

# **A Guide to Youth Justice in Scotland: policy, practice and legislation**

## **Section 10: Mental Health**

**June 2021**

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## 1. Introduction

It is without question that all professionals working with children in conflict with the law have a pivotal role in prevention, early intervention and care planning for children and young people who have needs in the area of mental health. The complex needs of this particular group are now well established. As discussed below, there is growing evidence that many children and young people presenting with risk of harm to themselves or others also have histories of serious childhood adversity, and that both risk and adversity are associated with a greater likelihood of developing mental health difficulties later in childhood or adulthood (Fox, Perez, Cass, Baglivio, & Epps, 2015). For children and young people with such complex needs, early identification, or differentiation of mental health from additional needs, is vital to inform timely and effective intervention and therefore prevent escalation in difficulties over time.

Aside from the knowledge that childhood adversity itself often drives early contact from social work (which provides opportunities for prospective monitoring), key components of the social work role itself also afford excellent opportunities for promoting mental wellbeing and informing decisions about care and treatment from the earliest point. These include a unique perspective across a range of systems and routine contact with children and young people, families and those *in loco parentis*; together with legal knowledge and a role in the application of statutory legislation. This is even more true in the context of current mental health and social care legislation, which promotes a whole system approach to integrated care. Opportunities for social work practitioners to collaborate or lead in effective care include, through early identification of need or resilience, direct intervention with children and families or through undertaking collaborative interventions with multi-agency colleagues.

The aim of this section is to offer advice and guidance to practitioners working with children and young people in conflict with the law where there are concerns about their mental health. It is not a review of the evidence base, nor is it a comprehensive summary of all mental health problems and their interventions. The primary purpose is to provide key information for practitioners to raise awareness of some of the more common mental health presentations encountered in youth justice and related services. This section includes a brief introduction to the link between mental health and offending behaviour, the policy context, an overview of the typical structure of mental health services and some information on what we know about mental health needs relevant to children and young people and how these are classified. The section will conclude with some general guidance on how practitioners might respond to and support children and young people experiencing difficulties with their mental health.

## 2. Mental Health and children in conflict with the law

Although most children and young people who come into conflict with the law will naturally refrain from offending behaviour as they grow older, there are a small group of children who will persist with this behaviour into adulthood. It is well established that the population of children and young people involved in more serious or chronic offending behaviour are some of our most vulnerable young people in terms of their social, educational, emotional, physical and mental health needs, and the poor outcomes associated with these vulnerabilities.

Whilst there is limited research on the mental health needs of children and young people in conflict with the law in Scotland, this is growing (Dyer & Gregory, 2014; Mental Welfare Commission for Scotland, 2014). A study examining the mental health needs of a sample of children referred to [the Intervention for Vulnerable Youth \(IVY\) service](#) found that on average children, although not formally diagnosed, displayed symptoms of four psychiatric disorders per person, with 64% of children displaying four or more. Symptoms of attachment disorder (92%) and post-traumatic stress disorder (75%) were overwhelmingly represented in this group (Murphy, 2018).

However, enhanced need in this population has been well established elsewhere (Almond, 2012). For instance, UK population-based studies of children and young people have found prevalence of mental health problems to be between 10% (Green, McGinnity, Meltzer, Ford, & Goodman, 2005; Rees, Bradshaw, Goswami, & Keung, 2008) and 20% (Scott & Hill, 2006) of the general population. In contrast, the rate of mental health problems of those in conflict with the law tends to be significantly greater than that of the general population. Some studies have found rates of between 25% and 81% (Newman, Talbot, Catchpole, & Russell, 2012; The Mental Health Foundation, 2002), with those in custody having the highest rates of up to 95% (Lennox, 2014). Other studies have found lower rates, but still significantly higher than the general population. For example, the [Centre For Mental Health](#) reports that children who end up in custody are three times more likely to have mental health problems than those who do not and that they are very likely to have more than one mental health problem, to have a learning disability, to be dependent on drugs and alcohol or to have experienced a range of other challenges.

The most common mental health difficulties for both the general population and the population of children in conflict with the law are conduct disorders, emotional disorders, attention disorders, and substance misuse (The Mental Health Foundation, 2002), which captures the full range of emotional, social, and behavioural difficulties. However, the complexity within the population of children in conflict with the law can be understood to be relative to the higher frequency of difficulties, the greater severity of the problem, and multiple problems occurring at the same time (comorbidity). An additional factor complicating understanding of individual mental health needs in this population (and children in general) is the potential for under-identifying internalising difficulties (such as anxiety or depression), as these may be obscured by, or manifest as, externalising problems (such as behavioural difficulties). Additionally, children and young people often appear to be below the threshold required for a formal diagnosis but have subthreshold symptoms across a number of mental health difficulties which can have a significant impact on their daily functioning. Finally, the question of what way, if any, mental health difficulties relate to offending behaviours adds further complexity.

With regards to understanding why children and young people in conflict with the law may be at increased risk of experiencing mental health problems, there has been a growing body of research linking early traumatic or adverse childhood experiences not only with increased risk of serious offending across the lifespan (Fox et al., 2015), but also with increased risk of developing a range of mental health problems in adulthood (Couper & Mackie, 2016; Read & Bentall, 2012; Varese et al., 2012). For example, research has indicated that 50% of mental health problems are established by the age of 14 years and 75% by the age of 24 years, with childhood adversity having been shown to account for around a third of future mental

health problems (The Mental Health Foundation, 2002). The extent to which difficulties in adulthood are linked to experience of the above disorders in childhood or indeed the exact mechanisms involved in these links and factors associated with resilience continues to be explored in current research. Regardless, these findings nonetheless serve to underline the complex needs of this group of children and young people, but also a possible genesis in early adverse experience, which supports a focus on prevention and early identification of need (Keyes et al., 2012).

### 3. Policy Context

The UNCRC (1990) sets out the civil, political, economic and social rights of every child under the age of 18. Within its 54 articles, two are specific to health and wellbeing:

Article 24 (health and health services): Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy. Richer countries must help poorer countries achieve this.

Article 39 (recovery from trauma and reintegration): Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life.

In Scotland, policy and service developments over the years have worked towards achieving these two articles. Over approximately the last 15 years, there has been a growing emphasis on the promotion of a multi-agency approach to maximising mental well-being in children and young people. This has largely focussed on exploring service-based opportunities to prevent and respond to mental health needs in an integrated way and at the earliest point possible. These aims and principles are encapsulated in a range of strategies and policy documents released over this period. Notably, [The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care](#) built on the earlier recommendations of the [Scottish Needs Assessment Programme report](#), and proposed that all agencies have a role in supporting the mental health of children and young people.

However, perhaps the culmination of these agendas can be seen with [Getting It Right for Every Child \(GIRFEC\)](#). Since its introduction, GIRFEC has developed from a set of standards reflecting key principles to a method of informing attainment of key outcomes, many of which are now enshrined in legislation in the form of the [Children and Young People \(Scotland\) Act 2014](#). While not exclusively focussed on mental health needs per se, key components of GIRFEC embrace the idea that good mental health is not a discrete notion and is impacted by a variety of family, social, psychological, and community factors. To this extent, we can perhaps infer that early identification and promotion of good mental health is everyone's business, not just that of specialist mental health practitioners. Therefore, in promoting the best possible outcomes for the mental health needs of children and young people in conflict with the law, a comprehensive multi-agency response across different levels of mental health expertise is understood to be vital.

GIRFEC principles were further reflected in the wider [Mental Health Strategy for Scotland 2012-2015](#) which aimed to improve mental health outcomes through the introduction of

HEAT targets (Health, Efficiency, Access, Treatment) and supporting initiatives such as [The Matrix: A guide to delivering psychological therapies for children](#). HEAT targets were designed to optimise access to mental health assessment and treatment but have since been replaced by Local Delivery Plan (LDP) standards. LDP standards are priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance. The current performance on standards specific to the needs of children and young people is documented on the [Scottish Government website](#). The Matrix guide supports delivery of the above standards by providing guidance on common mental health needs in children and young people and outlining evidence based approaches to meeting these needs. Importantly, while much of this focuses on the role of specialist psychological or mental health practitioners in delivering or supervising intervention in NHS contexts, it nonetheless highlights that specific practitioners, with a range of experience and training, can be supported by specialists in delivering interventions and at various levels of intensity. These interventions can range from self-help and information sharing to highly specialist intervention - depending on level of need. While a specific role for practitioners working with children in conflict with the law is not outlined, what is clearly indicated is that early intervention, mental health promotion and working to basic psychologically informed principles should be relevant to all practitioners.

These broad aims clearly correspond with GIRFEC agendas, and health and social care integration. The Scottish Government has recently published their [Mental Health Strategy: 2017-27](#), which is the first national strategy since the integration of health and social care. It aims to achieve parity between mental and physical health provision and one of the key areas of focus is prevention and early intervention. Their ambitions for prevention and early intervention are as follows:

- Every child and young person to have appropriate access to emotional and mental well-being support in school
- Appropriate, evidence-based, parenting programmes should be available across Scotland
- Evidence-based interventions to address behavioural and emotional issues in children and young people should be available across Scotland
- Mental health support and treatment for young people involved in offending who have mental health problems should be available across Scotland
- Mental health training for non-mental health staff should be available across health and social care services
- Training in first aid approaches for mental health should become as common as physical first aid

Despite these policies and initiatives being in place, there were known anecdotal difficulties with children and young people being able to access existing mental health provision in Scotland through Child and Adolescent Mental Health Services (CAMHS). However, there was no concrete evidence of these difficulties until an audit of rejected referrals to CAMHS was commissioned by the Cabinet Secretary in October 2017. The audit was undertaken by the Scottish Association for Mental Health (SAMH) and NHS Information Services Division (ISD), and also provided an opportunity to hear the voices of children, young people and their families (Scottish Government, 2018). The findings indicated that most decisions to reject referrals were based on paper referrals without a face-to-face assessment. The report concluded that "There is a strong indication of a gap in services for children and young



people who do not meet the criteria for the most specialist help” (Scottish Government, 2018:9) and made recommendations as to how CAMHS could be improved to resolve the identified issues. The recommendations were across four broad categories: further research, meeting the needs of young people and their families, making immediate changes to CAMHS, and improving data collection. Public Health Scotland are now publishing national statistics on [CAMHS waiting times](#) which includes some information on rejected referrals.

A further report on CAMHS by Audit Scotland (2018) called for a step change in order to improve children and young people’s mental health. In particular, the report noted several key concerns around current CAMHS provision:

- Although the Mental Health Strategy is focused on early intervention and prevention, mental health services are focused on specialist care and responding to crisis
- The system is complex, fragmented, and access to services varies throughout the country
- Services for children and young people are under significant pressure

The report concluded that rectifying the situation is not straightforward as there is a lack of information available to enable service redesign, including inadequate data on mental health services for children and young people and a lack of evidence on the outcomes from use of existing services.

Scottish Ministers accepted all of the recommendations from the audit and commissioned the Children and Young People’s Mental Health Taskforce to implement the recommendations and develop a whole system approach to children and young people’s mental health in Scotland. In addition, the [Youth Commission on Mental Health Services](#), an independent taskforce commissioned by Scottish Government and COSLA has provided recommendations and advice to support the redesign and expansion of the service response to mental health issues from birth to 25 years and has emphasised preventative approaches. Since this time the [Children and Young People’s Mental Health and Wellbeing Programme Board](#) has been set up to oversee reforms in mental health provision for children, young people and their families and a set of key deliverables have been developed. The key deliverables, which sit below the ambition of having one system that supports their mental health and wellbeing needs in an integrated way, are:

- Enhancing existing community based supports and developing innovative new approaches for emotional/mental distress
- Enhancing the crisis support available to children and young people
- Strengthening local partnership planning for improved mental health and wellbeing outcomes
- Exploring opportunities to enhance the inspection focus on mental health and wellbeing outcomes
- Considering specific pathways for groups of children and young people who may be at increased risk of experiencing mental ill health, in line with GIRFEC
- Developing a CAMHS Service Specification for use across services in Scotland
- Developing a Neurodevelopmental Service Specification for use across services in Scotland

- Developing a support and improvement programme for CAMHS and Neurodevelopmental Services across Scotland
- Developing a programme of education and training to increase the skills and knowledge required by all staff to support children and young people's mental health

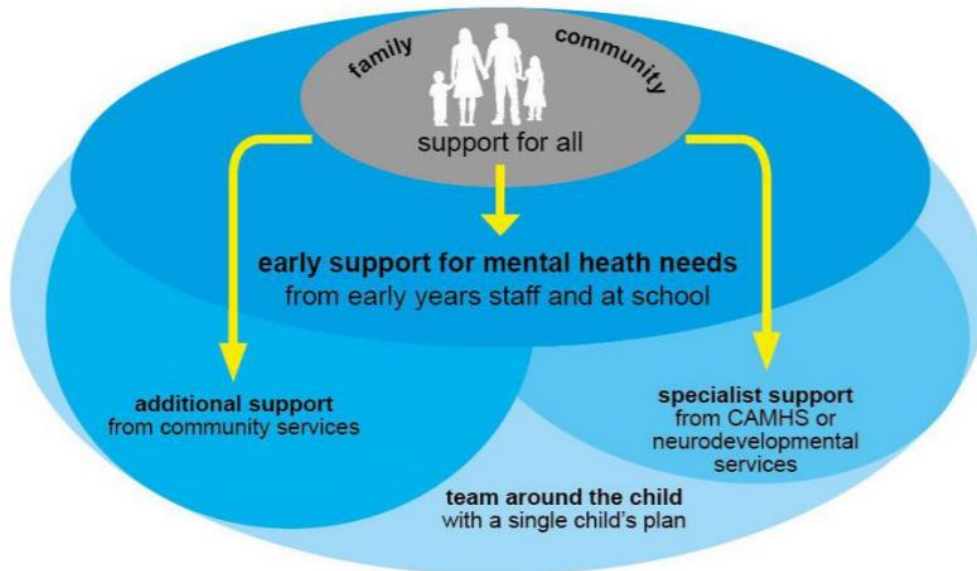
A product that has been developed through this programme board is the new national [CAMHS service specification](#). It is anticipated that the implementation of this will meet the recommendations of the taskforces and audits. The service specification outlines the provisions children, young people and their families can expect from the NHS.

At present in Scotland, CAMHS are generally delivered as part of a tiered health care system for children and young people aged six to either 16 years or 18 years depending on the area. The tiered approach is designed to help services organise and target their resources in the most helpful way. Service tiers are differentiated by level of severity or complexity of needs of the young person and/or family. There are also some variations in how a tiered model is applied across health board areas at the moment; however, the basic premise is that as it progresses from Tier 1, the more complex the actual or hypothesised mental health need, the more likely the need for specialist skills to meet that need, and possibly, the longer the duration of intervention. The tiered system of mental health care also encompasses other agencies, systems and people who may not be specialist mental health practitioners. While the current configuration of services across tiers can vary by area, every health board has a local CAMHS, to which children and young people can be referred. Depending on the locality, CAMHS may reflect a Tier 3 service, or a joined Tier 2/3 service. More populated localities will have Tier 4 teams. The only health board currently with a forensic CAMHS service specialising in working with young people at risk of serious offending and related mental health needs is Greater Glasgow and Clyde (which covers eight local authorities in either part or full).

However, the new service specification (if implemented) should bring a more consistent approach across Scotland. It states that CAMHS will be available to all children (0-18<sup>th</sup> birthday) who meet the agreed CAMHS referral criteria and there is a national referral proforma included within the specification. The following diagram from the CAMHS service specification (Scottish Government, 2020) highlights that CAMHS will support both universal and additional children and young people's services, including new and enhanced Community Mental Health and Wellbeing Supports (Tier 1 and Tier 2), by providing consultation, advice and training, and where appropriate, supervision of those staff providing psychological interventions. Tier 3 will be provided by CAMHS locality teams who will be supported by Tier 4 services which have specific and additional expertise, but are often provided over a larger area (e.g. Forensic CAMHS, Psychiatric Inpatient Care).



**Diagram 1:** CAMHS within the agreed Children and Young People's Mental Health and Wellbeing model:



In addition to the setup of CAMHS services, the new specification indicates that CAMHS locality teams (Tier 3) will provide services for a range of mental health issues and is clear that this includes 'moderate to severe emotional and behavioural problems, including severe conduct, impulsivity, and attention disorders'. It specifies that the Forensic CAMHS service "supports a range of agencies and professionals in addressing the mental health and risk management needs of young people presenting with high risk behaviours. This is conducted through clinical consultations and specialist assessments. This will often include young people in the criminal justice system, prison and secure care. This service should be delivered on a regional basis with links to and from the National Secure Inpatient Psychiatric Service (opening in 2022)" (Scottish Government, 2020).

The wider [Independent Forensic Mental Health Review](#) has also reported recently and has recommended the creation of a single national forensic mental health system and a new NHS Board for forensic mental health services in Scotland (Scottish Government, 2021). In relation to children and young people the following recommendations were made:

- The new National Secure Adolescent Inpatient Service (NSAIS) does not fall under the remit of the new Forensic Board
- The NSAIS sets up a service to provide access to forensic specialist expertise for local CAMHS teams to support clear pathways into and out of the NSAIS
- A clearly defined pathway be agreed between the new Forensic Board and the NSAIS for young people who need to transition to adult forensic mental health services
- Clear interim arrangement put in place for young people who require forensic or learning disability inpatient facilities prior to the NSAIS being opened.

Further developments have also been taking place specifically in relation to mental health provision in custody and secure care. The Report on Expert Review of Mental Health

Services at HMP&YOI Polmont reported in May 2019. HM Inspectorate of Prisons for Scotland (2019) concluded that the two high level strategic issues that warranted attention were the lack of proactive attention to the needs, risks and vulnerabilities of those on remand, and in the early days of custody and the systemic interagency shortcomings of communication and exchange of information that inhibits the management and care of young people entering or leaving the establishment. Additionally, recommendations were made about reducing social isolation; improving the sharing and transmission of information for children and young people entering or leaving custody; developing a bespoke suicide and self-harm strategy for children and young people; taking a more strategic and systematic approach to prison healthcare; developing an enhanced approach to the suicide prevention work; having more consistent learning and review processes to maximise learning; and the Scottish Government having a central coordination point to review and learn from national and international practice (HM Inspectorate of Prisons for Scotland, 2019).

In relation to secure care, the [Secure Care Pathway and Standards in Scotland](#) (2020) set out what all children in, or on the edges of, secure care should expect across the continuum of intensive supports and services, including in respect of their mental and emotional health and wellbeing, before, during and after any stay in secure care. If the Standards are to be fully implemented and meet the aim of improving experiences and outcomes for children and young people, all agencies with roles and responsibilities, including mental health and specialist support services, will require to be involved.

In the context of the above policy drivers, shared themes of early intervention, awareness of mental health, evidence based approaches and interdisciplinary and interagency working, all point to the fact that practitioners working with children in conflict with the law are key partners in a mental health response, given their role in assessing need and supporting our most vulnerable children and families. To support all relevant practitioners, a [Mental Health Improvement and Suicide Prevention Framework](#) has been produced by NHS Education for Scotland and NHS Health Scotland which defines the knowledge and skills specific to roles and responsibilities in relation to mental health improvement and the prevention of self-harm or suicide. [Learning resources](#) have also been developed across the four identified levels of informed, skilled, enhanced and specialist to support improvement. A similar package of resources have been developed by NHS Education for Scotland in relation to [trauma informed practice](#).

Whilst progress is being made, the recent manifesto produced by the Mental Health Foundation Scotland (2021) [A Wellbeing Society: Delivering Good Mental Health For All](#) calls for a prevention agenda to empower individuals, families, and communities to protect and improve their mental health and for all political parties to adopt a “mental health in all policies” approach. It clearly highlights the significant amount of change that remains to be made to create a ‘wellbeing society’.

## 4. Mental Health Difficulties: Classification and Diagnosis

Traditionally, both the [American Psychiatric Association](#) and the [World Health Organisation](#) have produced classification systems (DSM-5 and ICD-11) respectively. Both offer diagnostic criteria for mental disorders/mental health conditions and, in general, they can be considered largely analogous. These systems can be thought of as a dictionary for mental

disorders. However, the task of identification is more complex. For example, the experience of mental ill-health or emotional distress can be considered normative at times. As such, rather than discerning if a problem is simply present or absent, there is a need to consider severity. If it is present, can it be considered mild, moderate or severe? Guidance here is less clear.

The prevailing classification systems do not offer guidance on how to understand or prioritise difficulties when an individual meets the diagnostic criteria for multiple disorders. Nor do they comment on how different difficulties develop, or are maintained, or how they interact with each other over time. This is important to bear in mind, as we know that complexity and comorbidity of mental health difficulties is common when working with children in conflict with the law. It should also be borne in mind that children and young people can often be sub-threshold on a number of different diagnoses, which can result in greater impairment than would be indicated by the diagnostic profile. This can also have implications in terms of reduced access to intervention and prevention of further escalation (DeJong, 2010).

It is recommended when considering the mental health of children and young people in conflict with the law that a biologically, socially, and psychologically informed case formulation, which can account for all presenting concerns together, as well as speculate on their development and maintenance, should be sought (Johnstone & Gregory, 2015). It is suggested that clinical features that cut across diagnoses (e.g. emotional dysregulation may drive mood difficulties, violent behaviour, and interpersonal difficulties etc.) are important to pay attention to, likely reflecting important intervention targets. Practitioners who have knowledge about a child or young person, their history and experiences can make a significant contribution to the development of a highly individualised case conceptualisation.

## 5. Types of Mental Health Difficulties

This section provides an overview of the mental health disorders/conditions that are experienced most frequently by children and young people and signposts to where more information can be obtained in relation to best practice when working with children or young people experiencing these.

### 5.1 Anxiety Disorders

Anxiety is a relatively common childhood difficulty, which can be thought of as a collection of affective, physical, cognitive and behavioural symptoms. Broadly speaking, it can be viewed as a reaction in response to some feared stimulus (e.g. needles, separation from caregiver, thoughts of illness, negative evaluation, failure, etc.) (American Psychiatric Association, 2013). The object of fear can be highly subjective and diverse. However, there are several distinct types of anxiety presentation which are common in children and young people. A brief description of how anxiety manifests in different anxiety problems follows, although not all will be discussed in depth.

In terms of the differing anxiety presentations, brief but severe episodes of anxiety may be experienced as a panic attack, during which acute physical symptoms become so intense that an individual feels as if they are losing control, are choking, or may die. Following the experience of a panic attack an individual may become highly anxious about having another

and adjust their lifestyle in the hope of preventing further instances. This often involves avoiding going outdoors, or doing so alone, which is called agoraphobia.

Other types of anxiety presentations include generalised anxiety, in which an individual has worries about many things, and thus potentially exhibits symptoms in response to many stressors. Alternatively, anxiety can be specific to a very particular stimuli (e.g. dentists, vomit, needles, birds, etc.), which is a phobia. Anxiety can also present with regard to separation from caregivers, or in response to the need to speak (selective mutism), both of which tend to manifest more so in early childhood. Alternatively, anxiety or panic can manifest primarily in the interpersonal context and arise due to fear of rejection (social anxiety), and this is particularly common in adolescence. Obsessive Compulsive Disorder is also a form of anxiety. In this case, anxiety arises secondary to a distressing obsessive thought, belief or prediction. Compulsive or ritualised behaviours are then used to prevent a feared outcome, and thus reduce anxiety. Anxiety often presents alongside depressive mood or substance misuse or as part of a traumatic stress reaction. As with other emotions, it is normal to experience anxiety. The threshold for mental health services will be the extent of impact the anxiety is having on everyday life. Hyper vigilant states may lead to over-estimation of threat and associated defensive or aggressive behaviours which may be of significance to children and young people in conflict with the law.

In terms of treatment, interventions vary depending on the particular presentation, and age and stage of the child or young person. Behavioural therapies or cognitive behavioural therapies (CBT) with the child/family are often effective, and are considered evidence-based in terms of anxiety treatment. Psychopharmacological interventions may be offered in the short term in more severe cases. Where there are multiple presenting problems, of which anxiety is just one, a more multi-faceted or eclectic intervention may be tailored to the particular child or young person's needs.

For more in-depth information, [NICE](#) have produced various guidelines, which can be consulted depending on the specific anxiety in question. In addition, NHS Education Scotland have also developed an online training resource [An introduction to Cognitive Behavioural Therapy for Anxiety](#), and there is a section on anxiety disorders in [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#).

## 5.2 Neurodevelopmental Disorders

The DSM-5 describes the neurodevelopmental disorders as “a group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning” (American Psychiatric Association, 2013)

Neurodevelopmental disorders can range from global impairments, such as global developmental delay, to specific limitations such as language disorder. These disorders can frequently co-occur and symptoms can include excesses as well as deficits. Two fairly common Neurodevelopmental Disorders in children who engage in offending behaviour are Attention Deficit/Hyperactivity Disorder and Autism Spectrum Disorder which are considered further below.

### 5.2.1 Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a collection of behavioural symptoms broadly characterised by impaired attention, over-activity and impulsivity. There are a range of clinical features across cognitive, affect, behaviour, physical and interpersonal domains (Carr, 2006).

For a diagnosis of ADHD the characteristic difficulties need to have an early onset (prior to six years of age) and difficulties should be observable across contexts, such as home and school. ADHD can co-occur with Conduct Disorder (see below) or mood problems like depression or anxiety. Problems with learning, sleep, self-esteem and school achievement often become apparent as the child develops.

Assessment and treatment of ADHD is conducted via local CAMHS and treatment varies depending on the age and unique presentation of the child. With maltreated children, careful consideration is needed when assessing for ADHD, in order that manifestations of complex post-traumatic stress (see below) are not mistaken for neurodevelopmental problems, such as ADHD or Autistic Spectrum Disorder as the indicated treatment differs significantly depending on the diagnosis (Johnstone, 2017). Incorrect diagnosis will likely result in unsuccessful treatment, which may perpetuate symptoms, and in the case of children and young people in conflict with the law, maintain risky behaviour. Where there are indicators of childhood maltreatment along with behaviours that appear congruent with ADHD, it may be helpful for referrers to request that mental health services consider the possibility of both ADHD and traumatic stress in their assessment. Further guidance on ADHD is available via the [Scottish Intercollegiate Guidelines Network](#).

[The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#) details a summary of the most evidence based interventions in terms of ADHD (and other mental health concerns), which generally indicate high intensity school interventions, parent training, and education and drug treatment. In addition, [NICE guidelines on Attention deficit hyperactivity disorder: Diagnosis and management](#) were reviewed and updated in 2018.

ADHD is considered a risk factor for violent behaviour (Farrington, 2015). There may be multiple mechanisms of risk in this regard. For example, the associated impulsivity may predispose behaviour in the absence of consequential thinking. Alternatively, over time the associated educational or interpersonal difficulties may contribute to a negative self-view or sensitivity to perceived rejection, which may become a trigger for violent reactions.

### 5.2.2 Autistic Spectrum Disorder (ASD)

ASD is defined by substantial impairment across three domains: social, language/communication and thought/behaviour (American Psychiatric Association, 2013). It is an enduring, life-long disorder, with no cure. The degree of impairment associated with a diagnosis of ASD can vary from mild to severe. ASD has traditionally been differentiated into either Autism or Asperger's Syndrome. Those with Asperger's share the clinical features of ASD, but tend to have better language skills and no intellectual impairment. As elaborated on in Carr (2006), the clinical features of ASD are grouped into interpersonal, affect, behaviour, language, cognition, physical and sensory.



To meet diagnostic criteria an individual will have to be seen to have difficulties with both social communication, reciprocal communication and restricted or repetitive behaviours (American Psychiatric Association, 2013). Diagnosis must be made via a multi-disciplinary assessment, which might include speech and language therapists, occupational therapists, nursing, psychiatry, paediatricians, or psychologists. Individuals with ASD are thought to lack Theory of Mind, or the ability to understand the mental states of others. This mechanism may underpin an apparent lack of empathy in the moment. It does not mean that ASD children cannot care about others.

ASD tends to be identified early in infancy or early childhood; however, it can go undiagnosed. ASD impacts upon all aspects of the child or young person's life and it is crucial to understanding their risks and needs. Some features of ASD, for example, difficulty with regulating emotions or taking on the perspective of others, are shared by complex traumatic stress responses. Other features, such as lack of empathy or behaviour problems are shared by extremely unusual but severe and concerning personality traits, such as psychopathic traits in adults. Given the high instance of childhood maltreatment in the population of children and young people in conflict with the law, practitioners may on occasion need to make complex differentiations between traumatic stress and ASD, and on rarer occasions emerging personality traits (Johnstone, 2017). When this dilemma arises, in-depth multi-modal assessment is indicated and should be sought via local specialist mental health services.

The literature with regard to ASD and violence risk is not definitive; however, emerging clinical wisdom suggests that besides drivers associated with lack of empathy, individuals with ASD who engage in violent conduct may do so when denied access to their special interest, in the context of change, or in response to sensory vulnerabilities. Understanding the presence and relevance of ASD is important, particularly in relation to legal issues, as ASD may undermine a child or young person's competence to understand and engage with legal proceedings. Where there is a query of ASD, it should be carefully considered and local ASD specific services, or CAMHS services, may have a role in assessment. CAMHS may be more appropriate for children and young people where there are complexities and other diagnostic considerations may also need to be eliminated or formulated alongside a potential ASD diagnosis. The [Scottish Strategy for Autism: Outcomes and Priorities 2018-21](#) indicates that the Scottish Government will 'continue to facilitate improvements for autism assessment and diagnosis for all age groups and genders through Improvement Programmes and the Autism Knowledge Hub. For more in-depth information, there is a section on ASD in [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#) and [NICE](#) have produced a range of guidelines as well. There is a [SIGN guideline](#) to which the reader can refer for further information. The National Autistic Society has [guidance on working with individuals with ASD who are also engaged in criminal proceedings](#).

Behavioural interventions in response to specific concerns associated with ASD, such as anxiety, sleep difficulties, or communication problems, may be of benefit. The majority of interventions in response to ASD will likely be undertaken by parents/carers, or by implementing systemic or environmental changes.



### 5.3 Disruptive/Conduct Disorders

Disruptive/Conduct disorders include conditions involving problems in self-control of emotions and behaviours that manifest in behaviours that violate the rights of others or bring them into conflict with the law/authority figures. The disorder most frequently identified in children in conflict with the law is Conduct Disorder (CD) which is marked by a repetitive and persistent pattern of aggressive, defiant and antisocial conduct. A diagnosis of CD can be made when a child is aged six to 18 years. Younger children with conduct problems might be diagnosed with Oppositional Defiant Disorder (ODD). To meet the criteria for CD, a child's behaviour must be significantly out with what would be expected, given the child's age and/or stage of development. Examples of such behaviours include initiating fights, bullying, cruelty to others or to animals, destructive behaviour, stealing/robbery, fire-setting, severe disobedience/defiance and weapon use.

For a diagnosis of CD some other conditions must be excluded, including psychotic illness or ADHD. CDs have been described as the single most costly disorder of childhood and adolescence as they are difficult to treat, tend to be intergenerationally transmitted, and associated with poor outcomes in a range of domains (criminality, mental health, physical health, educational attainment, social/occupational adjustment) (Carr, 2006). In the UK, CDs are the disorders most commonly referred to CAMHS, likely because younger children referred to CAMHS with behavioural problems may fall into this category. Practitioners will be aware that such problem behaviours develop for many reasons and reflect a complex interaction of historical and contextual factors. To best understand risk in a child or young person who presents with CD, an understanding of an individual's unique aetiological factors and antecedents is required.

In terms of interventions in adolescence, there is some evidence for the efficacy of anger management interventions when the presentation is considered to be mild. Where difficulties are severe, family and systemic therapies are reported in the literature to be the most effective interventions ([NES, 2015](#)). For children and young people in conflict with the law, rather than individual therapy, a more complex multi-agency response is required. With regard to CD, local CAMHS thresholds apply, and currently there may be variation in referral criteria. It is recommended that if practitioners would like support with assessment, formulation, and treatment of a child or young person with potential CD, that they contact their local CAMHS team for advice about making a referral.

The reader is referred to the [relevant NICE guidance](#) for a more in-depth consideration as well as [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#).

### 5.4 Depressive Disorders

From a diagnostic perspective, there are various sub-types of depression with differences in duration, timing and aetiology. However, the common feature of all of these is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. Signs of depression exist across the domains of perception, cognition, affect, behaviour, somatic, interpersonal and behaviour (Carr, 2006).

Depression is more common in adolescents than younger children, and may occur alongside other difficulties such as CD type presentations, anxiety, ADHD, or as part of a traumatic stress reaction. Depression is more likely in boys when they are pre-pubescent and more likely in girls when they are post-pubescent. There is no one theory to explain the development of depression, and it can arise for a number of reasons. Life events typified by significant loss or transition often appear salient. Early intervention with depressed children and young people is vital to promote more positive long-term outcomes and avoid recurrent episodes (Davey & McGorry, 2018). There are a range of potential treatments available, which can be accessed via CAMHS services, and there may be alternatives in the community for mild to moderate cases. These include CBT, family therapies, and interpersonal therapy (IPT) in adolescence. [NICE have developed a set of guidelines](#) for the management of depression in children and there is a section on mood disorders, including depression, in [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#).

## 5.5 Trauma and Stressor Related Disorders

Post Traumatic Stress Disorder (PTSD) can develop following traumatic events. In the literature, two types of PTSD are identified. Type I is considered to be traumatic stress that emerges following the experience of a catastrophe or threat to life, such as a physical or sexual assault, car accident, natural disaster or the death of a loved one. With this type of PTSD, the difficulties relate to reliving the traumatic event, or trying to avoid reminders of the traumatic event, which prompt anxiety and emotional arousal. Symptoms common to PTSD generally occur across four domains - cognition, affect, behaviour and interpersonal - and can include symptoms such as intrusive thoughts, flashbacks, intense distress in response to reminders, hypervigilance, emotional numbing, avoidance of reminders, sleep difficulties, relationship problems and isolation. Such difficulties are considered to be normal in the immediate aftermath of a traumatic experience. For a diagnosis of PTSD however, the symptoms need to persist in the longer-term (American Psychiatric Association, 2013). In terms of treatment, PTSD (Type I) tends to respond well to CBT tailored towards trauma and developmental stage ([NES, 2015](#)).

The second type of traumatic stress response, or Type II, is known as complex (or developmental) trauma. This reflects the difficulties which are thought to be associated with experience of multiple and chronic traumatic events or processes over the course of development, often in the relational context. This type of presentation has been summarised by the National Child Traumatic Stress Network as having symptoms across the following domains: interpersonal (e.g. problems with boundaries, distrust and suspiciousness), affect (e.g. difficulty with emotional self-regulation, difficulty knowing and describing internal states), cognition (e.g. problems processing novel information, difficulty planning and anticipating), learning (e.g. problems with language development, problems with orientation in time and space), behaviour (e.g. self-destructive behaviour, oppositional behaviour), physical (e.g. hypersensitivity to physical contact, somatic complaints), dissociation (e.g. amnesia, depersonalisation and derealisation) and identity (e.g. disturbances of body image, shame and guilt) (Cook et al., 2017).

CAMHS referral criteria have traditionally tended to be informed by, and respond to, Type I PTSD. This is possibly as a result of the lack of an adequate classification category in DSM or ICD in relation to complex trauma. There is however growing support for and

understanding of complex trauma as a valid conceptualisation of the difficulties that result from maltreatment of children. Children and young people who are in conflict with the law often have significant histories of maltreatment. It is therefore suggested that complex trauma cannot be disregarded. Reflecting this, the new ICD-11 contains both PTSD and complex PTSD.

Traditionally, maltreated children can present with difficulties which attract diagnoses of ADHD, ASD, CD (or ODD), anxiety, depression or self-harm. The features of many of these diagnoses overlap with complex trauma characteristics in some form and there is a complicated differential diagnostic task for clinicians when considering a child or young person with multiple presenting concerns and a history of abuse and/or neglect. Multiple experts in the field support a phase-based set of often multi-modal interventions which target complex sets of difficulties associated with complex trauma, first outlined by Herman (1992) in her seminal work. Briere and Lanktree (2013) have put forward a treatment guide specific to adolescents.

Enhancing self-regulatory capacities and safety is often a priority. Promoting attachment, providing advocacy, building skills and competencies are other likely methods of intervention. The response to trauma in children and young people will likely not involve an in-depth narrative of the significant traumatic events at the beginning of treatment, which will probably be a longer-term therapeutic task. Indeed, many individuals will not address traumatic events directly in this way until adulthood, if at all; however, there are still a range of important interventions as highlighted above which are relevant.

The experience of childhood trauma may influence risk of violence in numerous ways - for example, the modelling of violence, by denying safety and the development of self-regulation capacities, or by engendering the belief that the world is unsafe and one must be vigilant and protect oneself. The idiosyncratic nature of the impact of trauma should be considered on a case-by-case basis.

CAMHS referral thresholds in terms of traumatic stress may vary, and where there are concerns, it is recommended that practitioners contact their local CAMHS service to discuss whether a referral is appropriate.

More in-depth information can be found in [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#) and in [NICE](#) guidance. In addition, the Scottish Government commissioned NHS Education for Scotland (NES) to develop a [National Trauma Training Framework](#). To date this work has resulted in [Transforming psychological trauma: A skills and knowledge framework for the Scottish workforce](#) which was published in May 2017, the publication of the [Scottish Psychological Trauma Training Plan](#) in 2019 and various [e-learning resources](#) including an e-module on [Developing your trauma skilled practice](#).

## 5.6 Schizophrenia/Psychotic Disorders

The first episode of psychosis usually occurs for individuals in their late teens or early adulthood, with males tending to experience earlier onset than females. An episode of psychosis is usually preceded by a prodromal phase, which can be a period of weeks, months or even years during which a person experiences sub-threshold psychological or

behavioural abnormalities in cognition, emotion, perception, communication, motivation or sleep. Changes in mood, social isolation or occupational or educational failures may also be observable, along with low frequency or intense delusional beliefs or hallucinations. These phenomena translate over time into a deterioration that precedes the onset of clear clinical symptoms of psychosis across perception, thought, emotion, behaviour and interpersonal domains e.g. hallucinations (involving any of the senses), delusional beliefs, inappropriate affect, impaired goal-directed behaviour, and withdrawal from peer relationships.

[NICE have produced guidance](#) with regard to psychosis in children and young people, which can be consulted for more in-depth consideration. Early identification and intervention in response to the first episode of psychosis has a significant and positive impact on longer-term outcomes. Where there are concerns of this nature prompt referral to mental health services is recommended and such cases will be prioritised by CAMHS. In terms of evidence-based interventions, CBT for psychosis or related mood difficulties, and family interventions, are indicated. With violence risk and psychotic presentations, command hallucinations (perceptions of being told to do something) or delusional beliefs (e.g. that they are being targeted or persecuted) may be relevant and critical in terms of violent conduct.

Further details can also be accessed in [The Matrix 2015: A guide to delivering evidence-based psychological therapies in Scotland](#).

## 5.7 Non Suicidal Self Injury

Self-harm is considered to be any act where injury is purposely inflicted on the self, in the absence of suicidal ideation or intention (suicide will be considered at section 5.8). It is common for self-harm to occur in the context of other mental health difficulties and/or adverse life experiences. Adolescents who engage in self-harming behaviour often have difficulties with regulating their emotions, solving problems and engaging with supports. When there is no suicidal function associated with self-harming behaviour, other functions need to be considered so that interventions can be put in place. Common functions, observed clinically, include:

**Punishment** Self-harm is driven by a sense of deserving punishment or guilty feelings. This is often associated with a severely negative self-view.

**Distraction** When emotional pain is unbearable, self-harming behaviour may serve as a distraction and may be viewed as a positive alternative to emotional distress.

**Relief** Individuals who report self-harming often cite a sense of relief or release associated with the act.

**Control** Self-harm may give children and young people a sense of power or control over themselves when things around them are overwhelming or seem out with their ability to change.

**Communication** Self-harming may serve as a vehicle to communicate great distress.

These functions are not mutually exclusive, and for the same individual differing functions may apply to different instances of harm over time.

[NICE have produced guidance](#) on the management of self-harm. The evidence base in terms of intervention with children and young people is limited. In terms of CAMHS input, CBT adapted for self-harm and group interventions show some promise. It is likely that eclectic interventions geared towards improving self-regulation capacities and promoting engagement in positive relationships will have some success.

## 5.8 Suicidal Behaviour Disorder

Suicide attempts can be thought of as self-harming behaviours with intent to die. Suicide is a significant public health concern. In response to this, the Scottish Government launched their [suicide prevention strategy 2013-2016](#) and more recently [Scotland's suicide prevention action plan: Every life matters \(2018\)](#). This action plan highlights that the rate of death by suicide in Scotland has fallen by 20% between 2002-2006 and 2013-2017 and that suicide rates in children and young people have also been falling. However, following the tragic deaths by suicide of a number of children and young people in custody in Scotland, an [expert review of mental health services at Her Majesty's Prison and Young Offender Institute \(HMP YOI\) Polmont](#) was undertaken and the Justice Committee of the Scottish Parliament undertook a short inquiry to explore issues around the [secure care and prison places for children and young people](#) in Scotland, both of which made a number of recommendations for improvements.

The assessment of suicidal behaviour or intent is complex and involves the consideration of many factors across numerous domains. These include suicidal ideation/intent, available methods and lethality of same, precipitating factors, motivation, individual/psychological factors, mental health, historical factors and family factors.

Research has identified some key empirically derived risk factors associated with suicide which mental health services will consider (Logan, 2013), e.g. mental health difficulties, especially mood disorders; prior suicide attempts; substance misuse; prior self-harm; physical illness; and unemployment. In terms of identification prior to a CAMHS referral, a set of consensus warning signs identified by the American Association of Suicidology (Rudd et al., 2006) is a guide:

Contact emergency services or request support from a mental health service provider when you see the following:

- **Someone threatening to hurt or kill themselves**
- **Someone looking for ways to kill themselves: seeking access to tablets, weapons or other means**
- **Someone talking or writing about dying, death or suicide**

**NHS 24** on 111

**Samaritans** on 116 123

**ChildLine** on 0800 11 11

**Breathing Space** on 0800 83 85 87

Seek help from mental health services should you witness, hear or see anyone exhibiting any one or more of these behaviours:

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities without thinking
- Feeling trapped - like there is no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic mood changes
- No reason for living or no sense of purpose in life

Where there are clear threats of actions in terms of suicide, a child or young person should be referred urgently to mental health services and kept safe in the interim, and their access to lethal means restricted. Where concerns are thought to be imminent, i.e. that the child or young person has suicidal intent and means, they should be brought directly to emergency services, given the potentially life-threatening nature of the situation. Support can be offered through the [Samaritans](#), [ChildLine](#), and [Breathing Space](#).

When concerned, asking about suicide is important and may lead to the individual feeling less isolated, better understood and cared for. It is important to include parents or carers, hold a non-judgemental stance, remain calm, and ask open-ended questions. There are established [training courses](#) available to practitioners who wish to develop their skills in terms of responding to initial concerns about suicide.

More in-depth information can be found in the NICE guidance [Preventing suicide in community and custodial settings \(2018\)](#), which covers ways to reduce suicide and help people bereaved or affected by suicides.



## 6. Support for mental health

Practitioners are often left wondering how they can best respond to a child or young person's mental health needs. Where presentations are complex there may be a need for high-intensity individualised medical or psychological interventions specifically tailored to the unique perpetuating factors relevant to that child or young person. Referrals may therefore need to be made to specialist services such as CAMHS. In some cases there may also be a need for a child or young person to be detained under mental health legislation. The following section provides an overview of what is helpful to consider when referring a child or young person to CAMHS as well as the type of support provided for through mental health legislation. First though, the section outlines what we can all do within our role to support children and young people, regardless of the intensity of additional specialist support required.

### 6.1 Universal support

The [Mental Health Improvement and Suicide Prevention Framework](#) has been produced by NHS Education for Scotland and NHS Health Scotland to support those who have “the opportunity and ability to positively impact on their own and others’ mental health and wellbeing, and contribute to supporting people experiencing mental distress, mental ill health, and preventing self-harm or suicide”. It details the essential knowledge and skills required by individuals across the four identified levels of informed, skilled, enhanced and specialist. All staff working in health and social care should as a minimum have the knowledge and skills at the informed level, although those likely to have direct and/or substantial contact with individuals who may be at risk of mental ill health, self-harm or suicide are likely to require knowledge and skills at the skilled level. The required knowledge and skills are detailed across six domains, as follows:

- Promote good mental health and wellbeing
- Tackle mental health inequalities, stigma and discrimination
- Support people in distress or crisis
- Promote resilience and recovery
- Prevent self-harm or suicide, and
- Improve the quality and length of life for people living with mental ill health

Generally, whether or not the level of mental health difficulties experienced by children warrant a referral to CAMHS or detention under mental health legislation, there are often certain commonalities with regard to the vulnerabilities underpinning mental health difficulties and certain considerations in terms of response may be of value:

- **Ensure safety**  
Work to ensure that the child or young person exists in a safe (physically and psychologically) environment cannot be underestimated. Ongoing threat, in the form of bullying, physical, emotional or sexual abuse, or harassment will likely perpetuate significant distress, and impact on other social or psychological interventions.

- **Listen**

Often practitioners feel the need to 'do' something about an individual's distress, even when there is no clear course of action or solution. The anxiety associated with this helpless position may at times cause the listener to disengage, or divert attention elsewhere. Listening with curiosity and empathy is in itself an important intervention - sometimes a person may just need to be heard and have the complexity of their situation acknowledged.
- **Ask questions**

There can be a perception that asking questions may be re-traumatising, or may promote risky behaviours such as suicide or self-harm. It is suggested that this is more often not the case and that non-judgemental questions, or showing curiosity in response to what the child or young person is sharing can foster a sense of being understood, noticed, and perhaps even cared for.
- **Normalise**

Adolescents, especially those with histories of maltreatment or low self-esteem, may feel that mental health difficulties set them apart from others, or are something to be ashamed of. Feeling abnormal may perpetuate the difficulties they are experiencing and it is important to remind them that experiencing strong emotions or distress is normal, especially in difficult contexts.
- **Build relationships**

Often children and young people in conflict with the law have had significant adversity in their interpersonal relationships from an early age. This may translate into difficulties with trusting others and feeling safe in relationships, which in turn perpetuates mental health difficulties and they may not have the skills to build trusting relationships. Day-to-day interactions have the potential to act as interventions, in that anything that models how to be open, trusting, reliable, playful, consistent or responsible in relationships is of great benefit over time. This may involve reflecting aloud with the child or young person about your thinking, expectations, or intentions.
- **Promote attachment**

Safe and secure relationships are protective in terms of mental health and systemic efforts to facilitate positive relationships will promote resilience and well-being. This may involve strengthening family relationships or promoting social interaction and inclusion.
- **Build competency**

Mental health difficulties are often underpinned by low self-esteem or efficacy. Supporting and encouraging a child or young person to build competence in an occupational or recreational area of interest to them can promote well-being.
- **Regulate**

Often a child or young person's problems stem from a difficulty with regulating behaviour and/or emotions and they may be overwhelmed by emotions or exhibit challenging or worrying behaviour. Regulation difficulties may be secondary to a neurodevelopmental concern (e.g. ASD, ADHD), attachment difficulties, or trauma, or

some combination of all three. What the child or young person will need is support to regulate themselves, which at first or at times of crisis may require intense support. Acting as an external regulator involves multiple tasks and is usually contingent on having a positive relationship:

- **Recognition** Children and young people often have difficulties knowing what it is they are feeling, to know when difficult emotions are coming, what they are, why they happen when they do, and what to do about them. This leaves the child or young person in a vulnerable, powerless, and overwhelmed position. Practitioners can facilitate recognition by reflecting about the child or young person's perspective and experience, for example, "I can see by the expression on your face that you're angry right now", "I'm wondering if you're feeling worried?", "I think lots of people in your position would be feeling sad right now" and so on. This process will help them to label and recognise their emotions, which is a first step in regulation.
- **Modulation** Helping the child or young person to understand what triggers strong emotions and how they can cope with them is important in terms of making these emotions less overwhelming and therefore promoting self-regulation. This can be done without relating to past experiences or other situations and dealing with the present, for example, "I noticed when you lost that game, your mood seemed to change, and then you called your friend a name, I wonder if you were trying to let us know how angry you felt. Maybe next time, if you lose you try something different..." Such interactions serve to contain emotions, model empathy, curiosity, caring and help the child or young person to recognise the relationship between events, their feelings and behaviour.

*With Scotland* have produced a range of potentially useful resources. Their report on using the social work relationship to promote recovery may be particularly useful to practitioners (Mitchell, 2012). Additionally, NHS Scotland and NHS Education for Scotland provide a range of [learning resources](#) on their website in relation to the improvement of mental health and prevention of self-harm and suicide. The [Distress Brief Intervention \(DBI\) programme](#), which supports people presenting to frontline services in distress, is now also available nationally to those above the age of 16.

## 6.2 Referrals to CAMHS

When considering a referral to CAMHS it is important to remember that the service is for children and young people age 0 to their 18th birthday with clear symptoms of mental ill health which place them or others at risk and/or are having a significant and persistent impact on day-to-day functioning. Most children will only require to access CAMHS when an intervention within primary care, education or a community-based service has not been sufficient to improve outcomes. Given the recent research highlighting the high level of referrals to CAMHS and difficulties accessing CAMHS, reference should be made to the [national referral proforma \(Annex 1\)](#) when considering a referral. In addition, this section highlights briefly what to consider including in referrals.

### **Details of symptoms**

Providing descriptions of the symptoms observed/described, their onset, frequency and intensity will be helpful for informing initial decisions about how to progress the referral. Information on the settings or contexts within which these occur should also be provided where possible.

### **Impact on daily functioning**

As well as describing the symptoms observed it is helpful to describe how these are impacting on the child's day-to-day functioning as well as on those around them. This will help to inform decisions about whether the referral meets the threshold for CAMHS, and if not, where the most appropriate route to access advice/guidance/intervention is.

### **Previous intervention/support and outcome**

Details of any support or interventions previously provided and the outcomes of these will also assist decisions as to whether the referral is appropriate for CAMHS and meets their threshold. Any barriers or difficulties encountered in achieving positive outcomes should also be included so that as full a picture as possible is provided.

### **Current assessment and formulation**

Wherever possible a summary of your current assessment and formulation should be provided, highlighting your rationale for CAMHS involvement at this point in time and the outcomes that you would hope to achieve as a result. It will also be helpful to outline intentions about your ongoing involvement and role should a CAMHS referral be accepted.

## **6.3 Detention under Mental Health Legislation**

At times, when children are alleged to have committed an offence and have come into contact with the criminal justice system there may be concerns that they have some form of 'mental disorder'. Mental disorder is the term used within the relevant mental health legislation, the Mental Health (Care and Treatment) (Scotland) Act 2003, and is defined as those with 'mental illness, learning disability and personality disorder'. The 2003 Act, which came into force in 2005, increases the rights and protection of people with mental disorders, including children, and provides options to allow for the appropriate assessment and treatment at various stages of the legal process. The principles on which the Mental Health Act is founded are derived from the work of the [Millan Committee](#) (known as the Millan Principles). The Millan Principles are:

- Non discrimination - People with mental disorders should whenever possible retain the same rights and entitlements as those with other health needs.
- Equality - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.
- Respect for diversity - Patients should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
- Reciprocity - Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

- Informal care - Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion
- Participation - Patients should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Patients should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.
- Respect for carers - Those who provide care to patients on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
- Least restrictive alternative - Patients should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
- Benefit - Any intervention under the Act should be likely to produce for the patient a benefit which cannot reasonably be achieved other than by the intervention.
- Child welfare - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

The [Scottish Mental Health Law Review \(SMHLR\)](#) is currently reviewing the 2003 Act with the aim of further improving the rights and protections of individuals with a mental disorder and removing barriers to those caring for them. As well as reviewing the 2003 Act, it is also considering the need for convergence of incapacity, mental health and adult support and protection legislation. The [SMHLR interim report](#), published in 2020, includes a section on the findings so far from the Children and Young People Advisory Group. The report states that the SMHLR will take account of the recommendations made in 2019 by the [Independent Review of Learning Disability and Autism in the Mental Health Act \(Rome Review\)](#). One of the fundamental recommendations from this review is that learning disability and autism be removed from the definition of mental disorder; another is that Scotland works towards a law that removes discrimination in detention and compulsory treatment on the basis of disability in line with the United Nations Conventions on the Rights of Persons with Disabilities. The SMHLR final report is expected to be published in September 2022.

The 2003 Act makes specific provisions to safeguard the welfare of children (a child is defined as any person under the age of 18 years). Section 2 makes provisions to safeguard the welfare of any child, emphasising that decisions should be taken that “best secures the welfare of the patient”. Police have a duty to ensure that vulnerable people and those in custody who, owing to mental disorder, appear to be unable to understand sufficiently what is happening or communicate effectively with the police, can access appropriate adult support. This support is designed to help vulnerable people (aged 16 or over) understand what is happening and to facilitate communication between them and the police and is detailed in the [Appropriate Adults Standard Operating Procedure](#). Guidance has also been produced for local authorities about their [statutory duties in relation to the provision of appropriate adult services](#).

When a child is held in custody before a court appearance and relevant professionals become aware of signs of possible mental disorder then a mental health assessment is normally requested. This assessment is generally carried out by a forensic medical



practitioner who can ask for an urgent psychiatric assessment and if required an assessment by a Mental Health Officer. The outcome of the mental health assessment should be communicated to the police and should be included in the police report to the prosecutor. The guidelines identify that the main issues likely to be considered in these circumstances are:

- Does the person appear to be suffering from a mental disorder?
- Does he/she currently pose a risk to him/herself or other people?
- Do they require assessment or treatment in hospital?
- If so, how urgently is this required?
- Is the person fit to be interviewed and if so, do they require an appropriate adult?
- Is the person fit to plead were they to appear in court?
- May the person require community mental health services?

Depending on the outcome of the assessment the following options are available: informal admission or contact with psychiatric services; application for a compulsory treatment order; immediate admission under Emergency Detention Certificate or a Short Term Detention Certificate; recommendation for an assessment or treatment order; or no recommendation at present but suggestion that non-urgent psychiatric assessment is sought while the person is on remand. An application for an assessment or treatment order is generally the most appropriate option when the alleged offence is serious and/or the person appears to pose a significant risk to others.

Concerns about possible mental disorders that require assessment may also arise during the court process. Section 130 of the 2003 Act provides detail about two types of pre-sentence orders – assessment and treatment orders. These can be used pre-conviction and post-conviction before sentencing and are used to make sure that people who appear to have a mental disorder are assessed, and if required, treated, prior to the final disposal of the case by court. An assessment order can authorise detention in a specified hospital for up to 28 days and in certain circumstances the giving of medical treatment. A treatment order can authorise detention in a specified hospital for the whole of the pre-trial or pre-sentence stage and in certain circumstances the giving of medical treatment.

The prosecutor may apply for an assessment or treatment order when a person has been charged with an offence, a relevant disposal has not been made in the proceedings in respect of the offence and it appears to the prosecutor that the person has a mental disorder. Scottish Ministers may apply for an assessment or treatment order when the person has been charged with an offence, has not been sentenced, is in custody and it appears to the Scottish Ministers that the person has a mental disorder.

The court may make an assessment order when there are reasonable grounds for believing that (based on the evidence of a medical practitioner):

- The person has a mental disorder;
- It is necessary to detain the person in hospital to assess whether medical treatment is available, treatment would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder and if not provided with it there would be a significant risk to the health, safety or welfare of the person or the safety of any other person (Section 52D(7));



- If an assessment order were not made there would be a significant risk to the health, safety or welfare of the person or a significant risk to the safety of any other person;
- The hospital proposed by the medical practitioner is suitable for the purpose of assessing the conditions above;
- If an assessment order was made the person could be admitted to the hospital before the expiry of the period of seven days beginning with the day on which the order is made;
- And that it would not be reasonably practicable to carry out the assessment unless an order was made.

If an assessment order is made, the responsible medical officer must submit a written report to the court within 28 days on the individual's mental condition and whether they meet the conditions of Section 52D(7) described above so that a decision on how to proceed can be made. On receiving the report the court will revoke the assessment order and decide on one of the following options: make a treatment order; commit the person to prison or such other institution to which the person might have been committed had the assessment order not been made or otherwise deal with the person as the court considers appropriate; or extend the assessment order for a period not exceeding seven days on one occasion only.

If a person is on an assessment order pre-trial, the order ends if:

- A treatment order is made
- They are liberated in due course of law
- Summary proceedings are deserted
- Solemn proceedings are deserted
- They are acquitted
- They are convicted
- They are found insane in bar of trial

If the person is on an assessment order post-conviction but pre-sentence, the order ends if:

- A treatment order is made
- Sentence is deferred
- A sentence is imposed
- One of the following mental health disposals is made - interim compulsion order, compulsion order, guardianship, hospital direction, any disposal under section 57, probation order with a requirement of treatment.

The court may make a treatment order if it is satisfied based on the evidence of two medical practitioners (one must be an Approved Medical Practitioner) that:

- The person has a mental disorder;
- It is necessary to detain the person in hospital to assess whether medical treatment is available, it would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder and if not provided with it there would be a significant risk to the health, safety or welfare of the person or the safety of any other person (Section 52D(7));
- The hospital proposed by the approved medical practitioner and the medical practitioner is suitable for the purpose of giving medical treatment to the person;

- And that if a treatment order were made, such person could be admitted to such hospital before the expiry of the period of seven days beginning with the day on which the order is made;
- And that having regard to all the circumstances and any alternative means of dealing with the person, it is appropriate.

During the treatment order the Responsible Medical Officer will prepare a report to inform the various statutory options available. Pre-conviction the options to consider are insanity in bar of trial, insanity at the time of the offence, diminished responsibility and what the appropriate disposal should be. Published guidance on the 2003 Act on [Compulsory powers in relation to mentally disordered offenders](#) provides a detailed overview of these options and defines them as follows:

Insanity in bar of trial - "If a person's mental disorder is such that he/she cannot participate adequately in the court process, (i.e. cannot understand the proceedings or instruct a legal representative as to a defence), then it has long been held that it is unfair for that person to be tried. If this is the case the court may find the person insane in bar of trial (or insane and unfit to plead) and there is no trial, or where the trial has commenced, it will be discharged".

Insanity at time of offence - "If a person was mentally disordered at the time of the offence then this may affect his/her legal responsibility for his/her actions. In some cases the court may find that the person's mental condition was such that he/she cannot be held responsible for his/her actions, he/she is then acquitted on account of insanity".

Diminished responsibility (only applicable to charges of murder) - "In murder cases, a person's condition may be such that although he/she cannot be acquitted on account of insanity, he/she may be found to be of diminished responsibility. The latter is a mitigating plea as opposed to a defence and therefore does not result in acquittal, but in conviction for the lesser offence of culpable homicide".

A treatment order can last for the whole pre-trial period. However, where the responsible medical officer is satisfied that the conditions in section 52D(7) of the Act are no longer met or that there has been a change of circumstances since the order was made which makes the continued detention no longer appropriate, they must submit a report in writing to the court. The court may revoke, confirm or vary the treatment order.

If the person is on a treatment order pre-trial, the order will end if:

- They are liberated in due course of law
- Proceedings are deserted
- They are acquitted
- They are convicted
- They are found insane in bar of trial

If the person is on a treatment order post-conviction but pre-sentence, the order will end if:

- Sentence is deferred
- Sentence is imposed

- One of the following mental health disposals is made - compulsion order, guardianship order, hospital direction, any disposal under section 57 of 2003 Act, probation order with a requirement of treatment.

The Mental Welfare Commission provide information about good practice including a [Rights in mind booklet \(2017\)](#) and a more detailed guide to [Human Rights in Mental Health Services \(2017\)](#). It is particularly important to be aware of individual's rights given that the [Mental Welfare Commission](#) has found that over recent years there are increased numbers of children being detained under the 2003 Act. Increases were noted to be particularly stark in the age group 16-17 years, for whom the number of Emergency Detention Certificates and Short Term Detention Certificates increased from 24 to 59 and from 44 to 114 respectively between 2009-10 and 2018-19. In their analysis of the characteristics and presentation of 16 and 17 year olds detained, they found that only 51% of those detained on an Emergency Detention Certificate (2014/15 -2018/19) had the consent of a Mental Health Officer recorded. Having an independent Mental Health Officer consent to the emergency detention is a safeguard to protect the interests of children and young people. The lack of this safeguard in around half of the emergency detentions made is concerning and the issue has been raised by the Mental Welfare Commission to the Scottish Mental Health Law Review.

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