution on improving the mental health of the population, Towards a strategy on mental health for the European Union (2006/2058(INI)) *"calls on the Commission to place the reform of psychiatry on the agenda for EU accession negotiations; considers that prison is not a suitable environment for those suffering mental ill health and that alternatives should be actively pursued."*

- the 2006 Committee of Ministers Recommendation Rec(2006)2 to member states on the European Prison Rules, Article 12.1 states that: *"Persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose."* and in Article 12.2. *"If such persons are nevertheless exceptionally held in prison there shall be special regulations that take account of their status and needs."*

- the committee of Ministers of the Council of Europe in its 2008 Recommendation CM/Rec(2008)11 to member states on the European Rules for juvenile offenders subject to sanctions or measure, Article 5 specifies that *"The imposition and implementation of sanctions or measures shall be based on the best interests of the juvenile offenders, limited by the gravity of the offences committed (principle of proportionality) and take account of their age, physical and mental well-being, development, capacities and personal circumstances (principle of individualization) as ascertained when necessary by psychological, psychiatric or social inquiry reports."*

The training of all professionals working with young people with mental health problems, illnesses and disorders is called for by:

- the Committee of Ministers, in its 2006 Recommendation Rec(2006)2 to member states on the European Prison Rules, Article 81.3 underlines that "*Staff who are to work with specific groups of prisoners, such as foreign nationals, women, juveniles or mentally ill prisoners, etc., shall be given specific training for their specialised work."*

- the European Parliament, in its 2009 Resolution on Mental Health (2008/2209(INI)), Article 29 *"Proposes that mental health should be incorporated into the programmes of study of all healthcare professionals and that provision should be made for continuous education and training in that sector."*

The collaboration among agencies appointed to the safeguard the well-being of children and young people with mental health problems, illnesses and disorders is called for by:

- The European Parliament, in its 2006 Resolution on improving the mental health of the population. Towards a strategy on mental health for the European Union (2006/2058(INI)), Article 20 *"Calls for a multi-disciplinary and multi-agency response to tackling complex mental ill health situations, such as how best to support children or adolescents with developmental or behavioural problems or eating disorders, and/or whose parents in many cases themselves suffer from mental ill health (or are kept in long-term institutions)."*

- the Committee of Ministers, in its 2006 Recommendation Rec(2006)2 to member states on the European Prison Rules, Article 40.2 points out that *"Health policy in prisons shall be integrated into, and compatible with, national health policy."*

Developing law reform

Introduction

Any reform that takes places for young offenders with mental health problems needs to have support both at the government level and from the wider community. Therefore, to be effective, reforms must include consensus building on the need for reform and how it is to be carried out.[122]

Essential elements in developing law and policy reform[1]	
Identify problems and causes Draft proposals Do a compatibility check (national law, international standards)	• Legal research, development of drafting • Ensuring access to socio-legal, economic and other empirical research • Developing discussion and consultation papers, reports and draft legislation • Reviewing compatibility of proposed reforms with international human rights standards • Reviewing compatibility with existing legislation
Cost analysis	• Researching the full cost of implementing the existing system • Examining the costs of implementing the reform • Looking at long-term and indirect costs and benefits of policy and law changes • Legal research, development of drafting • Considering which is the most effective allocation of resources across the system as a whole
Inclusive consultation Building consensus	• Discussion of consultation methods, timing and use of the responses • Use of consultants, working parties and advisory group, seminars and public meetings • Engagement with the general public and with particular interest groups • Approaches tailored to diverse populations, such as those which are large, small, indigenous, ethnic minorities, scattered, disabled, with literacy problems

122 Penal Reform International (2010) Making Law and Policy that Work: A handbook for Law and Policy Makers on Reforming Criminal Justice and Penal Legislation, Policy and Practice

Dissemination Training	• Developing a plan for engaging with government and others to ensure legislation and reform is disseminated, for example, to police, judges, prison service officials and probation services, defendants and prisoners
Monitoring and evaluation	• Ensuring internal (institutional) monitoring and evaluation • Considering the role of independent national inspectorates • Developing external (that is, civil society) monitoring processes to track the success and failures of the reforms, and to identify lessons learnt and further steps (legislative, policy etc.) needed to complete or further develop the reform programme • Developing criteria to be used for evaluation • Linking the reviews to compliance with recommendations made under international and regional treaties

Strategies that can assist the development of fair and effective law and policy reform:

- **Look backwards as well as forwards:** Look back at what has gone before as well as forwards towards future implementation, and balance the two, to see what has worked and what will work.
- **Identify the political context:** Laws are generally shaped through political processes, so the political context becomes crucial to legislative reform. Understand the power dynamics and interest groups at all levels.
- **Listen to public opinion:** Reform requires more than a textual review of existing legislation and jurisprudence and will benefit from public forums and other opportunities to gauge public perceptions of the situation.
- **Take a holistic approach.** This takes into account not only the interdependence of the various parts of the justice and health systems, but also their interdependence with the other state systems which provide social support, education and child welfare, etc.
- **Make use of good practice:** Good practice is reflected in the standards and norms that have been developed at international and regional level. In addition, practical examples of implementing those standards and norms and insight into the experience are available in neighbouring and other countries
- **Use the support available from the international agencies and organisations:** there are a variety of agencies and organisations that are able to provide technical assistance to jurisdictions in their advocacy programme.[123]

123 Penal Reform International (2010) Making Law and Policy that Work: A handbook for Law and Policy Makers on Reforming Criminal Justice and Penal Legislation, Policy and Practice

Fourth IJJO International Conference

The fourth IJJO International Conference was held on 9th and 10th November 2010 and focused on the importance of achieving a better understanding of the situation of young offenders with mental health problems, illnesses and disorders. It called for a holistic approach to the issue, which covers the child's social, family and personal circumstances. Indeed, it was established that this, and the principle of the child's best interests, should guide all prevention and intervention policies that attempt to address their mental health needs. Experts highlighted the importance of developing and improving an integrative and multidisciplinary collaboration between juvenile justice and health systems to provide an effective response to the needs of these, particularly vulnerable, children.

The outcome of discussions at the conference was a group opinion outlined in this chapter. The opinion aims:

- To raise awareness of the issues arising when dealing with children with mental disorders in the juvenile justice system.
- To expose the main challenges to be considered at all decision-making levels in order to better respond to the needs of young offenders with mental health problems.
- To improve juvenile justice responses to young offenders with mental health problems by establishing links between the health and justice systems and promoting a multi-disciplinary approach in addressing these children's needs.

Opinion on the situation of young offenders with mental health issues

Tool 1: The opinion of the 4th IJJO International Conference

The opinion can be used to:

- Show an overall assessment of the context of the situation
- Highlight the problems and needs of young offenders with mental health problems
- Provides research for inclusive consultations among key stakeholders
- Provide a basis with which to build consensus on the issue among different groups
- Engage with the general public and other civil society members
- Form the basis of discussion papers, reports and legislation
- Provide a baseline with which to assess existing national practice and legislation

The full attainment of one's mental health is a primary condition for human well-beings. The World Health Organization (WHO) has officially defined this as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.[124] When a person does not have full mental well-being, they may be said to be suffering from a mental health problem, a mental disorder, or a mental illness. Both adults and children may suffer from a problem with their mental health.

Children and young people in the criminal justice system appear to be at greater risk of suffering from a mental health problem, disorder or illness than other children. In 2005 Harrington and Bailey interviewed 300 people in the juvenile justice system and found that 'a third of young people had mental health needs, a fifth with depression, a tenth reporting self-harm in the past month and a tenth suffering anxiety and post-traumatic stress symptoms. Hyperactivity was reported in 7 per cent of the young people and psychotic like symptoms in 5 per cent. Almost a quarter had learning difficulties and a further third has borderline learning difficulties.[125] In turn, reports of the American Academy of Child and Adolescent Psychiatry indicate that 40% to 70% of young people in the juvenile justice system have some kind of mental disorder compared to 20% of young people in the general community.[126] Indeed, where 20% of youth in juvenile justice have chronic, long-term disorders, only about 10% of youth in

124 World Health Organization, The World Health Report 2001: Mental Health—New Understanding, New Hope (Geneva: WHO, 2001).

125 Stepehnson et al (2011) Effective Practice in Youth Justice: Second Edition. Oxford. Routledge.

126 Arroyo W., Buzogany W., &Hansen G. (2001)*Task Force on Juvenile Justice Reforms: Recommendations for Juvenile Justice Reform.*Washington, DC: American Academy of Child andAdolescent Psychiatry (AACAP).

the general community are of that type.[127] It is crucial to assist the two groups of young people 1) those who meet the criteria for one or more types of mental disorder and 2) those who have persistent, serious and chronic disorders. All people suffering from mental health issues have the right to receive professional help but young offenders deserve extra care. In particular incarcerated young people are a unique, understudied and highly vulnerable patient population.[128]

Mental health disorders: A widespread issue among young offenders

In comparison to the rest of the population, young offenders are more likely to suffer from poor health. Mental health problems, illnesses and/or disorders are common among both male and female young offenders. Resources for assessing and treating mental health problems, illnesses and disorders for young people are limited.[129] A study recently conducted in the United Kingdomhas shown that the primary obstacle to providing decent mental health services is funding.[130] As such, the possibility that mental disorders are undiagnosed is very likely. This means that we are unable to accurately understand the needs and risks of young offenders on an individual level and at policy level. Even where mental health problems, illnesses or disorders have been diagnosed, it appears that these issues cannot be treated because of a lack of appropriate facilities. [131]

The lack of diagnosis or treatment of mental health problems, illnesses or disorders becomes a more acute issue when a young person is deprived of his/her liberty. The WHO states in its latest publication that in many countries, resources are not directed towards providing detainees with support and care. Instead, in low and middle income countries people with mental health conditions can be abandoned or placed in long term psychiatric institutions or prisons where they very often do not receive adequate care and frequently are exposed to violations, which further exacerbate their conditions.[132]

127 Dr. T. Grisso

128 Joseph V. Penn (2008). Psychotropic Medications in Incarcerated Juveniles: Overprescribed or Underprescribed?.Archives of Pediatrics and Adolescent Medicine.

129 Commission for Healthcare Audit and Inspectionand Her Majesty's Inspectorate of Probation (2009) Actions speak louder -A second review of healthcare in the community for young people who offend.

130 Youth Justice Board for England and Wales (2005) Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community. Retrieved from http://www.yjb.gov.uk/publications/Resources/Downloads/MentalHealthNeedsfull.pdf

131 U.S. House of Representatives - Committee on government reform - Minority staff special investigation division. (2004) Incarceration of youth who are waiting for community mental health services in the United States.

132 Mental health and development: targeting people with mental health conditions as a vulnerable group. WHO. 2010

Juvenile detention centers, are not only failing to treat young people with mental health problems, illnesses or disorders, but they may often make their conditions worse. Experiencing confinement, having to deal with bullying, and being apart from beloved ones is likely to exacerbate mental issues.[133] In the case of troubled adolescents this experience can be devastating and can crystallise an existing pathology. Even more devastating could be the social stigma those young offenders get attached once having been detained in a juvenile prison, a stigma that could pose real challenges for re-entering society.[134]

Prevention, detection and evaluation of mental disorders

The social background of young people in the criminal justice system is often characterised by poverty, poor educational attainment, chaotic family lives and abuse or neglect. These factors contribute to poor mental health.[135]

Early screening for existing mental issues in young offenders is crucial. It is necessary to protect their health, and to determine the right treatment in order to prevent future criminality, as stated by the European Parliament[136] as well as by the Council of Europe.[137] In some cases it may be that young people with mental health problems, illnesses or disorders find themselves in the criminal justice system because they have not received the appropriate care by the appointed health care agencies.[138]

Screening and assessment is also an essential part of developing treatment programs for young people with mental problems, illnesses or disorders.[139] A psychological evaluation of young people should take place as early as possible in the criminal justice

133 Farrant, F. (2001) Troubled inside: Responding to the mental health needs of children and young people in prison.Prison Reform Trust. Retrieved from http://www.prisonreformtrust.org.uk/uploads/documents/Troubled_Inside_Children.pdf

134 Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé (2007) Problemesethiques poses par des demarches de predictionfondees sur la detection de troubles precoces du comportement chez l'enfant. Avis n. 95

135 World Health Organization Regional Office for Europe (2003) Promoting the health of young people in custody

136 European Parliament (2009) European ParliamentResolution on Mental Health (2008/2209(INI))

137 Council of Europe - Committee of Ministers (2004) Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder.

138 Grisso, T. (2004)DoubleJeopardy: Adolescent Offenders with Mental Disorders.Franklin E. Zimring.

139 Grisso, T. (2010). 'Guiding Principles when Developing Treatment Programs for Young Offenders with Mental Disorders'. 4th IJJO International Conference.'Building integrative juvenile justice systems: Approaches and methodologies regarding mental disorders and drugs misuse' .Rome. 2010.

process.[140]Recognising the need for psychiatric care at an early stage can prevent young people being detained in inappropriate conditions. It is also relevant to consider that the accurate assessment of a young person's mental health problem, illness or disorder is likely to reduce any danger they pose to the public.[141]

Effective diagnosis at an early stage is also likely to mean that professionals are able to intervene early and put measures in place to prevent self-harm and suicide by young people. Studies conducted in the United States found that suicide rates among juvenile detainees can be from two to four times higher than in the general population[142] and concern over this issue seems to be increasing[143]. Similarly, in Australia, research indicates that young offenders have a higher death rate than similarly aged non-offenders[144], with as many as 70 percent of deaths attributable to drug overdoses and suicide. UK research indicates that young people in prison are 18 times more likely to commit suicide than in the community.[145]

Dual diagnosis, where young people have a mental health problem, illness or disorder and an alcohol or drug problem, is also common among young offenders.[146] Within the juvenile justice system, it has been estimated that 61% of young people with a mental health problem, illness or disorder also show signs of substance misuse.[147] Co-morbidity between substance misuse and, for example anxiety or depression, increases the risk that a young person will become an adult offender.[148] Indeed, co-morbidity is the norm rather than the exception.[149] Therefore, early screening procedures should include an investigation into substance misuse again, at an early stage in the criminal justice system.[150]

140 Prinz, R. &Poulin, M.E. (2003) Evaluation Issues in Mental Health Programming in the Juvenile Justice System.Juvenile Justice Evaluation Center Guidebook Series

141 Grisso Thomas (2004). Double Jeopardy. Adolescent Offenders with Mental Disorders.

142 Hayes, L. (2000) Suicide prevention in juvenile facilities.Juvenile Justice Journal7(1), 24-32.

143 Abram K.M., Choe J.Y., Washburn J.J., Teplin L.A., King D.C.,&Dulcan M.K. (2008) Suicidal ideation and behaviors among youths in juvenile detention. Journal of the American Academy of Child and Adolescent Psychiatry, 47(3), 291-300.

144 Anne Wilson ,Phillip Tully (2009). Reintegrating young offenders into the community through discharge planning: a review of interventions and needs of youth in secure care. Australian Journal of Primary Health15(2) 166–172.

145 Prison Reform Trust (2007)

146 American Psychiatric Association (1994)Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC: American Psychiatric Association.

147 See 12

148 Grisso, T. (2008) Adolescent offenders with mental disorders.The future of children – Juvenile justice, 18(2), 143-164.Princeton University Press. Retrieved from:
http://www.futureofchildren.org/futureofchildren/publications/docs/18_02_FullJournal.pdf

149 See 6

150 Wasserman, G.A., Jensen, P., KO, S.J., Cocozza, J.J., Trupin, E., Angold A., Cauffman, E., &Grisso, T. (2003) Mental Health Assessments in Juvenile Justice: Report on the Consensus Conference. Journal of the American Academy of Child and Adolescent Psychiatry, 27(4), 752-761.

Penal responsibility of children with mental health problems, illnesses or disorders

Are young offenders with mental health problems criminally responsible?

Central to the issue of young offenders and their mental health is whether or not they can be considered criminally responsible for their actions. The criminal justice system is built on the foundation that individuals should not be convicted of an offence unless they intentionally chose to commit it and were able to make a rational choice at the time of the crime.[151]

In theory, when defendants do not meet these conditions they are found to be mentally unstable, and therefore cannot be convicted of a crime, because they cannot be said to understand what they have done. However, juvenile justice professionals tend not to pay sufficient attention to signs and symptoms of mental health problems, illnesses or disorders in young offenders. As such, they may be subject, not to acquittal, but to prolonged sentences and/or more restrictive measures.[152]

It is therefore of primary concern that young people have their mental health problem, illness, or disorder acknowledged. Their mental health issues, as well as their lack of development, are both reasons why it may be inappropriate for a young person to stand trial.[153]Legal standards on incompetence to stand trial for young offenders are still blurry. It is thus necessary to give more weight to the fact that criminal incompetence should be an impediment to conviction. Indeed, it must be remembered that young people under the age of 18 are still under the age of full penal majority and must therefore be understood to be different from adults.

Judging whether a child has a mental health problem, illness or disorder and what kind of sentence would be appropriate for him or her can be often challenging. As such, a single assessment is not sufficient for a full judgment of the defendant. Further assessments need to be conducted to verify if the sentence has been fair and then if the treatment undertaken has achieved any positive affect.

151 Arrigo, B.A. & Shipley S. L. (2005) Introduction to Forensic Psychology: Issues and Controversies in Law, Law Enforcement and Corrections. (2nd ed.) New York: Elsevier Academic Press.

152 Boesky, L.M. (2001) Mental Health Training in Juvenile Justice: A necessity. Corrections Today, 63 (5), 98-101.

153 Kruh, I. &Grisso, T. (2008) Evaluation of juveniles' competence to stand trial. New York: Oxford University Press.

Criminal system vs. health care system?

Children who display mental health problems, illnesses, or disorders by the time they are in contact with the criminal justice system will often have experienced them long before. As such, educational agencies are important in reporting risky behaviours that can possibly be linked with an existing mental health problem, illness or disorder. In turn, general health care services are responsible for uncovering, preventing and treating mental health problems.

As detecting mental health problems, illness or disorders is sometimes so difficult, often the children themselves are unaware of it. Therefore children are most often diagnosed for the first time when they enter the juvenile justice system. Although the justice system is therefore important in identifying mental health problems, illness or disorders[154], in many countries the system does not have the resources for providing mental health screening and/or treatment to all those who would need it.[155]

Therefore, two challenges face experts trying to develop policy and practice for dealing with young people with mental health problems, illness or disorders. First, recognising the limits of their knowledge (what we can do). Second, the obligations of the system (what we should do).[156]

The only way the justice system can undertake effective care towards young people in the criminal justice system, and at the same time ensure public safety, prevent crime and recidivism, is through establishing an effective collaboration with health care services. In several countries, the justice system, once concerned about psychological issues only in relation to criminality, has recently re-evaluated the role of psychologists and the importance of psychological matters in young people's lives, in regards to the respect for their fundamental rights as individuals (for example, by recognising the weight of psychological harm as comparable to physical harm).

Psychological expertise has become more and more vital for completing an evaluation of the young person during prosecution and in detention, yet it is just as critical when dealing with their protection, safeguarding of their development and their reintegration into society.

Creating an effective collaboration between the justice system and health care means building common knowledge so that judges and forensic psychologists are working from the same points of reference.

154 Ibid
155 See 17
156 See 14

Health and justice. Need for close links

Mental health assessments, when taking place when the young person is in contact with the criminal justice system, bring with them ethical considerations. In these circumstances two opposite interests come into play: the judicial interest aims at establishing the truth and taking consequent criminal measures; whilst the therapeutic interest aims at building a relationship based on trust (therapeutic alliance).

It is essential that one interest is to be shared by both parties. That is that the children and young people's best interests must be safeguarded at all times. This is especially important for children who are suffering from a mental health problem, illness or disorder. Despite the fact that sometimes the interests of justice and health care systems can seem to be conflicting, the best interest of the child should always be the primary goal that inspires team work and cooperation between these two agencies.

If mental health professionals involuntarily discover information that could be relevant for trial it should be disclosed only if this information is regarding real risks to the child or others. Nevertheless, even in that case, they should only be used by professionals where strict information sharing guidelines are in place. Mental health professionals' first task, however is not to investigate the child's guilt but to establish their competence for assessment and therapy. Nevertheless, it appears that in practice there is a lack of communication and transfer of information between juvenile justice and mental health stakeholders. This can prevent the continuity of regular treatment and sees the development of measures that do not take into account the background of the young person and their risks and needs.

Providing the child with the means to recover from a mental health problem, illness or disorder and their full reintegration into society, should be the ultimate shared mission of both the justice and the health care systems.

Multi-disciplinary training of stakeholders and professionals

Many different professionals come into contact with young offenders with mental health problems, illness or disorders to varying degrees and at different stages of the criminal justice system. These professionals include judges, lawyers, probation officers, supervisors and correctional facilities workers. The question is: are they always aware of the mental health issues that are there? Also, mental health professionals are often unfamiliar with judicial rules and the opportunities that influence the possibilities for treatment.

An individualised response to children and young people suffering from mental health problems, illness or disorders and those with a dual diagnosis requires the necessary coordination between all the agents and organisations involved, particularly those connected to the public-health or therapeutic services, and those belonging to the juvenile justice system. It is therefore fundamental to provide specific training for judges, legal practitioners, juvenile justice stakeholders and mental health professionals about adolescent's developmental capacities and mental health problems, and their relation to legal questions about responsibility and children rights.

Sometimes symptoms of a mental health problem, illness or disorder can appear as a sudden crisis, requiring professionals to be prepared to act with promptness. In other cases underneath apparently calm behaviour, serious challenges can hide, and may surface more in self-harming behaviour.

One of the main peculiarities of dealing with a child or young person who may be suffering from a mental health problem, illness or disorder is that their lack of maturity makes a clear assessment difficult. In fact, a behaviour that in an adult would be perceived as symptomatic, observed in a child could be identified as the normal expression of their developmental stage.[157] Age, cultural and social background must therefore also be central in completing the young person's mental health assessment. It is necessary to understand how individual, physical, social, cultural and socio-economic characteristics relate to each other, in order to develop effective interventions and policies to promote mental health, prevent delinquency and reduce the risk of offending.

When considering correctional facility settings, the outcomes of undetected mental health problems, illness and disorders can be serious for both young people and staff. Young people's mental health issues can worsen in such contexts and staff can experience burn-out and stress. Because of the time they spend with the young people, and in virtue of the relationship they can build with them, correctional facility workers are particularly able to detect early signs of mental health problems, illness and disorders and provide help. They also need to be vigilant that disposed punishments can worsen any mental health problems, illness or disorder that the young people display.

Basic mental health training is essential for all those who come in contact with young people. A cultural change has to take place whereby the focus on 'control' should be replaced by a focus on treatment. This requires a new way of thinking and acting: a

157 See 6

pedagogical approach is required. This newly acquired knowledge could contribute to create a common ground for experts from juvenile justice and mental health services to communicate and collaborate in a more effective way.

Charter for the rights of children deprived of liberty with mental health issues

Introduction

The Charter for the rights of children deprived of liberty with mental health issues is designed as a safeguarding tool. These children are in a particularly vulnerable position. This Charter therefore reminds professionals what rights these children have and how they are to be upheld. It aims to outline the specified rights that deserve the attention of all the professionals who work with children in these settings, both medical and secure staff.

The Charter presented below is a version based on the one developed in Belgium by the Ministry of Health in collaboration with the secure hospital, the Centre Hospitalier Jean Titeca in Brussels. They began the process of setting up the charter in 2010. It was aimed at those working in residential, secure hospitals that were set up for children presenting both psychiatric and behavioural problems. These children may have acute behavioural problems, such as attacking members of staff, but also require protective educational and social measures and a therapeutic framework with the ambition of integrating their behavioural rather than using it as an excuse to break up the therapeutic relationship. These residential units for intensive treatment are also known as the 'For K service' because of the names they have adopted.The first, the 'Karibu' centre, opened in October 2003.

The Charter was based on:

- the International Convention relating to the rights of the child ratified by Belgium in 1991, in particular article 24, 1°
- the International Charter of hospitalized children, developed in Leyden in 1988 by various European associations
- the abstract written by UNICEF in 2008 on the experiences of adolescents in psychiatric facilities for children (in K beds)
- the Law of the 8th of April, 1965, relating to the protection of youth aimed at

youths who have committed an act which is qualified as an offense and the reparation of damage caused by this act (the law was modified by the laws of the 15th of May and the 13th of June 2006)
- the law of the 26th of June 1990 relating to the protection of mentally ill persons
- the law of the 22nd of August 2002, relating to the rights of the patient
- the Codes of deontology that apply to the diverse professionals represented within the services which welcome minors and take as their objective the care approved by a juridical authority

The Ministry of Health in collaboration with The Centre Hospitalier Jean Titeca in Brussels worked with many professionals including judges, people working in institutions for young offenders, social partners and psychiatrists to first draft the Charter. After this, they sought the opinions of many more professionals who were collaborating in the sector of 'approved psychological and medical care' particularly in the For K service and in the residential units for intensive treatment (UTI).

The next step was to have further meetings with professionals helping children who were working in mental health services and with the Ombudswomen for children in mental health services. Finally, a draft was sent to the Minister of Health. It is hoped that this Charter, if approved by the Public Federal Service of Public Health, could be included or annexed to the Bill of agreement that governs the modes of collaboration between Belgian juridical authorities and the concerned units of medical and psychological care.

Charter for the rights of children deprived of liberty with mental health issues

Tool 2: Charter for the rights of children deprived of liberty with mental health issues

The Charter can be used by countries to:

- Develop and draft child rights legislation
- Ensure the compatibility of proposed reforms with international human rights standards and existing legislation
- Engage with the general public and with particular interest groups
- Address the needs of this particular disadvantage group and advocate on their behalf.

Taking into account... (Please add all relevant National and European rules in relation with this subject)

1. ADMISSION TO CLOSED CHILD MENTAL HEALTH INSTITUTIONS

a. Admission which has been asked for by a juridical authority (or an administrative authority that has been legally authorised by a tribunal) must be recommended by a medical authority, which is a third party (ideally medical and multi-disciplinarian).

b. Admission into a specialised facility for children with mental health problems must only take place after psychological screening and assessment and after other, less invasive treatment, such as community care, has been considered.

2. RIGHT TO INFORMATION REGARDING TREATMENT

a. Children should be informed about the results of their psychological screening and assessment, and the proposed treatment, in a language adapted to their understanding. They must also be consulted regarding medicines they are to take and informed in a way they can understand the side effects and reasons such medicines have been prescribed for.

b. Children, at either their request, or that of their legal guardians have access to a doctor, ideally their general practitioner, outside of the facility for assessment or a third opinion during treatment and to ensure continuity of care. The child should not incur any costs for this.

3. RIGHT TO PARTICIPATE IN THE FORMULATION OF TREATMENT

a. Free and informed consent must be sought as soon as possible for all treatment plans. In addition, any therapeutic action and planning must engage the participation of children and adolescents in their formulation. The right to be informed of the objectives, methods of treatment, and their daily routine.

b. Any monitoring by the assigned judicial authority of objectives and methods of the treatment plan must be integrated into the consultation procedures established in the health institutions. There must be effective joint working between these two partners and clear protocols on the boundaries of confidentiality.

4. RIGHT TO PARTICIPATE IN THE RUNNING OF THE ESTABLISHMENT AND MAKE CHOICES

a. All children have a right to make informed choices about their living environment. The ability to make choices about one's life and have an active interest in one's environment aids recovery and resettlement.

5. RIGHT TO QUALITY CARE

a. Young patients have the right to specialised quality care which is carried out by a qualified multi-disciplinary team. This team should have continual training and the child's care must be coordinated in a team of professionals, in order to allow continuity.

b. Each young patient has the right to appropriate care adapted to their individual circumstances.

c. Each unit which admits young patients must have a treatment plan approved by the competent authorities.

d. The admission to services which are reserved for young patients is to be considered as priority.

e. The prescription of a medical treatment must focus on improving health and the quality of life of the patient. Its potential invasiveness must be weighed against the objectives and expected benefits.

f. At the demand of the patient, the presence of a trusted person (a doctor or

another professional) must be made possible during procedures of admission, care and upon leaving and/or within the framework of procedures provided by the law. The methods of reimbursement for this intervention must allow for a form of specific assistance which benefits minors who do not have (or whose families do not have) the sufficient financial resources at their disposal.

6. RIGHT TO RESPECT FOR PRIVACY

a. Children and adolescents have the right to a private life which extends to the reading of their mail, telephone calls that they make and receive and conversations which they wish to keep private.

b. Restrictions should only be made in exceptional cases if they are justified from a therapeutic and/or judicial point of view.

7. RIGHT TO PERSONAL AND FAMILIAL RELATIONSHIPS

a. The right to access to one's family must be continuously observed. This right can only be restricted in severe cases where it is felt that that contact with one's family would disrupt the child's treatment and recovery.

8. CONCERNING RESTRICTIVE MEASURES

a. Measures which restrict liberty must be clearly defined in the treatment plan or in a protocol annexed to it as well as the rules of the interior order. They can only be taken by reference to medical or legal requirements. Information on these measures must be accessible and known by the persons directly concerned. The duration of restrictive measures should be limited as much as possible.

9. RIGHT TO LEGAL COUNSEL

a. All children have a right to legal counsel at all stages of the assessment and treatment in a specialised institution. They must be freely allowed to contact and converse with the legal representative either inside or outside of the institution and staff must respect the confidentially of their communications.

10. RIGHT TO EDUCATION

a. All children undergoing hospital treatment must have their right to education upheld. Innovative treatments to ensure educational engagement must be

devised to enable all children, no matter how severe their illness, to have access to education. Only in extreme cases where their medical treatment or mental health problems are so acute that education is impossible should education be halted, and then only for a set minimum period of time. All efforts to resume education must be taken as soon as possible.

11. RIGHT TO CULTURAL AND RECREATIONAL ACTIVITIES

a. Children have a right to an environment that fosters a holistic approach to their care and wellbeing. As such, they must have access to a range of stimulating cultural, artistic, sports and other recreational activities. Access to these activities is the right of all children, and is particularly beneficial to children with mental health problems as they can contribute to their positive treatment.

b. It is also desirable that hospitals should allow children to receive pocket money, and for them to be helped to manage money responsibly.

Evaluation and Assessment

Introduction

Improving services and outcomes for young offenders with mental health problems, illness and disorders requires a robust method for evaluation and assessment. The IJJO has been inspired by the UNODC Criminal Justice Assessment Toolkit for this purpose. The toolkit was designed as a standardised and cross-referenced set of tools to enable United Nations agencies, government officials as well as other organisations and individuals engaged in criminal justice reform, to:

- Conduct comprehensive assessments of criminal justice systems
- Identify areas of technical assistance
- Assist agencies in the design of interventions that integrate United Nations standards and norms on crime prevention and criminal justice
- Assist in training on these issues

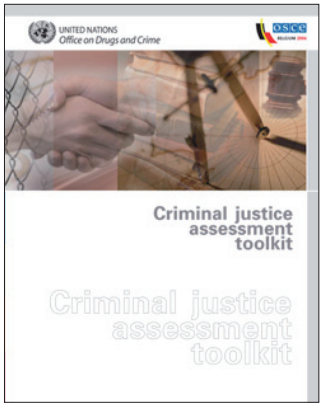
The Tools have been grouped within criminal justice system sectors, with the first four sectors as follows:

- Policing
- Access to Justice
- Custodial and Non-Custodial Measures
- Cross-Cutting Issues

The Tools are organised thematically, both to ensure ease of use and to assist the assessor in understanding the key issues confronting the system being assessed. The questions outlined in the following sections have been modified from the original handbook by UNOCD experts in order to be more relevant to the topic of young offenders and mental health.[158]

158 Any differences between the two documents are not the responsibility of UNODC.

Tool 3: The Criminal Justice Assessment toolkit



The Criminal Justice Assessment Toolkit is a practical guide intended for use by those charged with the assessment of criminal justice systems and the implementation of criminal justice reform. It can be used:

- As a basis with which to design specific evaluations and assessments of projects
- To ensure internal (institutional) monitoring and evaluation
- By independent national inspectorates
- To develop external monitoring processes to track the success and failures of the reforms, and to identify lessons learnt and further steps
- To developing criteria to be used for evaluation
- For linking the reviews to compliance with recommendations made under international and regional treaties

Policing

Police arrest and custody

The treatment of children deprived of their liberty is a key concern in terms of ethical policing. Unfair or prejudicial treatment not only impacts upon human rights, but also results in unsafe convictions where suspects are pressurised into confessing whether or not they are actually guilty.

Q.1. Does the police have an obligation to inform suspects of their rights upon arrest? Is there any special assistance available in respect of someone with mental illness?

Q.2. How are the medical needs of children deprived of their liberty dealt with? Is there a doctor on call who attends the police station? Is there special assistance available in respect of someone with mental illness?

Police Diversion

Q.1. Is the definition of insanity broad enough in penal legislation to ensure that those who are not criminally responsible for their actions are not subjected to criminal law? What is the role of the Police and their obligations in this situation?

Q.2. Does the police have the authority to divert people who are mentally ill from the criminal justice system, provided that they do not pose a threat to society? What criteria apply? How often does this happen in practice?

Q.3. If people can be referred to appropriate treatment (such as therapy for drug dependence, treatment for a mental condition), how many cases have been referred to treatment in the past 3-5 years and what were the outcomes? Is there any information on the rates of reoffending among those referred to treatment programmes? What are they?

Access to Justice

The extent to which prosecutorial discretion exists varies among systems. In some civil law systems, the decision to prosecute is made by the investigating judge after a preliminary inquiry, while in others; the public prosecutor decides whether a case should be prosecuted. Certain civil law countries follow a policy of requiring that every case be prosecuted where sufficient evidence exists to do so. This is known as the principle of legality or the concept of obligatory prosecution, in which only the lack of sufficient evidence may be the basis for declining to prosecute a case and is premised upon the principle of equality before the law—that is that all people are equal before the law and are to be treated equally when suspected of committing a criminal offence.

In other civil law systems the prosecutor has discretion to prosecute; to dispose of a case upon the fulfilment of conditions by the accused such as the payment of restitution or a fine, performance of community service, undergoing treatment or completing a programme, etc.; or not to proceed at all. Some systems grant this discretion on a limited basis, for instance, for offences whose punishment is less than a year in a detention facility while others grant this discretion, if not unconditionally, then with the broad sweep of allowing that which is in the public interest. In some civil law systems, the discretion to divert a case is vested in a judicial officer rather than the prosecutor.

In almost all common law systems, exercising discretion when prosecuting is a key function of the office of the public prosecutor, though the extent to which this is delegated down to prosecutors or held by the senior prosecutors differs. This broad discretion to do what is fair and just under the circumstance has been termed as the principle of opportunity or expediency. The exercise of discretion may depend on a range of factors over and above the adequacy of evidence. Other decisions that prosecutors make also require the exercise of discretion, such as whether to recommend the release of a suspect on bail in a detention hearing, whether to make a plea offer to a lesser charge than the primary charge, whether to allow a person to be diverted to a particular programme, though these latter two issues may require judicial approval in some countries.

The UN Guidelines on the Role of Prosecutors recognise both the potential benefits of the exercise of prosecutorial discretion and its potential unfairness if applied inconsistently or improperly. Guideline 17 requires a legal or regulatory framework that guides the exercise of discretion to ensure fairness and consistency. Guidelines 18 and 19 emphasise the value of prosecutorial discretion in resolving appropriate cases, including those involving juveniles, by using alternatives to formal adjudication. As such, prosecutorial discretion becomes a powerful mechanism to address issues ranging from reducing excessive caseloads that challenge the prison systems to the avoiding where unnecessary the stigmatisation and social costs of criminal prosecution and conviction, both to adults and particularly to children in conflict with the law. Therefore, enhancing the ability and capacity to exercise prosecutorial discretion appropriately may be a rich area for technical assistance.

Legal defense and legal aid

Q.1. What specific legal assistance can children and young people with mental health problems receive according to the law? What is the practice?

Q.2. What specific training do lawyers receive concerning children and young offenders and their psychology or possible mental issues?

The Prosecution Service

Caseload management

Q.1. Has the prosecution service implemented a screening process that allows cases to be assessed even prior to their assignment? What level of staff is assigned to screen cases? Have written protocols been developed to guide the screening of cases, including assessing the level of criminal history (if it exists), the instant offence (violent, non-violent), the quality and sufficiency of evidence, victim input, mental health and addiction issues, if any? Do these protocols include screening cases for possible diversion or alternative resolution mechanisms? Are the recommendations made by the screening staff binding upon the prosecutor who handles the case in court?

The prosecution and its alternatives

Q.2. Does the prosecutor have the legal authority to divert cases to alternatives to criminal prosecution such as mediation, treatment or community service? (Do any such alternatives exist?) If so, does this require judicial approval? At all stages? Are such alternatives limited to juveniles, drug offences, mental health, domestic violence, etc.?

Q.3. If diversion is not occurring, what are the impediments to it? For example, are prosecutors not permitted to withdraw charges? Are there no programmes? Are existing programmes viewed as ineffectual? Are there special courts dealing with classes of cases that might otherwise be diverted, such as drug treatment courts, mental health courts, family violence courts?

The Prosecution Service and its organisational management and operation

Q.4. Does the prosecution service participate in any special therapeutic courts such as drug treatment, family violence, or mental health courts? How has the prosecution service defined the role of the prosecutor on these teams?

Custodial and non-custodial measures

Detention prior to adjudication and alternatives to incarceration

In general, mentally ill young people are better treated outside detention facilities. Ideally they should be in the community in which they live, a principle recognised by the United Nations Principles for the Protection of Persons with Mental Illness for all special considerations relating to alternatives for the mentally ill. If detained, mentally ill children deprived of their liberty can often become the victims of other children in custody. They are vulnerable to assault, sexual abuse, exploitation, and extortion. In institutions where mentally ill persons are detained, it is essential to have adequately trained staff to monitor, supervise, and protect them. In comparison to the general population, there is a high incidence of mental illness among children deprived of their liberty. Therefore, specialised health professionals should be available in pre trial detention facilities and prisons, or there should be ready access to such specialists working in the civil healthcare service.

Q.1. Is the definition of insanity broad enough in the penal legislation to ensure that those who are not criminally responsible for their actions are not subjected to criminal law?

Q.2. Do the prosecuting authorities have the authority to divert persons who are mentally ill from the criminal justice system, provided that they do not pose a threat to society? What criteria apply? How often does this happen in practice?

Q.3. Does legislation allow courts to intervene on behalf of young pre-trial detainees suspected of having a mental illness, and acting on the basis of independent medical advice, to order that such persons be admitted to a mental health facility? How often does this happen in practice?

Q.4. Does legislation provide for special consideration to be given to impose non-custodial measures on mentally ill suspects at the pre-trial stage? In practice, on what percentage of/how many mentally ill suspects were alternative measures imposed, over the past 2- 3 years?

Q.5. Are mentally ill young pre-trial detainees placed under the special supervision of a medical doctor? Are they housed with other detainees or in a special unit? Are they placed in single cells?

Q.6. What kind of special psychiatric care do they have access to, if at all?

Q.7. Are there reports of abuse or violence against mentally ill detainees by other children deprived of their liberty?

The Detention system: general aspects

The number of prisoners in need of psychiatric care is rising in many countries. In fact, offenders who are mentally ill should not be detained in prisons, where they can rarely receive adequate treatment for their condition and where their mental health is likely to deteriorate. Instead, they should be given specialised care and treatment in the community. However, often psychiatric institutions and services in the community are overburdened with patients. Therefore, psychiatric patients who have committed offences may not be admitted. In addition, many prisoners may develop mental and psychiatric conditions as a result of imprisonment itself and being cut off from their families. Mental health problems arise and may become chronic in prisons with overcrowding and few activities, forcing prisoners to spend most of their time in their cells. If there is not a proper differentiation of prisoners according to risk levels, prisoner subcultures may have developed so that dominant hierarchies exist. This may affect the mental health of the vulnerable considerably, while increasing the risk of abuse that mentally ill prisoner's face from other prisoners. Measures must be taken by prison authorities to prevent such abuse, such as separation of the mentally ill from other prisoners and supervision. International instruments stress the importance of prisoners' access to psychiatric consultation and counselling. Staff members need to be alert to the symptoms of mental disturbance, and prison health services need to provide psychiatric assessments, psychiatric services and outpatient treatment. Please refe**r** to **UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare, 1991.**

Q.1. Are there large numbers of mentally ill children in detention facilities? What percentage of children are deprived of their liberty?

Q.2. Is the medical officer of detention obliged to see and examine every child deprived of his/her liberty as soon as possible after his or her admission and thereafter as necessary, to discover any physical or mental illness and to take all necessary measures? Does this include the noting down of any physical or mental defects that might hamper rehabilitation, and the determination of the physical capacity of every child to learn/work? Does this happen in practice?

Q.3. On what basis have children been diagnosed as mentally ill? For example, does the initial medical examination on admission to detention facility include an assessment of the child and young offenders' mental health? Is this standard practice? Is there evidence/a medical diagnosis to show that some of them have developed mental illness during detention? How much?

Q.4. To what extent does the detention facility's medical service provide for the psychiatric treatment of children deprived of their liberty? Is such treatment provided by specialists from civil healthcare services or by a psychiatrist of the detention facility? What does treatment consist of?

Q.5. What treatment is provided for the mentally ill? Are they transferred to specialist care in the civil health service? Are they accommodated in a special section allocated

to them with adequate medical care? Are they accommodated with other children deprived of their liberty or kept in isolation?

Q.6. Are children deprived of their liberty with serious psychiatric conditions transferred to appropriate civil healthcare facilities for treatment? How often does this happen in a detention facility visited?

Q.7. If the conditions and resources in detention facilities do not allow for Q.4 and Q.5 above, what measures are taken to protect the mentally ill from violence and abuse?

Q.8. What, if any, measures are taken to ensure the continuation of psychiatric treatment after release?

Social inclusion objectives, within the custodial or non-custodial measures

In general, mentally ill persons should be treated outside prison. Ideally they should be in the community in which they live, a principle recognised by the United Nations Principles for the Protection of Persons with Mental Illness.

Psychiatric conditions are prevalent in prison settings and prison health services need to provide psychiatric assessments, psychiatric services and outpatient treatment. International instruments stress the importance of prisoners' access to psychiatric consultation and counselling.

Mentally ill prisoners are at risk of abuse from other detainees. Measures must be taken by prison authorities to prevent such abuse, such as separation of the mentally ill from other prisoners and supervision.

Q.1. Does legislation grant courts the authority to intervene on behalf of juveniles pre-trial or detainees suspected of having a mental illness, and acting on the basis of independent medical advice or evaluation, to order that such persons be admitted to a mental health facility? UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, Principle 20.3. How often does this happen in practice?

Q.2. Does legislation provide for special consideration to be given to impose non-custodial measures and sanctions on mentally ill offenders, both at pre-trial and at sentencing stage? For example, are community sentences with a treatment element for the offender's mental illness provided for? How often does this happen in practice?

Q.3. Are the mentally ill sentenced to imprisonment or detention treated in a specialised hospital or in detention facilities? If they are treated in detention facilities, what facilities and treatment are provided for them?

Q.4. Are mentally ill children deprived of their liberty placed under the special

supervision of a medical doctor? Are they accommodated with other children or in a special unit? Are they in single cells?

Q.5. What kind of special psychiatric care do they have access to? Are specialists from the civil health care service engaged in the care of mentally ill children in detention?

Q.6. Do they have access to all suitable regime activities? Which ones? Is there recognition that the mentally ill may also suffer from problems like drug addiction and require treatment for those issues in addition to mental health treatment?

Q.7. What kind of special support do mentally ill children deprived of their liberty receive in preparation for release and post-release? Is their care coordinated with civil health care services, so that they can continue any necessary psychiatric treatment after release?

Q.8. Does the probation service provide any special support for the mentally ill? What does this consist of?

Q.9. Do social welfare services provide the mentally ill with any special support after release? What does this consist of?

Q.10. Are the rates of re-offending among mentally ill children deprived of their liberty, who have been diverted from the criminal justice process, received alternative sanctions and who have been deprived of their liberty, available? What are they? How do they compare?

Conclusion and recommendations

Conclusion

The aim of this volume was to point out the main issues that arise when dealing with young people suffering from mental health problems, illness and disorders in the juvenile justice system.

Two main challenges exist. The first is the limit of the current knowledge on adolescence in general, and the relationship between having a mental health problem, illness and disorder and engaging in criminal acts. The second is the role and the relationship between the juvenile justice system and the health care system respectively. How does one balance the need to ensure public safety whilst at the same time safeguarding children and young people's welfare?

Children and young people's antisocial behaviour is often the expression of the individual's vulnerabilities in areas such as their family situation and the social, emotional, cognitive, psychopathological and biological situation they find themselves in. It is often difficult to distinguish normal developmental problems with mental health problems, illness and disorders. As such, health care services should put extra attention into the prevention of anti-social behaviour by providing dedicated services within the community.

In addition to this, the consideration of each child's psychological situation is essential for planning the individualised interventions and treatments for their needs. Further, when mental disorders include explicitly aggressive behaviour, criminal acts are more likely to occur. This is perhaps more likely to be displayed in adolescence than in adulthood.[159] It is therefore important to underline the importance of early screening and assessment for the implementation of effective practices.

The youth justice system plays a primary role in the prevention. However, in order to build an effective prevention plan, the high prevalence of mental disorders among

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young offenders cannot be ignored. As young offenders' mental health problems, illness or disorders often derive from exposure to a chaotic environment, therapies that address the child's social environment have proven to be very effective. For example, Cognitive Behavioural Therapies[160], Functional Family Therapies[161] and Multi Systemic Therapies.[162] These therapeutic programs do not require detention: and therefore implementing them would result in considerable savings for the justice system. However, the realistic implementation of these programs cannot only be the job of the justice system. It needs the collaboration of health care as well.

Recommendations

In order to effectively advise countries on the best policies to adapt with regard to young offenders with mental health problems, illnesses and disorders, the following recommendations have been devised.

At the international level

The IJJO recommends that at the international level:

- The United Nations Committee on the Rights of the Child requests States Parties to include in their periodic reports specific information regarding the protection of the rights of young offenders with mental health problems, illness or disorders and consequently issue specific recommendations to improve their treatment according with the Convention on the Rights of the Child.

- UN agencies and bodies (UNICEF, UNODC, WHO) working in the field of children's' rights, juvenile justice and health collaborate together to tackle this issue comprehensively and issue a global report covering the key aspects of mental health and young offenders to raise awareness on the specific needs of vulnerable children with mental health problems, illness and disorders in the justice system.

- The UN Special Rapporteur on Violence against children, the U.N Special Rapporteur on Torture and the European Committee for the prevention of Torture take the situation of young offenders with mental problems, illness and disorders into consideration when conducting studies on the situation of children within the justice system, in prison or deprived of their liberty.

160 Ibíd.

161 Sexton T., & Turner C.W. (2010) The Effectiveness of Functional Family Therapy for Youth With Behavioral Problems in a Community Practice Setting. *Journal of Family Psychology, 24(3),* 339–348.

162 Henggeler, Scott W., Schoenwald, S. K., & Rowland, M. D. (2002) ***Serious Emotional Disturbance in Children and Adolescents: Multisystemic Therapy.*** New York: Guilford.

- The Members of the International Panel on Juvenile Justice look closely at the needs of young offenders with mental health problems, illness and disorders when providing technical assistance in juvenile justice reform at the national level.

At the European level

The IJJO recommends that at the European level:

An evaluation and follow up is produced of:

- the Committee of Ministers Recommendation Rec(2006)2 to member states on the European Prison Rules
- the Committee of Ministers Recommendation CM/Rec(2008)11 to member states on the European Rules for juvenile offenders subject to sanctions or measure
- the Committee of Ministers Recommendation Rec(2004)10 to member states concerning the protection of the human rights and dignity of persons with mental health problems, illness or disorders to be carried out in order to evaluate how the mental and psychological well-being of children and young people in conflict with the law are ensured by national authorities.

- The European Institutions make greater commitments towards the recognition of the needs of young offenders with mental problems, illness and disorders when designing EU policies and strategies in the field of justice, health and children's rights.

In particular:

- The European Commission should take into consideration this important issue in the drafting process of the Communication " Towards an EU strategy on the rights of the child" and when drafting the Communication on European Judicial Training.

At National level

The IJJO recommends that at National level the competent authorities:

- Take effective measures for promptly screening and assessing mental health problems, illness and disorders among children and young people to prevent their entry into the justice system and to provide regular screening among those who already find themselves in detention.

- Make sure that all children who have been diagnosed with a mental health problem, illness or disorder, at whichever stage they are along the legal proceedings, are placed within facilities that are suitable for the effective treatment of their mental health issue.

- Use 'diversion' wherever possible. Crimes committed by young people with a mental health problem, illness or disorder should not automatically result in a judicial response, but therapeutic interventions in regular health care or by means of a civil law intervention should be seriously considered.

- Set adequate training standards for all those who work in the juvenile justice system and come in contact with children and young people with mental health issues so that shared knowledge can facilitate communication at all points in the criminal justice process. Specific education based on the prevention of risky behaviour, and its consequences in terms of mental health, should be promoted.

- Promote and facilitate communication and collaboration between the general health care system and the justice system in order to safeguard the well-being of children and young people with mental health problems, illnesses, or disorders and ultimately to prevent offending when linked to it.

- Develop specific mental health policies and strategies to ensure effective treatment and prevention programs for young offenders. These programs should include opportunities for family therapy and other community-based interventions. Within the global budget of public healthcare, a specific portion should be attributed to young offenders. Interventions should focus on opportunities instead of restrictions and on the strengthening of skills/competences.

- Build up awareness among judicial, health institutions and political authorities regarding providing proper mental health resources for young offenders since the treatment of their mental health disorders can be considered as one of the aspects of the prevention of recidivism and the promotion of young people's reintegration.

MHYO Glossary

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Mental Health: Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. An important consequence of this definition is that mental health is more than the absence of mental disorders or disabilities. Achieving mental health and maintaining it consists of two functions. One is about preventing and treating mental disorders, and the other is about fostering or promoting mental health and wellbeing.
Source: World Health Organization (WHO)

- Mental health problem: A range of emotional or behavioural difficulties that may cause concern to parents and carers and / or distress to the young person. These difficulties may be short or long term. Although they affect a young person's day to day life, they may not be diagnosable as a mental disorder.
- Mental disorder: those problems which meet the requirements of *ICD-10 International statistical Classification of Disease and Related Health Problems 10th Revision*[163]. These problems are associated with considerable distress and substantial interference in a young person's everyday life. It tends to be more severe and persistent than a 'problem'.
- Mental illness: Used in the mental health sector to refer to the most severe types of disorder.

Source: Stephenson et al (2011) Effective Practice in Youth Justice: Second edition. Routledge. New York

Mental health legislation: Mental health legislation comprises legal provisions for the protection of the basic human and civil rights of people with mental illness (including those concerned with the restraint and protection of individual patients, regulation of compulsory admission, discharge procedures, appeals, protection of property, etc.), and

163 World Health Organisation (1994) ICD-10 International statistical Classification of Disease and Related Health Problems 10th Revision

those promoting or prescribing facilities, personnel, professional training, and service structures.
Source: Child Mental Health Atlas (WHO, 2005)

Child: A child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier (source: article 1, Convention on the Rights of the Child). A child is a person below the age of 10 years.
Source: Child and adolescent mental health policy (WHO 2005)

Adolescent: Although there is no internationally accepted definition of adolescence, the United Nations defines adolescents as individuals aged 10–19: in effect, those in the second decade of their lives.
Source: UN

Age of criminal (penal) responsibility for juveniles: The age of criminal responsibility for juveniles, is recognised by legal systems and refers to the minimum and maximum age when a juvenile can be responsible for his or her offending or antisocial behavior but in a way different from an adult. The minimum age of criminal responsibility differs widely owing to history and culture. The beginning of that age shall not be fixed at too low an age level, bearing in mind the facts of emotional, mental and intellectual maturity.
Source: Beijing Rules

Offence: An offence is any behavior (act or omission) that is punishable by law under the respective legal systems.
Source: Beijing Rules

Juvenile delinquency: Antisocial or criminal behavior committed by minors.
Source: English Dictionary

Juvenile justice system: A juvenile justice system is the structure of the criminal legal system that deals with crimes committed by minors. Hereby, juvenile justice is the process of bringing minors to justice for their crimes. The juvenile justice system is separate from the adult justice system, with its own legislation, criminal procedure, court, sentencing practices, and treatment and incarceration facilities. Both punishments and (educational) measures as well as rehabilitation efforts are part of the juvenile justice system. Also, diversion and restorative justice can be applied. Agencies such as health, education and social welfare institutions are generally closely involved.
Source: Council of Europe &own formulation

Antisocial behavior: Antisocial behaviors are disruptive acts characterised by covert and overt hostility and intentional aggression toward others. These behaviors miss out consideration for others and may cause intentional or negligent damage to society. Antisocial behaviors exist along a severity continuum and include repeated violations of social rules, defiance of authority and of the rights of others, deceitfulness, theft, and reckless disregard for self and others. Antisocial behavior can be identified in children as young as three or four years of age.
Source: Wikipedia

Screening: The testing of a person or group of people for the presence of a disease or other condition.
Source: Oxford Dictionary of English

Risk assessment: Evaluation or estimation of the presence of threats or likely sources of danger to the person himself and his or her environment.
Source: Oxford Dictionary of English & own formulation

Community based care: Any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community.
Source: WHO

Prevention: Prevention is a term that refers to all organised activities in the community to prevent occurrence as well as the progression of mental disorders. It also means the timely application of means to promote the mental wellbeing of individuals and of the community as a whole, including the provision of information and education.
Source: WHO

Treatment: Relevant clinical and non-clinical care aimed at reducing the impact of mental disorders and improving the quality of life of patients.
Source: WHO

Rehabilitation: Care given to mentally ill patients in the form of knowledge and skills to help them achieve their optimum level of social and psychological functioning.
Source: WHO

DSM-IV TR: The Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV TR) is the handbook used by mental health professionals for diagnosing mental illnesses. Specific diagnostic criteria are included for all currently recognised mental health disorders. Originally published in 1994 by the American Psychiatric Association, it was released in 2000 as a text revision. Earlier versions of the DSM date back to 1952. The DSM-V is planned for publication in the year 2012.

Risk factor: A factor in the individual, family, school, peer group, neighborhood or society in general that may increase a person's chance of developing a disorder or deviant behaviour.

Protective factor: A factor in the individual, family, school, peer group, neighborhood or society in general that may protect a person's from developing a disorder or deviant behaviour.

Annex - Biographies

Prof. Dr. Thomas Grisso
University of Massachusetts Medical School

Thomas Grisso since 1987 works as a Professor at the Department of Psychiatry at the University of Massachusetts Medical School, where he also performs the function of the Director of Psychology as well as of the Law and Psychiatry Program. He holds a PhD in Clinical Psychology from University of Arizona and he has also been given the title of a honorary Doctor of Law at John Jay College of Criminal Justice, City University of New York. T.Grisso is a professional member of the American Psychological Association and the American Academy of Forensic Psychology and he is certified in forensic psychology by the American Board of Professional Psychology. His professional experience in the field of juvenile justice includes conducting clinical forensic assessment of criminal and juvenile cases, analysis of mental health needs of youth in the juvenile justice system or of risk of violence among adults and youth with mental disorders. Currently he has focused his research on the forensic mental health issues in juvenile justice, publishing and co-editing many books and articles. Recent books include Evaluating Juveniles' Adjudicative Competence (2005), Double Jeopardy: Adolescent Offenders with Mental Disorders (2004), and Speciality Competencies in Forensic Psychology (2011).

Cédric Foussard
Director. International Juvenile Justice Observatory

Cédric Foussard qualified with a Degree in Public Management from the Institute of Political Studies of the University of Aix-en-Provence (France) and has a Master's in International Relations from the Escuela Europea de Negocios (Spain). He began his professional career in the field of communication as part of the French Diplomatic Corps in the United States and in Uruguay, later joining the European Research Institute in Birmingham (United Kingdom).

In 2005 he took over the leadership of the International Juvenile Justice Observatory (IJJO), focusing on the promotion of a global approach to a juvenile justice without borders. In this capacity, he has coordinated different initiatives and projects with the goal of helping the development of a juvenile justice which is tailored to the parameters and minimum standards of international rules.

He has made a notable contribution to strengthening of the exchange of knowledge, experience and good practices, which is carried out by the International Juvenile Justice Observatory, playing an equally outstanding role in dialogue and collaboration with professionals, organisations, administrations, universities and international bodies involved in juvenile justice.

Agustina Ramos
MHYO Project Coordinator. International Juvenile Justice Observatory

Agustina Ramos holds a Degree in Psychology from the University of Salamanca (Spain) and is a specialist in systemic and family therapy. She began her work in the field of intervention with minors in conflict with the law and in vulnerable situations in England. She has also been involved in social-skills programmes and social and labour integration programmes offered by penitentiary institutions.

At the International Juvenile Justice Observatory, she coordinates the management and production of resources and document collections, as well as contributing to the promotion of projects and information exchange between the experts and specialists connected to the IJJO.

Marianne Moore
Freelance Consultant and Director Justice Studio Ltd

Marianne Moore is an internationally recognised specialist in Child Protection, Juvenile Justice, Prisons and Detention. She holds a MA in Youth Justice, Community Safety & Applied Criminology, from Middlesex University (2005-2006). M. Moore is Director of Justice Studio Ltd and a freelance consultant. Her clients include IJJO, UNICEF Afghanistan and Penal Reform International. She is currently designing and implementing a diversion policy for children in Afghanistan and is providing strategic assistance to two charities working with offenders in Uganda: the African Prisons Project and Sustain for Life. She has recently spoken on auditing standards in detention for the Rights Practice in China.

Prior to establishing Justice StudioLtd Marianne was a consultantat Cordis Bright Ltd where she led three large scale reviews of detention centres in the UK for the Youth Justice Board of England and Wales. She also coached youth justice professionals improving Youth Offending Services' compliance with UK Youth Justice National Standards.

Prior to working at Cordis Bright she was a consultant at Tribal Consulting and Capita Consulting. She began her career as a project Co-ordinator at HTSPE Ltd after spending 3 months in Bangladesh as a project worker. Ms Moore has many publications in the field of Juvenile justice, including: (2011) Justice for Girls? Girls in conflict with the law and sexual exploitation in Sierra Leone.Advocaid, African Prisons Project, Defence for Children International Sierra Leone; (2011) Evaluation of the Keppel unit at HMYOI Wetherby' Youth Justice Board for England and Wales; (2010) Juvenile Detention in Uganda: Review of Remand Homes and the National Rehabilitation Centre. African Prisons Project and (2007) 'is it really so different for girls? Challenging misconceptions about young offenders and aggression' The Community Safety Journal Vol. 6:3.

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With financial support from the EU's Daphne III Programme