CHILDREN AND YOUNG PEOPLE IN CONFLICT WITH THE LAW: POLICY, PRACTICE AND LEGISLATION

Section 8: Mental Health and Neurodiversity

June 2025

Children and Young People's Centre for Justice

Contents

1. Introduction

All professionals working with children and young people in conflict with the law have a pivotal role to play in prevention, early intervention, and care planning in relation to mental health. The needs of children and young people who come into conflict with the law are now well understood and can often be complex. There is growing evidence that many of these children and young people have histories of high levels of childhood adversity that can lead to trauma responses (Gibson, 2020, 2021; Murphy, 2018; Vaswani, 2018). They also have higher rates of neurodevelopmental issues than would be expected from rates evident in the general population (Williams et al., 2021). These experiences and circumstances, and some of the responses from systems/agencies, can lead to the development of further mental health difficulties later in childhood or adulthood (Fox et al., 2015; Nelson et al., 2020; Perry et al., 2018). 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, thereby preventing an escalation in difficulties over time.

Adolescence brings further challenges that can be detrimental to children, as noted in the Scottish Government's Mental Health and Wellbeing Strategy (2023):

> *"Periods of transition often put extra stress on children and young people's pre-existing resilience and coping strategies. The late teenage years are a point when mental wellbeing can decline … and can also be the point of onset of serious mental illness. Teenage years are also a stage in life where the increased use of online communities and social media can impact mental health, especially for young women. Experiences of bullying, harassment and abusive behaviour put young people at higher risk of poor mental health."*
>
> (Scottish Government, 2023a, p. 14).

There is also growing awareness of the impact of external factors, such as poverty, homelessness and inequality on mental health and wellbeing (Scottish Government, 2023a), issues that many children and young people in the Children's Hearings System (CHS) and in conflict with the law have experience of.

The work many practitioners from the human services sector (including social work, social care, education and employability) do with children and young people offers excellent opportunities for promoting mental wellbeing and informing decisions about care and intervention. These include a unique perspective across a range of systems and routine contact with children and young people and their families, combining legal knowledge with 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 (WSA) to integrated care.

The aim of this section is to offer guidance to practitioners working with children and young people in conflict with the law where there are concerns about their mental health, wellbeing, and neurodevelopment. It includes: a brief introduction to the link between mental health and those who come into conflict with the law; the policy context; an overview of the typical structure of related health services; and some information on what we know about children and young people's mental and neurodevelopmental health needs and how these are

classified, with some general guidance on how practitioners might respond to children and young people who are experiencing difficulties with their mental health and/ or may have diagnosed or suspected neurodevelopmental conditions.

2. Mental Health and Children and Young People in Conflict with the Law

In 2024, gathering data from the four nations, the Centre for Mental Health carried out an exercise Mapping the Health of the UK's Young People. Key findings (Doyle et al., 2024) highlighted the number of children and young people experiencing mental health difficulties in the UK has increased at an alarming rate in recent years, compounded by experiences of the covid 19 pandemic, the cost-of-living crises, poverty, and additional marginalisations. A call for action is made to address this crisis given the impact on young people's wellbeing, safety, education and future outcomes. The overall data showed that the older teenage years are associated with increased mental health difficulties, particularly in Scotland, where 350 in 1000 16–24-year-olds report experiencing mental health difficulties (Doyle et al., 2024, p. 5). An accompanying interactive map shows the results of the findings by particular issue, country, and locality.

Adjei et al. (2021) UK longitudinal cohort study showed that children who are persistently exposed to maternal mental ill-health and poverty were four to six times more likely to develop socioemotional problems at age 14, compared to peers from low poverty and adversity backgrounds. Socioemotional problems were assessed using the Strengths and Difficulties Questionnaire (SDQ), measuring five scales: hyperactivity, emotional symptoms, conduct disorders, peer problems and prosocial behaviour (Adjei et al., 2021), issues which we will see are often prevalent in children and young people in conflict with the law.

The link between poverty and poor mental health, including these socioemotional difficulties, is well established (Wickham et al., 2017) with data also showing links between poor mental health/ socioemotional difficulties and 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, some will persist with this behaviour into adulthood. Invaluable data from the Edinburgh Youth Transitions and Crime study (McAra & McVie, 2022) shows these individuals are found to be significantly more vulnerable than those who desist (stop) offending in adolescence, having experienced childhoods characterised by higher levels of adverse childhood experiences, poverty, and serious offending (McAra & McVie, 2022).

Whilst there has been limited research on the mental and neurodevelopmental health needs of children and young people in conflict with the law in Scotland, a study examining the mental health needs of a sample of children referred to the Intervention for Vulnerable Youth (IVY) service in relation to concerns regarding violent behaviour found that on average, although not formally diagnosed, these children displayed symptoms of four psychiatric disorders, with 64% displaying four or more. Symptoms of attachment disorder (92%) and post-traumatic stress disorder (75%) were overwhelmingly represented in this group (Murphy, 2018). A more recent report on the mental health needs of Scotland's prison population found that "There is a notable evidence gap in relation to the mental health needs of young people in prison"

(Gilling McIntosh et al., 2022, p. 10). However, in the absence of this information, estimates of the likely prevalence of some mental health problems were made using modelling from the non-prison population. For those under 21, estimates were that at least 16% would have a long-term mental health condition, 22% a history of self-harm, 35% an alcohol use disorder, 25% symptoms of anxiety over the past week and 15% symptoms of depression over the past week. A 2024 report by the HM Inspectorate of Prisons for Scotland on Young People's Experience of the Scottish Prison Estate revealed that 69% of under 25s reported having a mental health need in prison, and 36% had a disability or a long-term health condition, with 36% and 29% requiring support for drug and alcohol use respectively.

The most common mental health difficulties for both the general population and the population of children in conflict with the law are conduct, emotional, attention, and substance misuse disorders (The Mental Health Foundation, 2002); this covers the full range of emotional, social, and behavioural difficulties. However, the complexity with children and young people who come into conflict with the law is understood to be relative to the higher frequency of difficulties, the greater severity of the problem, and the fact that multiple problems occur at the same time (Hindley et al., 2017). An additional factor complicating the understanding of individual mental health needs is the potential for under-identifying internalised difficulties (such as anxiety or depression), as these may be obscured by, or manifest as, externalised problems (such as behavioural difficulties). Additionally, children and young people often appear to be below the threshold required for a formal diagnosis yet have subthreshold symptoms across several mental health difficulties, which can have a significant impact on their daily functioning. Finally, the question of how mental health difficulties relate to offending behaviours (if indeed they do) adds further complexity.

There has been a growing body of research linking early traumatic or adverse childhood experiences (ACEs) 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). Early trauma or ACEs can result in children becoming care-experienced, and the stigma and experiences resulting from this can affect mental health (Who cares? Scotland, 2022), this cohort more likely than non-care experienced peers to experience poor mental health and socioemotional difficulties (Sanders, 2020), and to be unnecessarily criminalised (Moodie & Nolan, 2016). These well-established links between poverty, adversity, poor mental health and socioemotional behavioural difficulties which can lead to conflict with the law in childhood and adolescence, as-well as the knowledge that contact with justice systems can perpetuate adverse outcomes (McAra & McVie, 2022), has significant implications of how and when we intervene with families. Prevention and early intervention on a structural level is crucial, however as practitioners we also need to be able to promote good health and wellbeing, and to both identify and promote recovery from poor mental and emotional health and wellbeing for the children and young people we work with.

3. Policy Context

The UNCRC (1990), now embedded in Scottish statute in the UNCRC (Incorporation) (Scotland) Act 2024 , 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. These are summarised by UNICEF as:

> **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 have worked towards achieving these two articles, with a growing and now well-established emphasis on the promotion of a multi-agency approach to maximising mental wellbeing in children and young people. The culmination of early agendas (Scottish Needs Assessment Programme report, 2001); the Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care, 2005) can be seen with Getting It Right for Every Child (GIRFEC), the holistic framework for all agencies supporting children and young people in Scotland, enshrined in the *Children and Young People (Scotland) Act 2014*. GIRFEC embraces the idea that good mental health and wellbeing are impacted by a variety of family, social, psychological, and community factors. This inference that early identification and promotion of good mental health is everyone's business, not just that of specialist mental health practitioners, has been affirmed by The Promise. It promotes the importance of nurturing primary carer relationships and whole-family supports, as-well as timely access to specialist mental health supports in promoting optimum mental health and wellbeing. 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 highlighted the strong correlation between poor mental health and deprivation, and between poor, specifically dis-organised, attachment in the early years and development of mental health problems in later life. It promoted a whole-person focus, setting personal and social outcomes as well as clinical ones - akin to GIRFEC's holistic approach. The strategy also highlighted the need to do more to address Conduct Disorders (CDs) in young children, drawing on research showing the links between early year externalising behaviours and CDs and antisocial and offending type behaviours in adulthood. Evidence based parenting programmes were promoted to address this, along with wider cross sector training on promoting infant mental health.

To assure consistency of delivery in relation to health and wellbeing outcomes, Local Delivery Plan (LDP) standards have been created - priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance. LDP Guidance (2020) details how these operate. The current performance on standards specific to the needs of children and young people is documented on the Scottish Government website. Wider health and social care integration correlating with the principles of GIRFEC is evident in the Scottish Government's Mental Health Strategy: 2017-27, aiming to achieve parity between mental and physical health provision; a key focus being prevention and early intervention.

Despite such policy initiatives however, there have remained difficulties with children accessing mental health provision through the Child and Adolescent Mental Health Service (CAMHS), who support under 18s in Scotland. An audit of rejected referrals, incorporating views of children and their families (Scottish Government, 2018b), indicated that most rejections 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, 2018b, p. 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 now regularly publish national statistics on CAMHS waiting times, including 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 nationally.
- Services for children and young people are under significant pressure.

It concluded that rectifying the situation was not straightforward due to a lack of information available to enable service redesign, including inadequate data on mental health services for children and a lack of evidence on what works.

Scottish Ministers commissioned the Children and Young People's Mental Health Taskforce to implement all 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, provided in 2019 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.

The Children and Young People's Mental Health and Wellbeing Joint Delivery Board (JDB) - a coalition between Scottish Government, COSLA, third and public sector partners and children and families - operated between 2021 and 2023 to address the need to improve mental health services for children and young people. Eight key deliverables were identified which included enhancing community-based support for mental wellbeing through investment in local partnerships and developing a training programme to increase skills and knowledge of all those working with children and young people. A summary of their work focus, achievements, and future recommendations can be found in their Final Report (2023).

Two significant key deliverables were development and implementation of national CAMHS and Neurodevelopmental service specifications.

***Child and Adolescent Mental Health Services (CAMHS)*:**
The CAMHS National Service Specification (2020) outlines referral criteria, minimum service standards, and the provisions children, young people and their families can expect. The below

diagram illustrates where CAMHS sits within the Children and Young People's Mental Health and Wellbeing model.

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

The service specification highlights CAMHS locality teams sit at Tier 3 of a four-tiered intervention model, with Tier 4 covering more acute conditions/cases via regional or national provision. CAMHS locality teams are said to have a role in supporting lower tier universal and targeted community services, supporting the wider system of mental health care for children under GIRFEC. Specialist CAMHS are for under 18s "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" (Scottish Government, 2020, p. 10).
CAMHS locality teams will provide services for a range of mental health issues (covered on page 4 of the specification) such as 'moderate to severe emotional and behavioural problems, including severe conduct, impulsivity, and attention disorders'. In addition, they will be supported by services providing more specific expertise for those with more complex/ specific difficulties (detailed on page 5), including need for inpatient care, experience of complex trauma, and forensic risks and needs.

Forensic Mental Health Services:
Forensic CAMHS (FCAMHS) "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" (Scottish Government, 2020). FCAMHS is only currently available in Greater Glasgow and Clyde however a pilot is underway widening it's provision to the West of Scotland using a 'hub and spoke' model. The proposed inpatient service, Foxgrove (NSAIS) for Scotland, will provide inpatient care for up to four 12–18-year-olds who have complex difficulties, need a high level of care, and present a significant risk of harm to others.

The wider Independent Forensic Mental Health Review (2021) - 'The Barron Review' - 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, 2021b). In relation to children and young people, the following recommendations were made:

- The new planned 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 arrangements put in place for young people who require forensic or learning disability inpatient facilities prior to the NSAIS being opened.

In response to the above review the Scottish Government commissioned a short life working group to "attempt to review and propose a redesign of the planning and governance of the delivery of the health care component of forensic mental health services within the wider health and social care landscape" (Government, 2023b, p. 3). It's Final Report of Option Appraisal Process (2023) provided for clarity a definition of Forensic Mental Health Services:

> *"Forensic mental health services provide person-centred, safe and effective assessment; care and treatment; for persons with severe and disabling mental health disorders* who pose a risk of harm to others; and who have come to the attention of the criminal justice system (or whose behaviour poses a risk of such contact); in conditions of therapeutic safety and security in hospital (high, medium or low), or in the community and in criminal justice custody."*

*as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003, whether or not they are, or may be, managed under its provision" (Government, 2023b, p. 7). Following sessions with stakeholders the group concluded there is desire for change, though closer to strengthening and building on current systems than systemic transformation.

Neurodevelopmental Services:
Specialist neurodevelopmental services sit alongside CAMHS, covered by the National Neurodevelopmental Specification for Children and Young People (2021). Specific neurodevelopmental pathways aim to provide appropriate and timely support, although CAMHS will support children where mental health problems are co-morbid with neurodevelopmental problems.

The specification sets out the principles and minimum standards of care expected "for children and young people who have neurodevelopmental profiles with support needs and require more support than currently available" (Scottish Government, 2021a, p. 1).

It provides guidance on neurodevelopmental terminology:

- **Neurocognitive functions** are selective aspects of brain functions - the ability to learn and use language, the ability to regulate attention, emotions, impulses (including movements and spontaneous utterances), social behaviours, and process sensory

stimuli. Like height, these traits may be significantly genetically influenced, and are present from birth. Like height, the statistical normal range changes, dependant on age. The societal norm for a selective neurocognitive function is defined by the general population and may be variably and narrowly defined.

- A **Neurodevelopmental disorder** is a term reserved for those who present with a 'functional' impairment in day-to-day life due to difference in one or more neurocognitive function which lie at the extreme of, or out with the normal range.
- **Neurodiversity** is the statistical normal range of a function in a population at a particular age. Diversity is a trait of the whole group, not a specific individual.
- **Neurotypical** describes individuals where a selective neurocognitive function falls within the prevalent societal norm.
- **Neurodivergent** describes individuals where a selective neurocognitive function falls out with the prevalent range.

Neurodevelopmental services should be available for all children aged 0-18 years, as well as young adults aged 18-24, or 26 for care experienced individuals (Scottish Government, 2021a). Within the document it is recognised that missed diagnoses and unmet needs can lead to ongoing problems in later life, including long-term mental ill health, as well as contact with the justice system. It also acknowledges that certain children and young people will require more robust transition plans, including those in contact with the justice system. The Children's Neurodevelopment Pathway Workbook has been produced to support the development and implementation of local neurodevelopmental pathways for children and young people (National Autism Implementation Team, 2021).

In September 2024 the National Autism Implementation Team (NAIT) and Scottish Government co-produced the Children's Neurodevelopmental Pathway Practice Framework: A workbook for assessment, diagnosis and planning (Rutherford et al., 2024). It highlights further terminology, including the term '**neuro-affirming practice'**: a strength-based approach to neurodevelopmental differences which is strengths and rights-based, where practitioners provide supports and adaptations that support the individual to be their authentic self, without trying to 'fix' or 'cure' their neurotype. The practice framework is rooted in GIRFEC, promotes key messages for neurodevelopmental pathways teams, covering guidance on referral, assessment, triage and diagnostic processes, among others, with appendices including Summary of Evidence Tables for common neurodivergent conditions; Autism Spectrum Disorder (ASD), Attention Deficit and Hyperactivity Disorder (ADHD), Intellectual Disability (ID), Developmental Language Disorder (DDL), Developmental Co-ordination Disorder, and Fetal Alcohol Spectrum Disorder (FASD). This resource is essential reading for anyone working with children and young people. It highlighted that, as of September 2024, seven local authorities had a distinct neurodevelopmental pathway, with data at that time showing 16.8% of children in Scottish Schools to be neurodivergent, and that with the average diagnostic rate nationally sitting then at 86%, showing that when neurodivergence is suspected it is highly likely to be present (Rutherford et al., 2024, p. 65)

Adolescent Mental Health in Custody & Secure Care:

Further developments have also taken place in relation to mental health provision in custody and secure care. The Report on Expert Review of Mental Health Services at HMP&YOI Polmont (2019) concluded two high level strategic issues warranting 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. Specific 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).

More recently a report Understanding the Mental Health Needs of Scotland's Prison Population (2022) concluded that there needed to be "joint and co-ordinated action from justice, health and social care and third sector providers" in order to overcome the structural challenges of supporting the mental health needs of individuals in prison (Gilling McIntosh et al., 2022, p. 6). Custody must be avoided for children and young people to best support their mental health, with the Children (Care and Justice) (Scotland) Act 2024 recognising that if children must be deprived of their liberty, it should be in secure care, with no children detained in the prison estate in Scotland post 28th August 2024, following the commencement of relevant sections of the Act. Community rehabilitation remains the preferred disposal option for children and young people, in line with Sentencing young people guideline for under 25's.

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, are required to be involved. In September 2024 CYCJ published their Scottish Government commissioned Reimagining Secure Care reports, advocating for an integrated model of care centred on the needs of children and families, with support available when and where it is needed. The Government are considering the findings and will respond by June 2025.

Recent Policy Developments and Workforce Supports:
The Mental Health and Wellbeing Strategy (2023) aimed to 'reset' the approach to 'mental health for everyone', following the Covid-19 pandemic, recognising mental health as a continuum comprising a range of needs, with some impacted disproportionately due to external factors such as poverty and inequality. It aims to ensure:

- Improved overall mental wellbeing and reduced inequalities.
- Improved quality of life for all people with mental health conditions, free from stigma and discrimination.

- Improved knowledge and understanding of mental health and wellbeing and how to access appropriate support.
- Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.
- More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
- Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
- Better informed policy, support, care and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
- Better access to and use of evidence and data in policy and practice.
- A diverse, skilled, supported and sustainable workforce across all sectors.

The Mental Health and Wellbeing Strategy Delivery Plan 2023-2025 describes what will be done during this period to meet strategic targets. The Mental Health and Wellbeing: Workforce Action Plan 2023-2025 reinforces the critical role of both the core mental health and wellbeing and the wider mental wellbeing workforce in promoting positive mental wellbeing, preventing poor or further deteriorating mental health, and in providing timely, effective support, care and treatment. It aims to develop a diverse, skilled, supported, and sustainable workforce, setting out how to do so under the 5 overarching aims of Plan, Attract, Train, Employ and Nurture, with time focussed outcomes identified for each, alongside case studies exemplifying current good practice. Practitioners working with children in conflict with the law are key partners in any 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, NHS Health Scotland and the Scottish Government, 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. Associated learning resources have been developed across the four identified levels (informed, skilled, enhanced and specialist) to support improvement. The NHS Education for Scotland (NES) National Trauma Training Programme offers similar packages of support relating to trauma-informed practice, accompanied by A Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland (2023). NES have also produced the Children and young people's mental health & wellbeing: a knowledge and skills framework for the Scottish Workforce. This framework, published in April 2021, takes a rights-respecting approach, and is intended to be useful for the development of all staff who work with children, young people, and their families. In addition, guidance has been produced to support the transition of individuals moving from children's mental health services to adult mental health services (Scottish Government, 2018a).

Relaunched in 2023, as an interactive online resource, The Matrix: A guide to delivering psychological therapies in Scotland provides useful guidance on common mental health needs

and outlines evidence-based approaches to meeting these needs. Their guidance on delivering effective psychological interventions to children and young people highlights the importance of considering developmental and systems contexts and work with parents when formulating individual interventions. The section on Mental Health Difficulties Across the Lifespan details features of, prevalence and recommended treatments of various mental health presentations, with specific tables of treatment recommendations for children and young people available for each. Populations Requiring Special Considerations and Adjustments specifically covers, amongst others, psychological therapies for Forensic Populations, Neurodivergent People, Conditions Specific to Childhood, and Intellectual/ Learning Disabilities, with most content expected in 2025. Whilst focus is on specialist psychological or mental health practitioners in delivering or supervising intervention in NHS contexts, practitioners with a range of experience and training working with children and young people 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. The matrix also highlights that when delivering interventions to children and young people there is consideration of: age and developmental stage; relevant systems and context of issues; the role of parent/ carer(s), who may indeed be the intervention focus; and the importance of collaborative working.

The Mental Health Foundation website has a variety of resources on how to look after your mental health, including specifically for children and young people and those supporting them. Their 2021 report A Wellbeing Society: Delivering Good Mental Health for All called 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 remains to be seen how far new policy initiatives will go to creating their aimed for a 'wellbeing society'.

In September 2024, the Scottish Government published the updated Children and young people - community mental health and wellbeing: supports and services framework which sets out how the supports that children, young people and their families require in relation to their mental health and emotional wellbeing should look like within communities, with a focus on accessibility.

4. Mental Health Difficulties: Classification and Diagnosis

The American Psychiatric Association, via the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the World Health Organisation, via the International Classification of Diseases (IDC) produce classification systems (current versions are the DSM-5-TR and ICD-11 respectively) which offer diagnostic criteria for mental disorders/mental health conditions. These systems can define and diagnose certain conditions, 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 and impact, guidance in which is less clear.

These 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 co-morbidity of mental health difficulties is common when working with children and young people 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.

This section should be read in conjunction with Section 6 Speech, Language and Communication Needs (SLCN).

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 best practice information in relation to these.

5.1 Anxiety

Anxiety is experienced as a feeling of unease, like worry or fear, and 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.

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, 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). This is particularly common in adolescence, impacting self-confidence, relationships, and education/ employment, leading to avoidance of situations and interactions that heighten anxieties - symptoms also manifesting as upset or anger at times. Obsessive Compulsive Disorder (OCD) is also a form of anxiety where 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. Public Health Scotland commissioned Health Behaviour in School Aged Children (HBSA) Scotland Survey (2022) which showed that, at age 15, 19% of boys and 49% of girls were classed as having moderate or severe anxiety; equating to 1 in 3 children in Scotland. The threshold for mental health services will be the extent of impact the anxiety is having on everyday life. Hypervigilant states may lead to overestimation 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 individual 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. Scottish Action on Mental Health (SAMH) have also produced a guide to Understanding Anxiety which discusses causes, symptoms, and ways to manage anxiety in more detail, as well as signposting to other resources and services.

5.2 Neurodevelopmental Conditions

Although Neurodevelopmental Conditions are no longer classed as mental health conditions, they have been included in this section because if these needs are not identified and met appropriately then longer-term problems can arise, such as mental ill-health and involvement in the justice system (Scottish Government, 2021a). The NAIT Adult Neurodevelopmental Pathways Report (2023) by Scottish Government/NAIT stated that whilst estimates were that 10-15% of the adult population in Scotland had a neurodevelopmental condition, up to 70% of those with seek mental health support, and comprise a significant proportion of adults involved in mental health and criminal justice services.

The DSM-5 describes 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).

Review of neuroscience study into the adolescent brain over the last 30 years shows that the pre-frontal cortex, the part of the brain responsible of executive function, continues to mature and be impacted by experiences into the 30's (Dow-Edwards et al., 2019). The adolescent brain is not mature, reliant still on external influences, impacting responsibility.

Neurodevelopmental conditions can range from global impairments, such as global developmental delay, to specific limitations such as language disorder. Conditions can frequently co-occur, and symptoms can include excesses as well as deficits. Recent research in England and Wales estimates around a half of prisoners have a neurodevelopmental condition (CJJI, 2021).

The Committee of the Rights of the Child observes that children may lack criminal responsibility on account of neurodevelopmental issues: "Children with developmental delays or neurodevelopmental disorders or disabilities (for example, autism spectrum disorders, foetal alcohol spectrum disorders or acquired brain injuries) should not be in the child justice system at all, even if they have reached the minimum age of criminal responsibility. If not automatically excluded, such children should be individually assessed."(United Nations Human Rights Committee, 2019). If a practitioner from any discipline working with a child or young person in conflict with the law therefore suspects a neurodevelopmental condition may be present, further assessment should be sought, and until such time as this is complete discussion of possible traits and how they impact the individual in terms of behaviour, decision making and maturity, should inform any assessment of need and be shared with relevant professionals (e.g. Social Worker, Lawyer, Court Clerk) in the justice process. Reports and assessments on a person with diagnosed or suspected neurodivergence must be informed by the NAIT Neuro-Affirming Reports Guide.

Neurodevelopmental conditions common to children in conflict with the law include Attention Deficit (Hyperactivity) Disorder (AD(H)D) and Autism Spectrum Disorder (ASD), which are considered further below, as are Acquired Brain Injury (ABI) and Foetal Alcohol Spectrum Disorder (FASD).

5.2.1 Attention Deficit Hyperactivity Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental condition with symptoms broadly characterised by impaired attention, hyperactivity, and impulsivity. It is understood to be caused by impairment of executive (cognitive) functioning (Brown et al., 2009) i.e. everyday mental skills like working memory, flexible thinking, and inhibition or self-control. It affects cognitive, behaviour, physical and interpersonal domains (Carr, 2006). It can be split into two behavioural categories; inattentiveness (difficulty retaining focus and concentration) and hyperactivity and impulsiveness; though not all individuals display the hyperactivity/ impulsiveness, referred to as having ADD (Brown et al., 2009), with 50% - 75% having the combined type (NICE, 2024a). Difficulties may include planning and organising, time management and perception, remembering what someone has said, following instructions, losing things, being easily distracted or diverted from a thought or task.

Prevalence globally is around 2-7%, increasing over time, but remaining relatively undiagnosed particularly in girls and older children, with a further 5% displaying symptoms but which are just under the diagnostic threshold (Sayal et al., 2018). ADHD is over-represented in those in conflict with the law, though much UK data is limited to secure settings: ADHD is estimated to impact 3-5% of the UK general adult population, yet around a quarter of prisoners (CJJI, 2021). A New Zealand study, (Anns et al., 2023), found young adults with ADHD to be overrepresented at all states of the criminal justice system, with (Cherkasova et al., 2022) meta-analysis and review of seven longitudinal American studies showed significant impairments in areas of educational and occupational functioning, mental and physical health, as well as higher rates of substance misuse, antisocial behaviours and unsafe driving, indicative of increased conflict with the law. Retz et al. (2021) narrative review discusses the increased prevalence of ADHD in conflict with the law populations globally.

ADHD has been said to correlate with violent behaviour (Farrington et al., 2017; Lundström et al., 2014), which could occur when for example, impulsivity or the development of a negative self-view or sensitivity to perceived rejection, trigger a reaction. It also has an impact on how individuals cope with the restrictions of incarceration, with increased aggressive incidents including self-harm reported, and higher rates of continued offending (Retz et al., 2021; Young et al., 2009). Lundström et al. (2014) sibling study also highlighted that the association they found between ADHD and criminality was to some extent due to how the family impacted the child's development, concluding that interventions aimed at reducing conflict with the law in adolescence should involve the individual and their family. Co-morbidity with disruptive behaviour disorders has been found to be a predictor of negative functional outcomes, and a suggested area of intervention focus (Cherkasova et al., 2022; Retz et al., 2021).

Some ADHD traits peek mid-adolescence, due to disparities in timings of brain development. It has been shown that in those with ADHD there is around a three-year delay in the maturation of frontal and temporal grey matter, where neurons and synapses are located, although ADHD brains do catch up by early adulthood (Shaw et al., 2007). This could explain why hyperactivity and impulsivity generally reduce during adolescence (Dow-Edwards et al., 2019). See the Theory and Methods section of this guide for more on brain development.

The DSM-5 states diagnosis requires persistent symptoms having begun before age 12, comprise six or more symptoms of inattention and/ or hyperactivity for children up to 16 and 5 or more for children up to age 17 and adults, and to exist across different domains such as at home and in school. The ICD-11 ADHD states that whilst there is often significant evidence of hyperactivity and inattentiveness before age 12, and typically before early to mid-childhood, these may not always be evident and come to clinical attention until later in life. ADHD can co-occur with a Conduct Disorder (CD), dyslexia, depression, or anxiety. Problems with learning, sleep, self-esteem, and school achievement often become apparent as the child develops. Rejection Sensitivity Disorder (RSD) is common with ADHD, characterised by a fear of rejection. Adolescents with ADHD are overly reactive and perceiving of social rejection cues, and more likely to miss positive social cues (Babinski et al., 2019). Despite inattentiveness in some settings those with ADHD can also display 'hyper-focus' – full absorption in an activity whilst appearing to 'tune out' of all else when engrossed in an activity, a beneficial trait when positive areas of interest are identified given task performance in this state improves (Ashinoff & Abu-Akel, 2021).

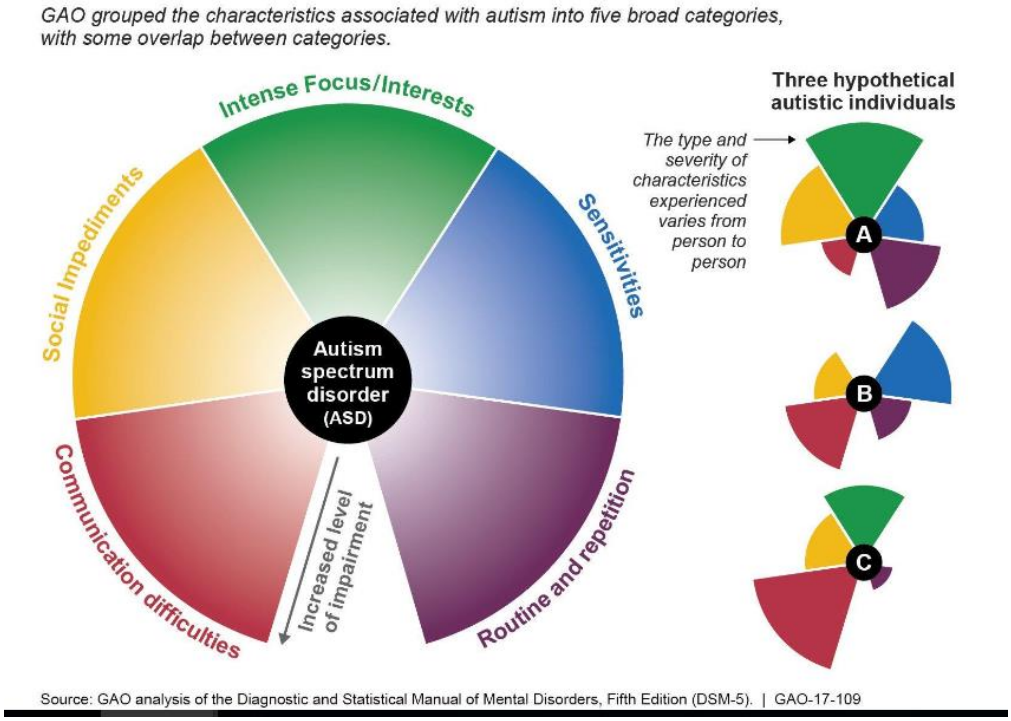
Where there are indicators of childhood maltreatment along with ADHD traits, both ADHD and traumatic stress should be considered in assessment. Symptoms can be similar, but treatment very different (Johnstone, 2017). Professional neurodevelopmental assessment should be sought but may take time, or a child may not consent, therefore "Understanding of support needs can be enhanced by diagnosis but should not wait for diagnosis" (Scottish Government, 2021a, p. 1).
Evidence-based interventions for ADHD generally include high intensity school interventions, parent training, education, and medication. Studies have shown earlier drug treatment of ADHD to have more effective long-term positive behavioural change (Dow-Edwards et al., 2019; Sayal et al., 2018), highlighting the importance of the early identification of symptoms and assessment. NICE guidelines on Attention deficit hyperactivity disorder: Diagnosis and management were reviewed and updated in 2019. As highlighted by ICM-11, certain traits, like impulsivity and hyperactivity tend to be most evident in structured situations requiring self-control. Changes to our expectations of children and young people and the environments in which they interact however provide more inclusive ways to support someone with ADHD; keeping sessions short, offering breaks and opportunities to be active, providing or not objecting to use of fidget spinners or similar, being aware information may need to be repeated and doing so without becoming annoyed with the person, providing text reminders for appointments etc. can help those with ADHD and others navigate the neurotypical world. Involving the child or young person, supporting them to work out what works for them (strengths/ limitations, preferred mode of communication etc) and consented sharing of this with key people and services involved can improve outcomes and relationships.

5.2.2 Autism Spectrum Disorder

The ICD 11 on Autism spectrum disorder states: Autism spectrum disorder (ASD) is characterised by persistent deficits in the ability to initiate and to sustain reciprocal social interaction and social communication, and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context. The onset of ASD occurs during the developmental period, typically in early childhood, but symptoms may not fully manifest until later, when social demands exceed limited capacities. Impact of symptoms/ traits must be sufficient to cause impairment in personal, family, social, educational, occupational or other important areas of functioning. They are usually a pervasive feature of the individual's functioning, observable in all settings, although they may vary according to social, educational, or other contexts. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities. ICD 11 goes on to describe specific diagnostic requirements.

Although described as a 'spectrum', classified at three levels by the DSM-5-TR (APA, 2013), however without accompanying guidance as to how to classify each level, it is more appropriate and helpful to consider those with ASD as individuals with a particular profile of strengths and limitations – essentially establishing their particular variation in ASD characteristics or traits to understand what supports and considerations they require within their given contexts. How an individual is impacted by ASD can vary, from mild to significant, meaning those with a diagnosis of, or suspected of having, autism can experience it, and therefore present, very differently

A helpful visual tool to illustrate this was developed by the United States Accountability Office (GAO), highlighting that each autism characteristic may vary in type and degree from person to person, and can fluctuate over time. The combination of characteristics results in a highly individualized condition, as illustrated below:



(GAO, 2016, pp. 5-6)

As the figures on the right show, a behaviour which is a key indicator for autism assessment for one person, may not be evident in another person with autism.

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. Some people with ASD often have difficulty reading other people, take things very literally, and may spend time alone and find it hard to make friends. These individuals may lack theory of mind - the ability to understand the mental states of others, and whilst this may be interpreted as a lack of empathy in the moment through a neurotypical lens, it does not mean that those with ASD lack empathy (NAS, 2023), they may also just process and/ or convey their understanding differently.

ASD impacts all aspects of the child or young person's life and, as with any child, 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 perceived lack of empathy or relationship difficulties are shared by distress behaviours of those who have experienced poor attachments and/ or trauma, or extremely unusual but severe and concerning personality traits. Given the high instance of childhood maltreatment and adversity in the population of children and young people in conflict with the law, practitioners may on occasion need to make complex

differentiations between social and linguistic deficits resulting from a lack of secure attachments and positive opportunities, 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.
Displays of distress/ violence in those with ASD may occur when they are denied access to their special interest, in the context of change, or in response to sensory overload/ feelings of being overwhelmed (NAS, 2023). See the NAS's Meltdowns - a guide for all audiences for advice on how best to response. Neither ASD or OCD is not associated with violence or a risk factor for violent behaviour (Lundström et al., 2014).

People with autism are not overly represented within the justice system, although evidence suggests certain profiles of ASD may have implications when a person with autism is involved in certain offence behaviours. For example, whilst there is no empirical causal link, there is suggestion that certain facets of ASD (such as need for order routines and predictability, cognitive styles, and obsessionality, repetition and collecting) may render an individual vulnerable to an interest in terrorist activities (Al-Attar, 2020) and terrorist recruitment (Soares et al., 2022), with individualised assessments and formulations taking into account the individual's autism profile essential. Al-Attar (2018) provides guidance to those interviewing people with autism involving the consideration of the seven facets of autism and how they relate to the alleged terrorism offence. Other considerations such as co-morbidity with mental health problems and social adversities should always also be considered, as with any holistic assessment. Those with ASD may also be vulnerable to carrying out non-violent, inappropriate sexual behaviour, possibly due to facets of ASD such as impaired impulse control and obsessional interests (Creaby-Attwood & Allely, 2017). Mogavero (2016) also discusses delayed social maturity and reduced exposure to normative sexual experiences and knowledge of those with ASD as potential contributing factors to inappropriate sexual behaviour, with features such as fixations and repetitive behaviour patterns impacting harmful sexual behaviour, generally without intent to harm or malice, highlighting the need for the justice system to identify and address these needs. Allely and Dubin (2018), in exploring the possession of child pornography in those with ASD. point to this behaviour being explained by symptomology, stating the behaviour is not a reflection of sexual deviance, and therefore recommend education and mental health interventions to best serve the interests of justice. Assessment, formulation and assessment of risk should be informed by consideration of the ASD and how it impacts the individual's needs and behaviours, and maturity, as related closely to culpability and intervention scope. This will involve input from those with clinical expertise.

Understanding the relevance of ASD for the individual is crucial, particularly in relation to legal issues, as ASD may undermine a child's ability to understand and engage with processes, and to develop and share informed views. As discussed ICD-11 ASD, some people with autism experience impaired intellectual functioning and/or language development, whilst others may not have, or present as having, difficulties in these areas. Often people with autism have fixations and interests which can manifest as hyperfocus which can be a strength when developing talents and interests (Ashinoff & Abu-Akel, 2021). Given autism may co-occur with a variety of other conditions, clinical assessment is recommended when traits are observed, with robust description of traits, triggers and impact assisting this.

Where there is a query of ASD, it should be carefully considered and local ASD-specific services, neurodevelopmental teams, or CAMHS, 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 need to be eliminated or formulated alongside an ASD diagnosis. NICE have produced a range of guidelines, there is also a SIGN guideline containing further information, whilst 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 beneficial. Most interventions relating to ASD however will likely be undertaken by parents/carers, and other key people, or by implementing systemic or environmental changes around the child or young person, to promote communication and environments which support integration, safety, and communication (See section 6, SLCN).

The Scottish Strategy for Autism: evaluation (2021) details findings, future focus and investment needs and priorities to continue to address inequalities experienced by those with Autism. The Scottish Government funded National Autism Implementation Team (NAIT) provides resources and guidance on implementation of evidence informed practice, including an Autism Based Practice Toolkit.

5.2.3 Foetal Alcohol Spectrum Disorder

Foetal Alcohol Spectrum Disorder (FASD) refers to a range of physical, emotional and developmental problems caused by maternal alcohol consumption during pregnancy, causing damage to the developing baby's brain. The physical structure of the brain is impacted by alcohol exposure in utero, impacting general intelligence executive functioning (affecting working memory and response inhibition), language development, learning and memory, adaptive functioning (life skills/ problem solving) and mental disorders (Mattson et al., 2019).

The Fetal Alcohol Advisory Support & Training Team (FAASTT) is funded by Scottish Government with a national remit to provide and facilitate training, consultation and research in order to enhance the capacity, knowledge and confidence of Scotland's health and social care workforce in their work with those affected by Fetal Alcohol Spectrum Disorders (FASD). FAASTT estimate that in Scotland 1 in 7 babies are born at risk of FASD and an estimated prevalence of 3.25-5%.

Although higher consumption of alcohol correlates with higher levels of impact, any alcohol use in pregnancy has been seen to have psychological and behavioural impacts, including impulsivity and attention deficit (Lees et al., 2020). The level of impact is dependent on how much and how often the mother drank during pregnancy, and at what point during the pregnancy alcohol was consumed (Coriale et al., 2013).

Characteristics of FASD therefore vary, can be attributed to alternate aetiologies, or co-exist with other diagnosis. It is estimated 50% of those with FASD also have ADHD, with higher rates of intellectual disability and mental health issues evident than in the general population (Weyrauch et al., 2017).

FASD can be difficult to diagnose, particularly if little is known about in utero experiences, though according to the NHS individuals with FASD may have issues with:

- movement, balance, vision and hearing

- learning, such as problems with thinking, concentration, and memory
- managing emotions and developing social skills
- hyperactivity and impulse control
- communication, such as problems with speech
- the joints, muscles, bones, and organs, such as the kidneys and heart

Regarding expressive communication, whilst both language production and comprehension can be affected, it appears common for expressive language to be less so (Coriale et al., 2013). Children and young people may therefore present as more capable than they are, which is significant when they come into conflict with the law and in contact with various systems, and intervention/disposal recommendations need to be made in accordance with their capacities. Medical advice should be sought when FASD is suspected, along with a mental health and speech, language and communication needs (SLCN) assessment to check for co-existing conditions and ensure communication can be adapted accordingly.

Impairments are permanent, however an understanding of a child or young person's difficulties can allow them to be better supported, minimising the impact on their life - albeit in some cases it is severe. Cognitive deficits can lead to 'secondary disabilities' such as academic difficulties, emotional and behavioural problems, and coming into conflict with the law, with early diagnosis, parental supports/education, and multidisciplinary support planning linked to better outcomes in this regard (Coriale et al., 2013).

The SIGN 156 (2019) Children and young people exposed prenatally to alcohol. Scottish Guidelines to aid healthcare professionals in diagnosing Fetal Alcohol Spectrum Disorder (FASD) offers best evidence guidance on assessment and treatment of FASD. Pathways may vary locally, and whilst these will come under new Neurodevelopmental Pathways eventually, practitioners should familiarise themselves with current local pathways, which may currently be via CAMHS initially.

The FASD Network UK provides a variety of online resources for children, young people and adults with FASD, carers, and professionals, including Tips for Individuals which provides strategies to cope with different aspects of FASD. As well as having a variety of resources (including videos) and research on their website, the FAASTT also run their online FASD Hub to support anyone working with or impacted by FASD, including a dedicated section for adults and young people, and links to national supports.

5.3 Acquired Brain Injury

An Acquired Brain Injury (ABI) is any injury to the brain post birth, falling into two categories. A Traumatic Brain Injury is caused by a traumatic external incident injuring the brain, such as caused during sports, road accidents, falls or through violence. A Non-Traumatic Brain Injury (Non-TBI) comes from internal disease processes, such as a stroke, infection, abnormal growth (such as a tumour), or lack of oxygen to the brain (Goldman et al., 2022). Around half the prison population are estimated to have an ABI, higher amongst women linked to

experiences of domestic violence (CJJI, 2021). ABIs can cause damage to the area of the brain impacted, which can affect brain functions of the affected area(s).

ABIs are more prevalent in males and younger people in poverty, with alcohol use one of the biggest risk factors (Kisser et al., 2017), for which young males from urban areas are particularly at risk (Cancelliere et al., 2017) follows that the children in the CHS who are involved in alcohol use and/or violence are at increased risk of TBIs. TBIs include concussion (which can be mild to severe), skull fractures, a brain bruise or bleed, and penetrating brain injuries - often caused by assaults (Goldman et al., 2022). Impairment to the functions of the brain affected is common and can also lead to further internal damage such as swelling or infections, again impairing function. TBI impact is extremely varied, given the complexities of the brain. A leading cause of death, they also cause seizures, hearing and vision problems, disorientation, and cognitive impairment, impaired ability to recall words and process information, and often impulsivity and impaired judgement (Goldman et al., 2022). ABIs impact skill in day-to-day functioning, with the realisation of this commonly negatively impacting self-esteem, associated fear of failure potentially triggering depression and anxiety (Max et al., 1997).

If a child is known to have experienced an ABI, or is involved in alcohol use and violence, good practice is to inquire as to lasting impact or prevalence of any of the above symptoms to establish if an ABI could be impacting behaviours or ability to communicate/ engage. Medical treatments and care management are varied, though levels of pre-ABI family functioning are linked to recovery, so consideration of family work to improve functioning and relationships should be given. CYCJ's Information Sheet on Brain Injury and the Criminal Justice System provides further information of the high prevalence of brain injury in children and young people in conflict with the law, and the implications this has for their navigating the justice system, and how their experiences can be improved.

5.4 Disruptive/Conduct Disorders

All children display behavioural problems at times. However, if issues such as defiance and poor emotional regulation continue for lengthy periods, and/ or behaviours are out of the ordinary and repeatedly break the established rules in their environment, then a Conduct Disorder may be present (Royal College of Psychiatrists, 2015).

According to APA Disruptive, Impulse Control and Conduct Disorders are: "a group of disorders that are linked by varying difficulties in controlling aggressive behaviors, self-control, and impulses. Typically, the resulting behaviors or actions are considered a threat primarily to others' safety and/or to societal norms". 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 between six and 18. 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 violation of rules/defiance, and weapon use. ICD-11 information on conduct disorders states "Criminal behaviours may occur impulsively or opportunistically, or in relation to substance use or

intoxication.", and that "Clinical assessment and diagnosis should focus on the broader pattern of behaviour rather than solely on the criminality of specific behaviours or incidents.", reinforcing the need for individual assessment and formulation, taking into account any diagnosed CD, but also other possible drivers for behaviours.

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 are associated with poor outcomes in a range of domains (criminality, mental health, physical health, educational attainment, social/occupational adjustment) (Carr, 2006).

DSM-5 added a specifier of 'callous-unemotional' (CU) CD type, which requires the individual to have displayed at least two of the following symptoms persistently over 12 months, in multiple relationships and settings: lack of remorse or guilt, callous lack of empathy (uncaring about others, even when having caused them harm), unconcerned about performance (academic of alternate activities, typically blames others for poor performance), and shallow or deficient affect (does not express feelings or show emotions to others, except in shallow ways for personal gain).

CD's are often present along with ADHD, depression, and substance misuse, and have a high correlation rate with adverse childhood experiences, and poor educational performance, substance use and conflict with the law (Sagar et al., 2019). 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); consistent, positive parenting practices can be effective in treating aggressive and oppositional behaviours, but require parental capacity and motivation, and along with other psychosocial interventions such as individual skill building, are more effective in those without the CU subtype (Buitelaar et al., 2013). For children and young people in conflict with the law, rather than individual therapy, a more complex multi-agency response is required. Effective treatment must be multi-modal, involving family and social systems-based interventions, and cover multiple areas over a lengthy period, crucially beginning with providing the individual and their family with psychoeducation on their condition and potential longer-term outcomes (Sagar et al., 2019).

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 NICE guideline on Antisocial Behaviour and Conduct Disorders in Children & Young People also offers a more in-depth consideration.

5.5 Depressive Disorders

Depression is generally a persistent low mood, however, there are different subtypes which can be diagnosed. 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 symptoms in children often include persistent sadness/low mood, being irritable or grumpy, losing interest in things they used to like, feeling tired/exhausted, and possible self-harm and/or thoughts of suicide (NHS, 2023). Depression is more common in adolescents than younger children, and may occur alongside other difficulties such as CD, anxiety, ADHD, or as part of a traumatic stress reaction. A 2022 study revealed that at age 15, 24% of boys and 31% of girls had low mood, with a further 8% of boys and 25% of girls at risk of depression (Inchley et al., 2023, p. 25).

Depression can arise for many reasons; life events like bereavement, or a home/school move, or by longer term issues such as family difficulties, bullying, abuse, or family history. Early intervention in children and young people is vital to promote more positive long-term outcomes and avoid recurrent episodes (Davey & McGorry, 2018; Johnson et al., 2018). There are a range of treatments accessed via CAMHS services, and there may be alternatives in the community for mild to moderate cases. These include cognitive behavioural therapy (CBT), family therapies, and interpersonal therapy (IPT) in adolescence.

To get the right support, the child must have someone they trust to talk to, to reassure them their feelings are normal, and things can get better. It can also be helpful to talk to friends or others experiencing depression, learning what helps them and that they are not alone.
Tips are available from the NHS on Talking to Teenagers, whilst The Mix offers supportive online chats and groups for 13- to 25-year-olds.

NICE guideline: Depression in children and young people for the management of depression in children has a section on mood disorders, including depression.

5.6 Trauma and Stress Related Disorders

Section 5 Trauma and Adversity, discusses trauma in more detail, and the prevalence of adverse childhood experiences, including the impact of traumatic events and stress, on the developing child. Below we will look at where diagnosable conditions can develop following trauma experience, with it helpful to first watch this video from the UK Trauma Council on childhood trauma and the brain.

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 PTSD page, and the NICE PTSD guideline. As noted above, NHS Education for Scotland (NES) has developed a National Trauma Training Programme.

5.7 Schizophrenia/Psychotic Disorders

Psychosis refers to the group of psychotic disorders, including schizophrenia. It is when thoughts and emotions are disturbed to the point people lose contact with reality. It has three main symptoms:

- Hallucinations: Seeing, hearing or even tasting or smelling things that don't exist outside their mind but feel very real, like hearing voices.
- Delusions: Strong belief in something that isn't true or views that are not shared, like believing someone is conspiring to harm them.
- Disordered thinking and speaking: Thoughts and ideas come very quickly which can make speech fast and confusing (Royal College of Psychiatrists, 2022).

Experience of symptoms is referred to as a psychotic episode. The first episode usually occurs in the late teens or early adulthood. Onset is usually preceded by a prodromal phase characterised by sub-threshold psychological symptoms, like mood swings, confusion, anxiety, depression, social isolation, reckless or disinhibited behaviour, and loss of concentration, and potentially low frequency or intense delusional beliefs or hallucinations (Somerset NHS Foundation Trust, 2023). Many of these symptoms are not atypical in teenagers and could also be representative of other issues/disorders. If behaviours become more pronounced or concerning, then medical advice should be sought. Early interventions such as talking therapies and stress management can prevent psychotic episodes.
Psychosis can be triggered by a traumatic experience, substance use, head injuries, childbirth (post-partum psychosis), or following a serious mental illness, like severe depression or Bi-Polar Disorder. Psychosis does not always signal a development of a psychotic disorder, with some people only ever experiencing one psychotic episode in their lifetime (Royal College of Psychiatrists, 2022).

Early identification and intervention in response to the first episode of psychosis has a significant and positive impact on longer-term outcomes. Urgent referral to mental health services is recommended. CBT and family interventions often accompany antipsychotic medication. It is rare for children and adolescents to be diagnosed with psychotic disorders, with the prevalence of psychotic-like experiences higher than diagnosis both in adults and

adolescents (Musci et al., 2023). Most children will recover from psychotic episodes with medical and therapeutic interventions.

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. In terms of evidence-based interventions, CBT for psychosis or related mood difficulties, and family interventions, are indicated. Regarding 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.

5.8 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 (suicidal ideation will be considered at section 5.9). 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. Young Minds have a comprehensive section for professionals responding to self-harm in children and Childline have online advice for children on how to build their own Mental Health First Aid Kit to help themselves when life begins to feel more challenging – which involves choosing who to speak to at these times

5.9 Suicidal Behaviour Disorder

Suicide attempts can be thought of as self-harming behaviours with intent to die. Suicide is a significant health concern, with a 2022 report highlighting that probable suicides were the leading cause of death among 5-24 year olds in Scotland between 2011 and 2020 (Public Health Scotland, 2022). 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 which made a number of recommendations for improvements. In response to this public health concern, the Scottish Government launched their most recent Suicide Prevention Strategy 2022-2032 and initial three year suicide prevention action plan - Creating Hope Together.

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 the lethality of these, 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.

The Mental Health Improvement and Suicide Prevention Framework, produced by NHS Education for Scotland and NHS Health Scotland in 2019, supports individuals to positively impact their own and others' mental health and wellbeing. Aiming to build capacity to prevent suicide, it details the essential knowledge and skills required by individuals across the four identified levels (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.

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. Public Health Scotland Suicide Prevention Learning Resources highlights 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 for specialised mental health support, as well as the type of support provided 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

Generally, whether or not the level of mental health difficulties experienced by children warrant a referral to CAMHS, neurodivergent pathways, or even detention under mental health legislation, there are often 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 environment (physically and psychologically) 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 wellbeing. 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 self-efficacy. Supporting and encouraging a child or young person to build competence in an area of occupational or recreational interest to them can promote wellbeing.

- **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 supported 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, knowing when difficult emotions are coming, what they are, why they happen when they do, and what to do about them. This leaves them 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.

Research indicates that having 'One Good Adult' is highly related to a range of factors that protect against poor mental health, such as perceived support from family and friends, life satisfaction, self-esteem, seeking social support for problems, optimism and using planning strategies to cope with problems (Dooley & Fitzgerald, 2012). *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). 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.

Assessment of Needs:
Assessment of mental or neuro-developmental health needs for children will from part of any multi-agency wellbeing assessment under the Getting it Right for Every Child (GIRFEC) policy, applicable to all children in Scotland requiring an assessment of needs. This model is covered in more detail in Theory and Methods, section 9 of this guide. Alternatively, some children, and young people over the age of 18 who are less likely to be subject to a multi-agency plan, may have their needs picked up as part of a single agency assessment. Many children and young people's presentations can be managed by adhering to the above guidance and by understanding their individual needs and how best to meet these, informed by knowledge of varying mental health and neuro-cognitive conditions, such as those covered earlier. Guidance may also be sought from specialist mental health and neuro-developmental services, although when it is apparent that the following of general support principles and specialist guidance by those in the individual's life are not sufficient, referral to a specialist mental health service may be required.

Services for those under and over 18 differ, with 16- and 17-year-olds potentially supported under either process, depending on local arrangements, culture, and wider contexts, and will be discussed in the next section.

As with any assessment additional procedures must be involved when there are concerns that a child or young person is at risk of harm and requires additional protections and safeguarding, potentially on account of features of mental health or neuro-divergent conditions. For children, the National Guidance for Child Protection in Scotland 2021 - updated 2023 should be followed, where necessary. It supports practitioners to respond appropriately to concerns, covering a range of specific needs and concerns which could necessitate a child protection response, including mental health issues, noting that "Child protection procedures are initiated when police, social work or health determine that a child may have been significantly harmed or may be at risk of significant harm." (p.91).

Adults can be supported under the Adult Support and Protection (Scotland) Act 2007, which contains measures to identify, protect and support individuals who are at risk of being harmed by themselves or others. The accompanying Adult Support and Protection (Scotland) Act 2007: Code of Practice (2022) provides information to practitioners as to the practical application of the legislation. Under s.3(1), the Act defines 'adults at risk' as anyone over 16 who meets the following three-point criteria:

- They are unable to safeguard their own well-being, property, rights, or other interests,
- They are at risk of harm, and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity they are more vulnerable to being harmed than adults who are not so affected.

Children between the ages of 16 and 18 who require support and protection can currently be supported under child or adult protection procedures, and services will need to consider which legal framework best fits each person's needs and circumstances (Scottish Government, 2023c, p. 9). The Institute for Research and Innovation in Social Services (Iriss) has recently published a guide to Understanding age in Child Protection guidance and Adult Support and Protection legislation (2024) and accompanying guidance and legislation table which provide insight into the variations of the two systems, informed by input form professionals who navigate them, with the table designed as a practical tool for practitioners to help establish which procedures to use in which circumstances. This may also be informed by available service provisions.

6.2 Referrals to Specialist Mental Health Services

CAMHS is available to all children, i.e. under 18's, with clear symptoms of mental ill-health which place them or others at risk and/or have a significant and persistent impact on day-to-day functioning. Most children will only require access to 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 provides an overview of 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.

The above considerations should also be made when referring young people to adult mental health services which are available to those aged 16 and over. National service provision under CAMHS has been discussed earlier in this guidance. Adult mental health service set up varies slightly across the 14 Scottish Health Boards, even in terms of language used. Most have Community Mental Health Teams (CMHT), perhaps called resource centres, for assessing and treating those with moderate to severe mental health difficulties, or complex long-term needs which may be managed under a multidisciplinary approach, with CMHTs generally comprising workers from a range of disciplines such nurses, doctors, occupational therapists, psychologists, and social workers.

Practitioners should familiarise themselves with service provision and referral criteria for adult mental health services in their local area, particularly when working with 16- to 18-year-olds, when a decision will need to be made as to whether to refer to the CMHT or CAMHS.

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 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, increased 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 (Scottish Executive, 2001).

The Scottish Mental Health Law Review (SMHLR) has reviewed 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 also considered the need for convergence of incapacity, mental health and adult support and protection legislation. The third SMHLR Report, published in July 2021, included a section on the findings so far from the Children and Young People Advisory Group, which recognised the need to effectively join up the legal and policy frameworks that affect children and young people who require support with their mental health. The report also indicated that the SMHLR would 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 (UNCRPD).

The SMHLR final report was published in September 2022. To take forward the recommendations they have been broken down into short, medium, and long term and there is a recognition that it will take time for them to be fully implemented.

In relation to children, recommendations cover:

- principles of respecting the rights of the child;
- rights to support; crisis services;
- emergency detention safeguards;

- 16- and 17-year-olds in CAMHS;
- interaction between child and adult legal provision; independent advocacy;
- accountability;
- autism, intellectual disability and other neurodevelopmental differences;
- safeguards for treatment;
- perinatal mental illness;
- relationships between parents and children; and
- exploring integration of child law and mental health law.

The review aspires for all mental health and capacity legislation and practice to comply with current human rights standards.

The Scottish Government issued their Response to the SMHLR in 2023, stating:

> *"Our vision is that our mental health system upholds human rights and enables people to live well, with choice and control over their own lives, as well as any care, treatment, or wider assistance they might need."*

There is emphasis on embedding a human rights culture across legislation, policy, and practice for those with mental illness/ lacking capacity, allowing for more autonomy in decision making about their care, focus on the least restrictive practices possible, and improving safeguards and accountability mechanisms. Acknowledging the level of change proposed will take time, the review proposes establishment of a Mental Health and Capacity Reform Programme to co-ordinate and drive change over time. Seven 'high-level priorities' for inclusion in the Reform Programme are stated, including Human Rights Enablement (incorporating early work with the workforce to understand and apply rights-based approaches in practice) and Mental Health Law Reform (this will involve exploration of definition of 'mental disorder' and who this should cover in future legislation, working alongside the development of legislation to enhance and protect the rights of those with a learning disability or neurodivergent condition).

The Scottish Government 2024 Learning Disabilities, Autism and Neurodivergence (LDAN) Bill: consultation sought views on legislative proposals to better represent the specific rights and needs of those with learning disabilities and neurodivergent conditions. The consultation called for earlier and improved identification of individuals with cognitive or neurological impairment, and fuller access to accessible and inclusive information within criminal and civil justice systems to aid understanding and participation. The consultation analysis published in August 2024 highlighted the need for cross-sector staff training on learning disabilities and neurodivergency, particularly around inclusive communication, for accessible and appropriately trained advocacy, and for accountability for non-adherence to any resultant strategies or legal requirements. It was also highlighted that many of the required changes to promote the rights and improve experiences and outcomes for those with neureodivergency or learning disabilities could and should be made without legislative requirements, with many aims of the proposed legislation coming under the remit of existing legislation and rights documents. The Scottish Government is considering the findings and has not included the LDAN Bill on its current programme for Government.

At present, 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 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; it 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 (which under the Children (Care and

> Justice) (Scotland) Act, once commenced, will be available for any child who meets the legal criteria and is over the age of criminal responsibility and under 18), 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 Medial 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 for Scotland provides information about good practice including the Rights in mind booklet (2017) which illustrates a patient's journey through inpatient care and provides information on their human and legal rights at each stage. The Mental Welfare Commission also have an online guide to Human Rights and Mental Health. It is particularly important to be aware of individuals' rights given that the Mental Welfare Commission (2020) found increased numbers of children being detained under the 2003 Act, without the authorisation of a Mental Health Officer (MHO) – an important safeguard. The issue was raised by the Mental Welfare Commission to the Scottish Mental Health Law Review, where there are recommendations to address this.

The latest Mental Health Act Monitoring Report 2023-24 by the Mental Welfare Commission for Scotland, expresses concern that numbers of those detained on an emergency detention certificate (EDC) without MHO agreement continues to rise: only 35.8% of EDC's had MHO consent this year, and was worryingly lower for those under 25 at 32%. Meanwhile the Children and young people monitoring report 2023-24 indicated that in 2023-24 there were 69 admissions, involving 59 children, to non-specialist hospital wards (primarily adult wards) for intervention in relation to their mental health difficulties, the lowest number in ten years. Sixteen of these children were 15 or younger, double the number of the previous year. This year's report continues to highlight a number of children had lengthy stays on wards not designed for their needs, with a significant minority of longer stays experienced by those who were care experienced or with a learning disability. With a continued lack of age-appropriate provisions during their stay, such as recreational activities (37% had none), education (85% had none), and advocacy (37% had none) - indicating shortfalls in meeting a number of UNCRC articles. The Commission welcomed the development of more localised intensive psychiatric care units (ICPU), highlighting that much remains to be achieved in relation to inpatient provision for children.

7. References

Adjei N. K, Schlutera D. K, Straatmannb V. S, Gabriella Melisa, Fleming K. M, McGovern R, Howard Louise. M, Kaner E, Wolfe, I., & Taylor-Robinson David. C. (2021). Impact of poverty and family adversity on adolescent health: a multi-trajectory analysis using the UK Millennium Cohort Study. *The Lancet Health Europe*, *13*. https://doi.org/10.1016/j.lanepe.2021.100279

Al-Attar, Z. (2018). Interviewing terrorism suspects and offenders with an autism spectrum disorder. *The International Journal of Forensic Mental Health*, *17*(4), 321-337. https://doi.org/10.1080/14999013.2018.1519614

Al-Attar, Z. (2020). Autism spectrum disorders and terrorism: How different features of autism can contextualise vulnerability and resilience. *Journal of Forensic Psychiatry & Psychology*, *31*(6), 926-949. https://doi.org/10.1080/14789949.2020.1812695

Allely, C., & Dubin, L. (2018). The Contributory Role of Autism Symtomogoly in Child Pornography Offending: why there is an urgent need for empirical research in this area. *Journal of Intellectual Disabilities and Offending Behaviour*.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Anns, F., D'Souza, S., MacCormick, C., Mirfin-Veitch, B., Clasby, B., Hughes, N., Forster, W., Tuisaula, E., & Bowden, N. (2023). Risk of Criminal Justice System Interactions in Young Adults with Attention-Deficit/Hyperactivity Disorder: Findings From a National Birth Cohort. *Journal of attention disorders*, *27*, 1332-1342. https://doi.org/10.1177/10870547231177469

APA (Ed.). (2013). *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* American Psychiatric Association, 2013.

Ashinoff, B. K., & Abu-Akel, A. (2021). Hyperfocus: the forgotten frontier of attention. *Psychological research*, *85*(1), 1-19. https://pubmed.ncbi.nlm.nih.gov/31541305/

Audit Scotland. (2018). *Children and young people's mental health*. Edinburgh: Audit Scotland Retrieved from https://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_180913_mental_health.pdf

Babinski, D. E., Waschbusch, D. A., & Waxmonsky, J. G. (2019). Sex and Pubertal Status Moderate the Association Between ADHD and Depression Symptoms: An Examination From Preadolescence Through Late Adolescence. *The Journal of clinical psychiatry*, *80*(3). https://pubmed.ncbi.nlm.nih.gov/31120201/

Briere, J., & Lanktree, C. (2013). Integrative Treatment of Complex Trauma for Adolescents. https://www.nctsn.org/interventions/integrative-treatment-complex-trauma-adolescents

Brown, T. E., Reichel, P. C., & Quinlan, D. M. (2009). Executive function impairments in high IQ adults with ADHD. *Journal of attention disorders*, *13*(2), 161-167. https://pubmed.ncbi.nlm.nih.gov/19420282/

Buitelaar, J. K., Smeets, K. C., Herpers, P., Scheepers, F., Glennon, J., & Rommelse, N. N. (2013). Conduct disorders. . *European Child and Adolescent Psychiatry*, *22*, S49-S54. https://doi.org/10.1007/s00787-01200361-y

Cancelliere, C., Coronado, V. G., Taylor, C. A., & Xu, L. (2017). Epidemiology of Isolated Versus Nonisolated Mild Traumatic Brain Injury Treated in Emergency Departments in the United States, 2006-2012: Sociodemographic Characteristics. *The Journal of head trauma rehabilitation*, *32*(4), E37-E46. https://pubmed.ncbi.nlm.nih.gov/28489698/

Carr, A. (2006). *The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach*. Routledge. https://www.amazon.co.uk/Handbook-Child-Adolescent-Clinical-Psychology/dp/1583918310

Cherkasova, M. V., Roy, A., Brooke S.G. Molina, Scott, G., Weiss, G., Barkley, A. R., Biederman, J., Uchida, M., Hinshaw, P. S., Owens, B. E., & Hechtman, L. (2022). Adult Outcome as Seen Through Controlled Prospective Follow-up Studies of Children With Attention-Deficit/Hyperactivity Disorder Followed Into Adulthood. *Journal of the American Academy of Child & Adolescent Psychiatry*, *61*(3), 378-391. https://doi.org/10.1016/j.jaac.2021.05.019.(https://www.sciencedirect.com/science/article/pii/S089085672100366X

CJJI. (2021). *Neurodiversity in the Criminal Justice System: A review of evidence.* Criminal Justice Joint Inspection: Criminal Justice Joint Inspection Retrieved from https://cjji.justiceinspectorates.gov.uk/inspection-report/neurodiversity-in-the-criminal-justice-system-a-reivew-of-evidence/

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., & Liautaud, J. (2017). Complex trauma in children and adolescents. *Psychiatric annals*, *35*(5), 390-398. https://doi.org/10.3928/00485713-20050501-05

Coriale, G., Fiorentino, D., Di Lauro, F., Marchitelli, R., Scalese, B., Fiore, M., Maviglia, M., & Ceccanti, M. (2013). Fetal Alcohol Spectrum Disorder (FASD): neurobehavioral profile, indications for diagnosis and treatment. *Rivista di psichiatria*, *48*(5), 359-369. https://pubmed.ncbi.nlm.nih.gov/24326748/

Couper, S., & Mackie, P. (2016). *Polishing the Diamonds': Addressing Adverse Childhood Experiences in Scotland*. https://www.communityfoodandhealth.org.uk/2016/polishing-diamonds-addressing-adverse-childhood-experiences-scotland/

Creaby-Attwood, A., & Allely, C. (2017). *A Psycho-Legal Perspective on Sexual Offending in Individuals with Autism Spectrum Disorder* (International Journal of Law and Psychiatry, Issue. Elsevier.

Davey, C., & McGorry, P. (2018). Early intervention for depression in young people: a blind spot in mental health care. *The Lancet Psychiatry*, *6*(3). https://doi.org/10.1016/S2215-0366(18)30292-X

DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or "in care" child population. *Clinical Child Psychology and Psychiatry*, *15*(4), 589-599. https://doi.org/10.1177/1359104510377705

Dooley, B. A., & Fitzgerald, A. (2012). *My World Survey: National Study of Youth Mental Health in Ireland*. https://researchrepository.ucd.ie/server/api/core/bitstreams/19fedd09-447f-4913-88d9-6306318d01e0/content

Dow-Edwards, D., MacMaster, F., Peterson, B., Niesink, R., Andersen, S., & Braams, B. (2019). Experience during adolescence shapes brain development: From synapses and networks to normal and pathological behavior. *Neurotoxicology and teratology*, *76*. https://pubmed.ncbi.nlm.nih.gov/31505230/

Doyle, J., Woodhead, D., Jones, H., & Bell, A. (2024). Mapping the mental health of the UK's young people. https://www.centreformentalhealth.org.uk/publications/mapping-the-mental-health-of-the-uks-young-people/

Farrington, D. P., Gaffney, H., & Ttofi, M. M. (2017). Systematic reviews of explanatory risk factors for violence, offending, and delinquency. . *Aggression and Violent Behavior*, *33*(124-36). https://doi.org/10.1016/j.avb.2016.11.004.

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child abuse & neglect*, *46*, 163-173.

GAO. (2016). *YOUTH WITH AUTISM* (Roundtable Views of Services Needed During the Transition into Adulthood, Issue. https://www.gao.gov/assets/690/680666.pdf

Gibson, R. (2020). *ACEs, Places and Status: Results from the 2018 Scottish Secure Care Census*. https://www.cycj.org.uk/wp-content/uploads/2020/07/ACEs-Places-and-Status.pdf

Gibson, R. (2021). *ACEs, Distance and Sources of Resilience*. https://www.cycj.org.uk/wp-content/uploads/2021/05/ACEs-Distance-and-Resilience.pdf

Gilling McIntosh, L., Rees, C., Kelly, C., Howitt, S., & Thomson, L. D. G. (2022). *Understanding the Mental Health Needs of Scotland's Prison*. https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/09/understanding-mental-health-needs-scotlands-prison-population/documents/understanding-mental-health-needs-scotlands-prison-population/understanding-mental-health-needs-scotlands-prison-population/govscot%3Adocument/understanding-mental-health-needs-scotlands-prison-population.pdf

Goldman, L., Siddiqui, E. M., Khan A, Jahan S, Rehman MU, Mehan S, Sharma R, Budkin S, Kumar SN, Sahu A, Kumar M, & K., V. (2022). Understanding Acquired Brain Injury: A Review. *Biomedicines*, *10*(9). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9496189/

Government, S. (2023b). *Reform of Delivery of Forensic Mental Health Services Final Report of Option Appraisal Process.* Retrieved from https://www.gov.scot/publications/reform-delivery-forensic-mental-health-services-final-report-option-appraisal-process/documents/.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), 377-391.

Hindley, N., Lengua, C., & White, O. (2017). Forensic mental health services for children and adolescents: Rationale and development. *Advances in Psychiatric Treatment*, *23*, 36-43. https://doi.org/10.1192/apt.bp.114.013979

HM Inspectorate of Prisons for Scotland. (2019). *Report on an expert review of the provision of mental health services for young people entering and in custody at HMP YOI Polmont*. HMPIS. https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Report%20on%20Expert%20Review%20of%20Provision%20of%20Mental%20Health%20Services%20at%20HMP%20YOI%20Polmont%20-%20Final%20Version.pdf

Inchley, J., Mabelis, J., Brown, J., Willis, M., & Curry, D. (2023). *Findings from the HBSC 2022 Study in Scotland. Health Behaviour in School Aged Children: World Health Organization Collaborative Cross-National Study (HBSC).* https://drive.google.com/file/d/1C-L09FsnATKeKMSdnrU5UCKJvOfthESa/view?pli=1.

Johnson, D., Dupuis, G., Piche, J., Clayborne, Z., & Colman, I. (2018). Adult mental health outcomes of adolescent depression: A systematic review. *Depression and anxiety*, *35*(8), 700-716. https://pubmed.ncbi.nlm.nih.gov/29878410/

Johnstone, L. (2017). Youth Psychopathy: a Developmental Perspective. In P. Tarbuck, P. Chitsabesan, & S. Bailey (Eds.), *Forensic Child and Adolescent Mental Health: Meeting the Needs of Young Offenders* (pp. 217-238). Cambridge University Press. https://doi.org/10.1017/9780511777127.019

Johnstone, L., & Gregory, L. (2015). Youth Violence Risk Assessment: A framework for Practice. In A. R. Joel Harvey, Heather Law (Ed.), *Young People in Forensic Mental Health Settings: Psychological Thinking and Practice* (pp. 96-122). Palgrave Macmillan.

Kisser, J., Waldstein, S. R., Evans, M. K., & Zonderman, A. B. (2017). Lifetime prevalence of traumatic brain injury in a demographically diverse community sample. *Brain Injury*, *31*(5), 620-623. https://doi.org/10.1080/02699052.2017.1283057

Lees, B., Meredith, L. R., E, K. A., Bryant, B. E., & Squeglia, L. M. (2020). Effect of alcohol use on the adolescent brain and behavior. *Pharmacology, biochemistry, and behavior*, *192*, 172-906. https://pubmed.ncbi.nlm.nih.gov/32179028/

Logan, C. (2013). Suicide and self-harm: clinical risk assessment and management using a structured professional judgement approach. In C. Logan & L. Johnstone (Eds.), *Managing Clinical Risk* (pp. 132-158). Routledge.

Lundström, S., Forsman, M., Larsson, H., Kerekes, N., Serlachius, E., Långström, N., & Lichtenstein, P. (2014). Childhood neurodevelopmental disorders and violent criminality: a sibling control study., *44*(11), 2707-2716. https://doi.org/10.1007/s10803-013-1873-0

Mattson, S. N., Bernes, G. A., & Doyle, L. R. (2019). Fetal Alcohol Spectrum Disorders: A Review of the Neurobehavioral Deficits Associated With Prenatal Alcohol Exposure. *Alcoholism, clinical and experimental research*, *43*(6), 1046-1062. https://pubmed.ncbi.nlm.nih.gov/30964197/

Max, J. E., Smith, W. L., Jr, , Sato, Y., Mattheis, P. J., Castillo, C. S., Lindgren, S. D., Robin, D. A., & Stierwalt, J. A. (1997). Traumatic brain injury in children and adolescents: psychiatric disorders in the first three months. *Journal of the American Academy of Child and Adolescent Psychiatry*https://pubmed.ncbi.nlm.nih.gov/9000786/, *36*(1), 94-102.

McAra, L., & McVie, S. (2022). *Causes and Impact of Offending and Criminal Justice Pathways: Follow-up of the Edinburgh Study Cohort at Age 35*. https://www.research.ed.ac.uk/en/publications/causes-and-impact-of-offending-and-criminal-justice-pathways-foll

Mitchell, F. (2012). *Using the social work relationship to promote recovery for adolescents who have experienced abuse and neglect.* http://www.socialwork.ed.ac.uk/__data/assets/pdf_file/0007/147697/using-the-social-work-model-to-promote-recovery-for-adolescents-who-have-experienced-abuse-and-neglect1.pdf

Mogavero, M. (2016). Autism, sexual offending, and the criminal justice system. *Journal of Intellectual Disabilities and Offending Behaviour*, *7*, 116-126. https://doi.org/10.1108/JIDOB-02-2016-0004

Moodie, K., & Nolan, D. (2016). *'Between a Rock and a Hard Place': Responses to Offending in Residential Childcare*. http://www.cycj.org.uk/wp-content/uploads/2016/10/Responses-to-Offending-in-Residential-Childcare.pdf

Murphy, C. (2018). *Balancing rights and risk: How can we get it right for children involved in violent behaviour?* CYCJ. https://www.cycj.org.uk/wp-content/uploads/2018/10/Balancing-Rights-and-Risk.pdf

Musci, R. J., Kush, J. M., Masyn, K. E., Esmaeili, M. A., Susukida, R., Goulter, N., McMahon, R., Eddy, J. M., Ialongo, N. S., Tolan, P., & Godwin, J. (2023). Psychosis Symptom Trajectories Across Childhood and Adolescence in Three Longitudinal Studies: An Integrative Data Analysis with Mixture Modeling. *Prevention science : the*

official journal of the Society for Prevention Research, *24*(8), 1636-1647. https://pubmed.ncbi.nlm.nih.gov/37615885/

NAS. (2023). National Autisic Society. https://www.autism.org.uk/advice-and-guidance/topics/behaviour/meltdowns/all-audiences

National Autism Implementation Team. (2021). *Children's Neurodevelopmental Pathway - the practice framework: A workbook for assessment, diagnosis and planning*. https://www.thirdspace.scot/wp-content/uploads/2021/05/Childrens-Neurodevelopmental-Pathway-and-Guidance-2021.pdf

Nelson, C., Bhutta, Z., Burke Harris, N., Danese, A., & Samara, M. (2020). Adversity in childhood is linked to mental and physical health throughout life. *BMJ*, *371*, 1-9. https://doi.org/10.1136/bmj.m3048.

NES. (2015). *National Trauma Transformation Programme*. NHS Education for Scotland. https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-transformation-programme/

NHS. (2023). *Depression in children and young people*. NHS Retrieved from https://www.nhs.uk/mental-health/children-and-young-adults/advice-for-parents/children-depressed-signs/

Perry, B., Griffin, G., Davis, G., Perry, J., & Perry, R. (2018). The impact of neglect, trauma and maltreatment on neurodevelopment: Implications for juvenile justice practice, programs, and policy. In P. Rotshtein (Ed.), *The Wiley Blackwell Handbook of Forensic Neuroscience* (pp. 815-835). John Wiley & Sons Ltd.

Public Health Scotland. (2022). *Scottish suicide information database*. https://www.publichealthscotland.scot/publications/scottish-suicide-information-database/suicide-among-young-people-in-scotland-a-report-from-the-scottish-suicide-information-database-6-september-2022/

Read, J., & Bentall, R. P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *The British Journal of Psychiatry*, *200*(2), 89-91.

Retz, W., Ginsberg, Y., Turner, D., Barra, S., Retz-Junginger, P., Larsson, H., & Asherson, P. (2021). Attention-Deficit/Hyperactivity Disorder (ADHD), antisociality and delinquent behavior over the lifespan. *Neurosci Biobehav Rev*, *120*, 236-248. https://doi.org/10.1016/j.neubiorev.2020.11.025

Royal College of Psychiatrists. (2015). *Behavioural problems and conduct disorder for parents and carers.* RC Psych. https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/behavioural-problems-and-conduct-disorder-for-parents.

Royal College of Psychiatrists. (2022). *Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr234-staff-support-following-patient-suicide.pdf?sfvrsn=f6571a69_12

Rutherford, M., Johnston, L., Maciver, D., Day, H., & Gray, A. (2024). *Children's NeurodevelopmentalPathway Practice Framework:A workbook for assessment,diagnosis and planning*. Third Space.scot: Autism Implementation Team Retrieved from https://www.thirdspace.scot/wp-content/uploads/2024/10/Childrens-Neurodevelopmental-Pathway-Practice-Framework-2024.pdf

Sagar, R., Patra, B. N., & Patil, V. (2019). Clinical Practice Guidelines for the management of conduct disorder. *Indian Journal of Psychiatry*, *61*, 270-276. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_539_18

Sanders, R. (2020). *Care experienced children and young people's mental health*. https://www.iriss.org.uk/resources/outlines/care-experienced-children-and-young-peoples-mental-health

Sayal, K., Prasad, V., Daley, D., Ford, T., & Coghill, D. (2018). ADHD in children and young people: prevalence, care pathways, and service provision. *The lancet. Psychiatry*, *5*(2), 175-186. https://doi.org/10.1016/S2215-0366(17)30167-0

Scottish Government. (2023a). *Mental Health and Wellbeing Strategy.* Retrieved from https://www.gov.scot/publications/mental-health-wellbeing-strategy/

Scottish Government. (2023c). *National Guidance for Child Protection in Scotland 2021 - updated 2023*. Retrieved from gov.scot (www.gov.scot).

Scottish Executive. (2001). *Report on the Review of the Mental Health (Scotland) Act 1984*. https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

Scottish Government. (2018a). *Principles of Transition*. https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2018/08/transition-care-planning-action-21-principles-transition/documents/00539633-pdf/00539633-pdf/govscot%3Adocument/00539633.pdf

Scottish Government. (2018b). *Rejected referrals to child and adolescent mental health services: audit*. S. Government. https://www.gov.scot/publications/rejected-referrals-child-adolescent-mental-health-services-camhs-qualitative-quantitative/

Scottish Government. (2020). *Child And Adolescent Mental Health Services: national service specification*. Edinburgh: Scottish Government Retrieved from https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

Scottish Government. (2021a). *Children and young people - national neurodevelopmental specification: principles and standards of care*. https://www.gov.scot/publications/national-neurodevelopmental-specification-children-young-people-principles-standards-care/documents/

Scottish Government. (2021b). *Independent Forensic Mental Health Review: final report*. Retrieved from https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/

Shaw, P., Eckstrand, K., Sharp, W., Blumenthal, J., Lerch, J. P., Greenstein, D., Clasen, L., Evans, A., & Giedd, J. R., J. L. (2007). Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation. *Proceedings of the National Academy of Sciences of the United States of America*, *104*(49), 19649–19654. https://pubmed.ncbi.nlm.nih.gov/18024590/

Soares, N., Allely, C. S., Straub, F., & Penner, M. (2022). Autism Spectrum Disorder, Extremism, and the Role of Developmental-Behavioral Pediatric Clinicians. . *Journal of Developmental and Behavioral Pediatrics*, *43*(8), 480-488. https://doi.org/10.1097/DBP.0000000000001108

Somerset NHS Foundation Trust. (2023). Somerset NHS Foundation Trust,. https://www.somersetft.nhs.uk/early-intervention-in-psychosis/step/acute-phase/

The Mental Health Foundation. (2002). *The Mental Health Needs of Young Offenders*. https://www.mentalhealth.org.uk/publications/mental-health-needs-young-offenders-update

United Nations Convention on the Rights of the Child, 1577 UNTS 3 (1990), (1990). https://treaties.un.org/doc/Publication/UNTS/Volume%201577/v1577.pdf

United Nations Human Rights Committee. (2019). United Nations Global Study on Children Deprived of Liberty: Commitee on the Rights of a Child. 23.

https://www.ohchr.org/en/treaty-bodies/crc/united-nations-global-study-children-deprived-liberty

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia bulletin*, *38*(4), 661-671.

Vaswani, N. (2018). *Adverse Childhood Experiences in children at high risk of harm to others. A gendered perspective.* https://cycj.org.uk/wp-content/uploads/2018/08/Adverse-Childhood-Experiences-in-high-risk_CYCJ-_Final-Version-proofed.pdf

Weyrauch, D., Schwartz, M., Hart, B., Klug, M. G., & Burd, L. (2017). Comorbid Mental Disorders in Fetal Alcohol Spectrum Disorders: A Systematic Review. *Journal of developmental and behavioral pediatrics : JDBP*, *38*(4), 283-291. https://pubmed.ncbi.nlm.nih.gov/28460370/

Who cares? Scotland. (2022). *Tend our Light: Mental health findings from our Annual Participation Programme*. https://www.whocaresscotland.org/wp-content/uploads/2022/08/APP-Mental-Health-Report-1.pdf

Wickham, S., Whitehead, M., Taylor-Robinson, D., & Barr, B. (2017). *The effect of a transition into poverty on child and maternal mental health: a longitudinal analysis of the UK Millennium Cohort Study.*

Williams, H., Schrieff, L., Hughes, N., Tonks, J., Chitsabesan, P., & Kent, H. (2021). Neurodisability and trauma in children and young people in conflict with the law. In G. Lansdell (Ed.), *Neurodisability and the Criminal Justice System, Comparative and Therapeutic Responses* (pp. 91-109). Edward Elgar Publishing Ltd.

Young, S., Gudjonsson, G. H., Wells, J., Asherton, P., Theobald, D., Oliver, B., Scott, C., & Mooney, A. (2009). Attention Deficit Hyperactivity Disorder and Critical Incidents in a Scottish Prison Population, Personality and Individual Differences *46*(3), 265-269. https://doi.org/10.1016/j.paid.2008.10.003