

TREATMENT OF SERIOUS  
YOUNG OFFENDERS  
1<sup>ST</sup> APRIL 2011



- Conduct disorders are characterised by a repetitive and persistent patterns of antisocial, aggressive or defiant behaviour.
  
- Young people with conduct disorder may exhibit
  - Excessive levels of fighting or bullying
  - Cruelty to animals or other people
  - Severe destructiveness to property
  - Firesetting
  - Stealing
  - Repeated lying
  - Truancy from school
  - Running away from home
  - Unusually frequent and severe temper tantrums
  - Defiant provocative behaviour



- For the diagnosis of conduct disorder, which requires an enduring pattern of a range of difficult behaviours of at least six months prior to diagnosis.
  
- Several terms have been used to describe conduct disorder:
  - Including antisocial behaviour
  - Acting out
  - Externalising behaviour
  - Disruptive behaviour and conduct problems



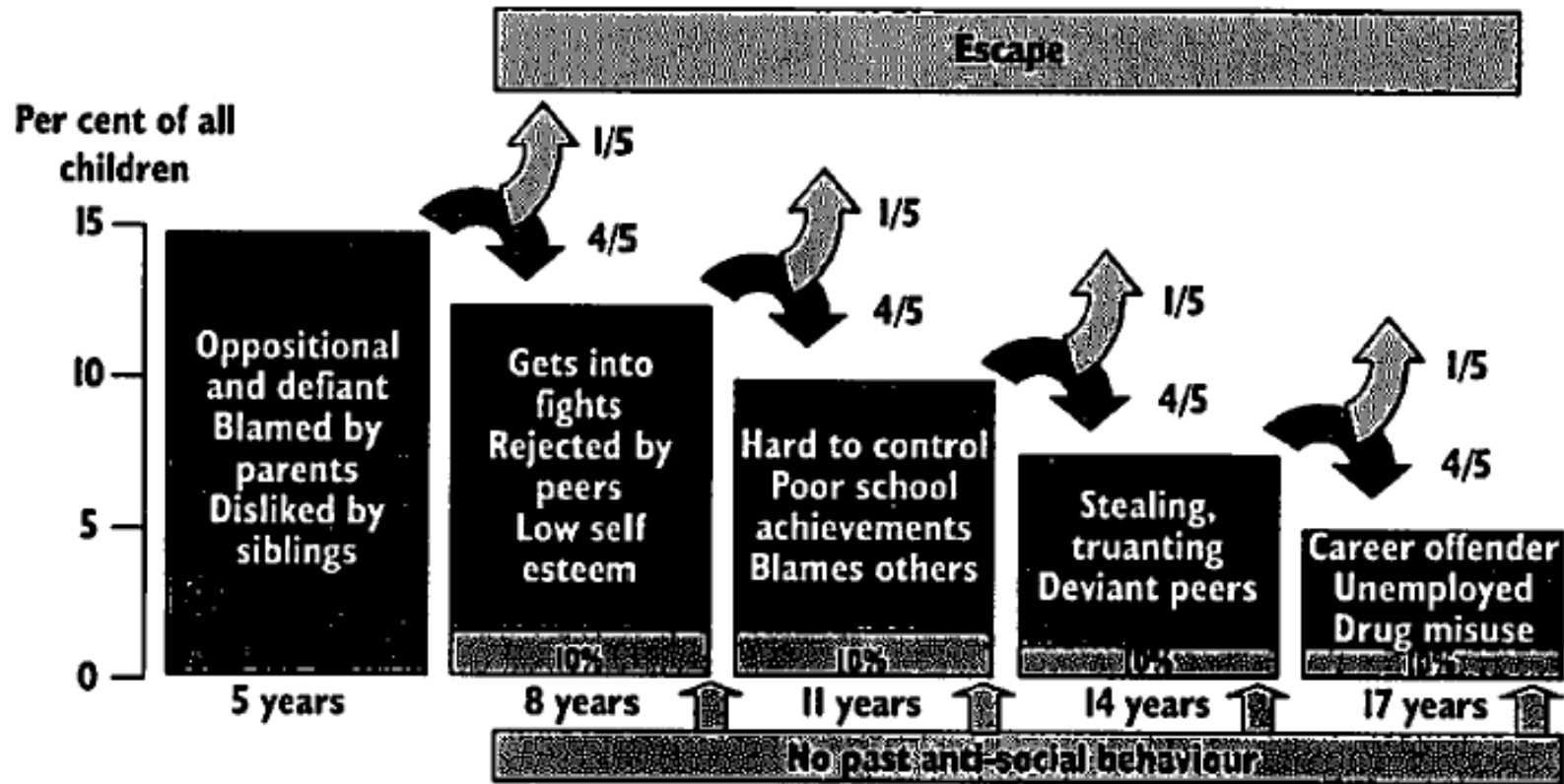
## Prevalence

Conduct disorders are now the most prevalent mental health problems in young people. In a British survey of young people between the ages of 11 and 15 it was found that , overall, conduct disorders occur in 7% of the population (up from 6.2% in 1999), affecting 8.1% of males (8.6% in 1999) and 5.1% of females (3.8% in 1999).

### Prevalence rates of conduct disorder in Great Britain for young people aged 11-15

<b>TYPE OF CONDUCT DISORDER</b>	<b>BOYS</b>	<b>GIRLS</b>	<b>ALL</b>
Oppositional defiant disorder	3.5%	1.7%	5.2%
Unsocialised conduct disorder	1.2%	0.8%	2.0%
Socialised conduct disorder	2.6%	1.9%	4.5%
Other conduct disorder	0.7%	0.8%	1.5%

# Continuity of Anti-social behaviour from 5-17



Source: Unpublished research by S. Scott for the Home Office, 2002

# Advances in developmental psychology

- Increased understanding of the continuities between child and adult life remind us many childhood disorders once thought to resolve with age are now known to “cast long shadows” over later development.
- (Maughan, B. & Kim-Cohen, J. (2005). Continuities between childhood and adult life. *British Journal of Psychiatry*, 187, 605-617.)
- Age relativity
- Discontinuity
- Co-morbidity
- Demographic issues

# ■ Explaining what we mean: Antisocial Behaviour

- Adult patients with history of conduct disorder have increased rates of:
  - Substance misuse
  - Affective, anxiety and
  - Eating disorders and
  - Some increase in rates of psychosis
- For society – future burden of poor adult health social adjustment
- Impact of domestic violence and sexual abuse
- Early child bearing
- Poor parenting with increased risk to next generation

# THE COMPLEXITY OF WHAT WE DEAL WITH

## **Co-occurring Mental Disorders**

- ADHD
- Substance Misuse
- Learning Disability

## **Complicating conditions**

- Prodromal psychopathic disorder
- Autistic traits
- Bullying
- Crime victimisation
- Adolescent partner violence

# We know a great deal and need to advice policy makers on best strategies:

## Individual

- Identified genotypes – most studied – candidate gene.  
MAO promoter polymorphism
- Interaction of genotype with maltreatment history
- Not search for the “bad” gene
- But gene – environment research will
  - benefit efforts to understand how brain mechanisms
  - connect external risk factors and genomic variation to the conduct disorders
- Perinatal Complications
- Temperament
- Neurotransmitters
- Verbal deficits
- Executive dysfunction (frontal lobe)
- Information processing and social cognitions

# Risks outside of family

## Neighbourhood

- Go beyond structural demographic characteristics
- “collective efficacy” “social control”.

## Peer Influences

- Rejection by
- Gravitation towards



# Family level influences

## **Concentration of crime in families**

- Fewer than 10% of families in any community account for more than 50% of that community's criminal offences
- Familial concentration – reflects co-occurrence of genetic and environmental risks
- There is genetic liability but it's the interaction that matters
- In those with genetic liability the experience of maltreatment greatly increases the risk of conduct disorder
- Therefore, awareness of genetic liability to conduct problems increases urgency to improve social environment.

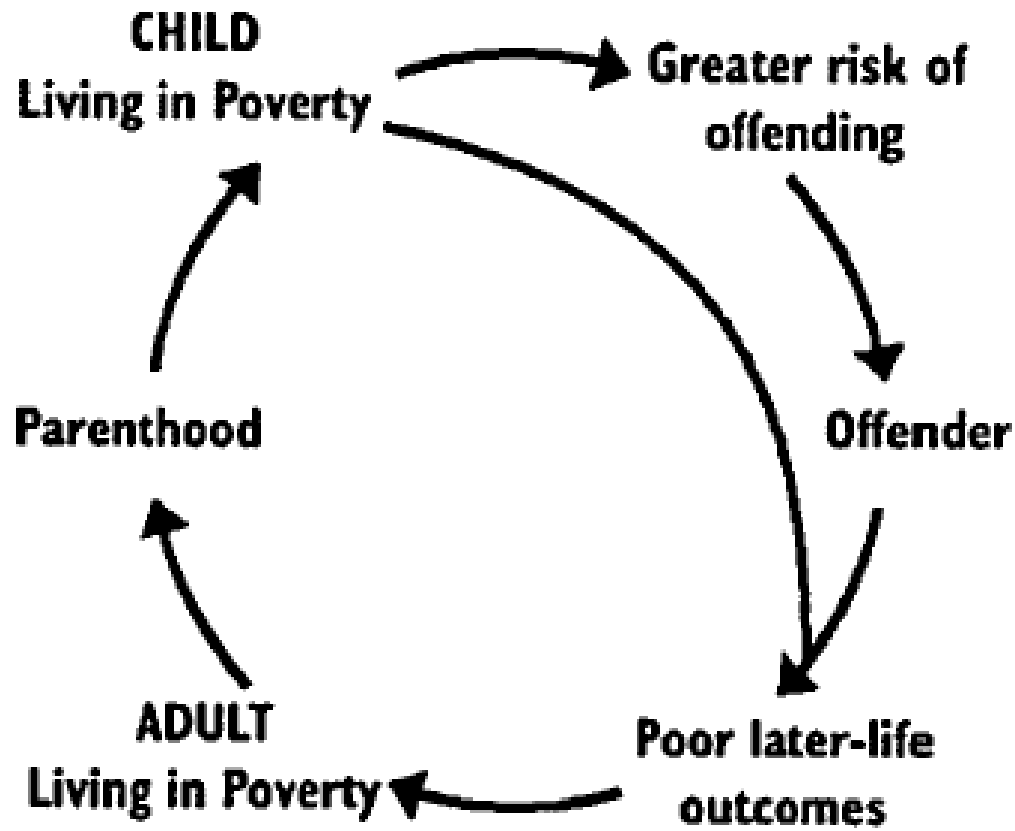
# Family poverty

## **Not direct link**

- Indirect mediated by family pressures
- Harsh discipline
- Low supervision
- Weak parent child attachment

NB. Lessons from the 1930's very relevant at time of "credit crunch"

# INTER-GENERATIONAL TRANSFER OF OFFENDING



# PARENT CHILD ATTACHMENT

Do attachment difficulties as measured by observational paradigms have an independent causal role or

Are attachment classifications markers for other relevant family risks.

## Discipline and Parenting

### Coercive parenting

- Genetic liability
- Effect of children's behaviour on parents
- Correlate of other features of parent/child relationship

# MOTHERS AND FATHERS

Mother's with depression (whilst rearing children) –  
increased risk of depression

Marital conflict and domestic violence

Children learn aggression normative part of family relationships effective way of controlling others aggression sanctioned not punished.

Prosocial father's absence – predict more aggression by his children

Antisocial father's presence – produces more aggression by his children increasing impact in relation to time each week spent caring for his children

# MALTREATMENT

- Physical
- Sexual
- Emotional
- Difficult to research for ethical reasons
- So likely mechanisms:
  - Threats to security of attachment
  - Difficulty in affect regulation
  - Distortion processing and self-concept

# MULTIAXIAL DIAGNOSTIC FRAMEWORK (ICD-10)



## Abnormality versus normality

- Axis I: Clinical psychiatric syndromes
- Axis II: Specific disorders of psychological development
- Axis III: Intellectual level
- Axis IV: Medical conditions
- Axis V: Associated abnormal psychosocial situations
- Axis VI: Global assessment of psychosocial disability (0 – 80)



# ICD10 MULTIAXIAL DIAGNOSIS

Axis One      Clinical Psychiatric Syndrome

Axis Two      Specific Disorders of Psychological Development

Axis Three    Intellectual Level

Axis Four     Medical Conditions

Axis Five     Associated Abnormal Psychosocial Situations

- 1            Abnormal intrafamilial relationships
- 2            Mental disorder/deviance or handicap in the child's  
              primary support group
- 3            Inadequate or distorted intrafamilial communication
- 4            Abnormal qualities of upbringing
- 5            Abnormal immediate environment
- 6            Acute life events
- 7            Societal stressors
- 8            Chronic interpersonal stress associated with school/work
- 9            Stressful events/situations resulting from the child's  
              own disorder/disability

**Axis Six      Global Assessment of Functioning**



## **Oppositional Defiant Disorder (ODD)**

ODD symptoms are sometimes followed by conduct disorder.

## **Attention Deficit Hyperactivity Disorder (ADHD)**

It may be difficult to distinguish between ADHD and conduct or oppositional behaviour. Co-occurrence of hyperactivity and conduct problems has been associated with poorer outcomes than either disorder on its own.

## **Depression**

Conduct disorder has been associated with depression in several studies. Conduct disorder with depression seems to place adolescents at a high-risk for future emotional, behavioural, social, academic, social and vocational problems. Depression has also been found to be prevalent amongst imprisoned young offenders.



## **Suicide**

A link between suicidal and antisocial behaviour has been suggested in one review (Fox and Hawton, 2004). Adolescents with disruptive disorders have been found to be at risk for suicide when there is comorbid substance abuse and a past history of suicidal behaviour.

## **Substance abuse**

The risk of substance abuse has also been found to be high within the conduct disordered population.

## **Learning disabilities**

Rates of comorbidity of learning disabilities and conduct disorder have been found to be high.

# ASSESSING NEED

NEEDS	N/A	Not a problem	Currently Met	Met In Part	Unmet	Don't Know (info not available)
<b><u>Health</u></b>						
Food						
Leisure Activities						
Self care / skills						
Impact of physical illness / disability						
Cultural Identity						
Money / benefits / allowances						
Living Situation						
<b><u>Mood and Thoughts, Psychological Problems</u></b>						
Hallucinations/delusions, psychotic illness						
Psychological problems						
Eating disorders, anxiety, phobias, OCD, ADD, PTSD						
Mood disorders (depression, mania)						
Autism / developmental disorders						

NEEDS	N/A	Not a problem	Currently Met	Met In Part	Unmet	Don't Know (info not available)
<b><u>Behaviour and Lifestyle</u></b>						
Destructive behaviour						
Hostile behaviour towards people						
Oppositional disruptive behaviour						
Sexually inappropriate behaviour						
Deliberate Self-Harm						
Substance / alcohol misuse						
<b><u>Relationships</u></b>						
Peers						
Family (inc. any with significant problems)						
<b><u>School / Work</u></b>						
Communication problems, language, vision, hearing						
Educational performance						
Specific/global learning difficulties						
Educational attendance						
Weekday occupation						



Three principal reasons for concern regarding mental disorders in youthful offenders.

- The custodial treatment obligation (i.e. the obligation to respond to mental health needs)
- Assurance of due process in adjudicative proceedings
- Public safety (i.e. to the extent that there is a relation between an adolescent's mental health status and future violent behaviour, the obligation to offer specific provisions).
- A substantial number of adolescents will show offending behaviour and will have a mental health disorder simply because of coincidental overlap between both conditions.
- Delinquent and antisocial behaviour reaches high levels among juvenile justice populations, a diagnosis of conduct disorder (CD) will often be made
- Because CD shows high comorbidity rates with several other psychiatric disorders (Angold et al 1999), increased levels of many types of disorder may be expected. Third, risk factors for youthful offending overlap substantially with those for several types of non-disruptive child psychiatric disorders
- Therefore, identical risk factors may underlie both antisocial behaviour and emotional or developmental problems.



Research on the prevalence of mental disorders in juvenile justice youth has increased steadily during the past years but remains limited compared with similar research in adults. 62 studies could be identified, totalling 23,000 individuals. Only 16 studies can be included, totalling 4495 individuals.

Although research consistently reveals high levels of psychiatric disorders among detained juveniles, rates vary widely by study, ranging from more than 50% to 100%



## Limitations of current research

1. The type and nature of psychiatric interviews varied by study.
2. The moment of investigation and the period of diagnostic assessment also differed by study.
3. Some studies focused on youth shortly after detention, whereas others investigated youth in the post adjudication phase.
4. The moment of assessment may have relevance because detention itself may influence the psychologic condition
5. With respect to psychiatric diagnosis, different time frames (e.g. point prevalence versus prevalence over a specific period) were often used.
6. Enormous difference exist among studies on relevant sociodemographic and criminological characteristics
7. Studies were conducted in different countries and, for those in the United States, in different states.
8. Some studies investigated antisocial youths referred specifically for psychiatric assessment.
9. Because information from parents is largely unavailable, almost all current prevalence studies have relied uniquely on the youths themselves as informants.



## **Screening and assessment instruments in clinical (non-forensic) settings**

## **Screening and assessment in forensic child and adolescent contexts**

Grisso and colleagues (Grisso et al 2005) point to four conceptual aspects of mental disorders in the forensic adolescent population that should be taken into account when screening for and assessing disorders

- Age relativity
- Discontinuity
- Comorbidity
- Demographic differences
- Pathways of care and the juvenile justice system

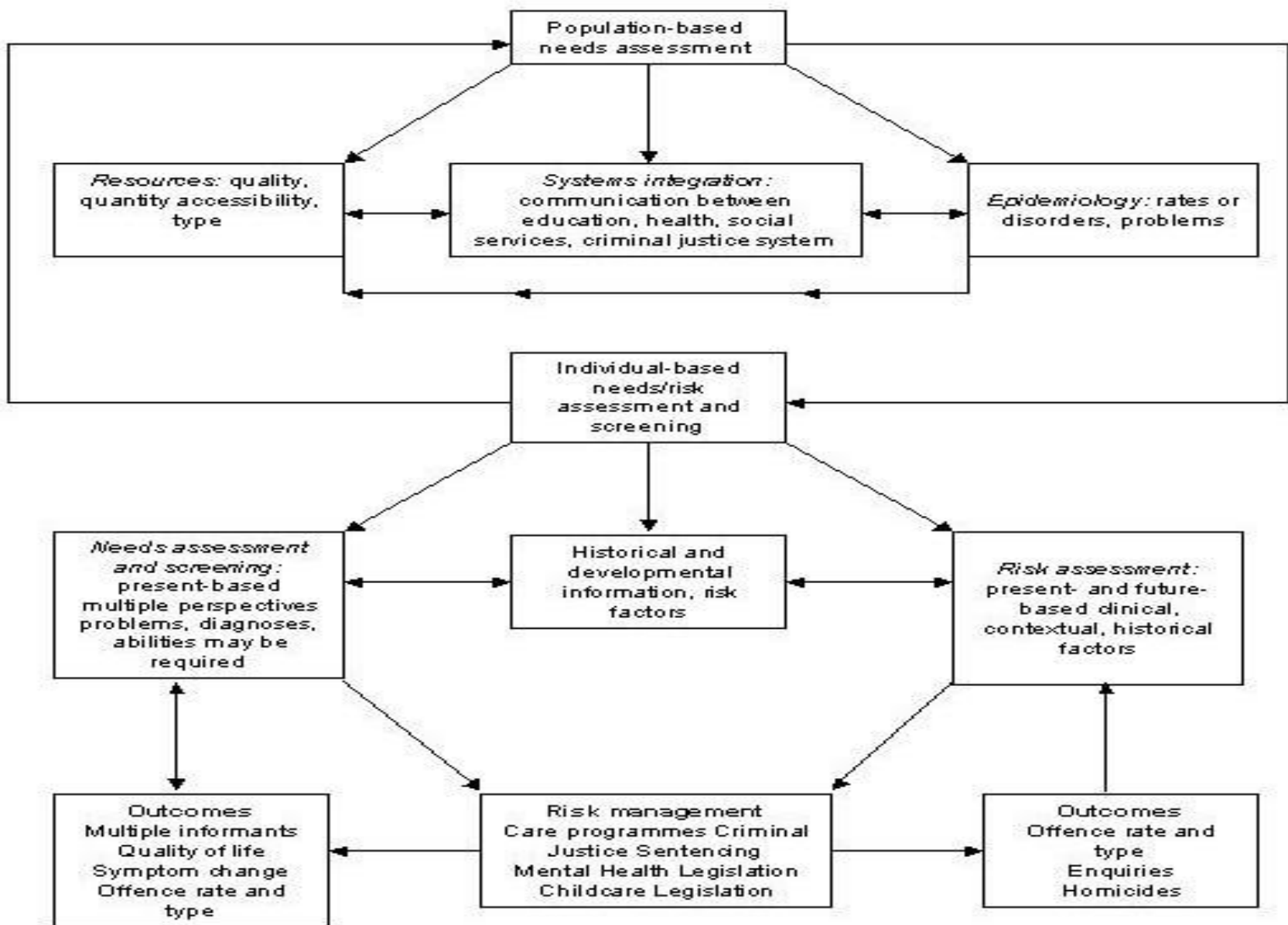


Fig. 1. Relationship between various screening, need assessment, risk assessment and management approaches in juvenile justice systems (Kroll, 2004)



## **Needs assessment**

Needs and risk assessment are two separate but intertwined processes. Assessment of danger to others and the need to address this problem is at the centre of legislative and policy decision making. The attention of the public and media are focused on this area. Risk assessment has a theory and methodology separate from needs assessment. It combines statistical data with clinical information in a way that integrates historical variables, current crucial variables, and the contextual or environmental factors. Some of these clinical and contextual factors are potential areas of need. Therefore needs assessment may both inform and be a response to the risk-assessment process (Bailey, 2002; Bailey & Dolan, 2004). The reciprocal process can be termed "risk management" when accurate information about the risk assessment, combined with recurrent needs assessment, leads to risk-management procedures. A recurrent needs-assessment and risk-assessment process should identify changes in problem areas, thus leading to monitoring or intervention as part of risk management. Core to this assessment are appropriate mental health screening tools and processes that are available to the young person at any point in the system (Bailey & Tarbuck, 2006)



**Forensic Mental Health** is an area of specialisation that in the criminal sphere includes the assessment and treatment of those who are both mentally disordered and whose behaviour has led or could lead to offending.

Child Psychiatrists need to be closely involved with developing specialist community and inpatient resources, including secure facilities for children and adolescents who may be:

- Mentally disordered offenders
- Sex offenders and abusers
- Severely suicidal and self harming adolescents
- Very severely mentally ill adolescents
- Adolescents who need to begin psychiatric rehabilitation in secure circumstances
- Brain injured adolescents and those with severe organic disorders



- Oppositional Disorders, Conduct Disorder and ADHD
- Depression Anxiety and PTSD in Childhood and Adolescence
- Autism Spectrum Disorders and Learning Disability
- Early onset psychosis
- “Psychopathic personality” in young people
- Substance Misuse
- Policy makers responding to need
- Improving Access to Child and Adolescent Mental Health Services (CAMHS)
- Role of Health Workers in YOTs
- Young Offenders with health needs in Custodial Settings
- Comprehensive Health Screening Tool
- Transfer to Appropriate CAMHS medium secure provision
- Substance Misuse
- Intensive Resettlement and Aftercare Provision (RAP) Schemes
- The role of CAMHS Specialist in Medico-legal Assessment



In providing information to the court, written reports have the advantage of a standard format that helps the consultant to be sure that s/he has considered all the relevant questions; it also provides a familiar structure for readers. In essence, for the sake of consistency and clarity, competence reports need to cover the following areas:

- Identifying information and referral questions.
- The description of the structure of the evaluation including sources and a notation of the confidentiality expectations.
- The provision of clinical and forensic data.

Treatment and Special Crimes

Juvenile Homicide

Sexually abusive behaviour

Firesetting/Arson

Adolescent Girls

# What policy makers should spend more money on: **INTERVENTIONS**

## **Principles of Intervention**

Fit needs of child and family

Needs and strengths

Especially multiaxial framework of ICD-10 (1996)

## **Choosing which Treatment Modality for which specific context**

### **Developing Strengths**

### **Engaging family**

### **Treating common conditions**

### **Making use of Guidelines**

AACAP – USA

NICE – England

SIGN – Scotland

### **Treating child in natural environment**

# Politicians stress the importance of equity: GIRLS



Young girls who engage in disruptive behaviour and fight are at risk of:

- Being rejected by peers
- Feeling alienated
- And unsupported in their relationships with peers and adults
- Struggling academically
- Affiliating with other peers prone to deviant behaviour
- Becoming involved in more serious antisocial behaviours
- Choosing antisocial romantic partners
- Initiating and receiving partner violence
- Becoming adolescent mothers
- Having children with more health problems
- Being less sensitive and responsive as parents

**Vs BOYS** Lord of the Flies by William Golding

# A care pathways approach – holistic and person-centred care



- The term care pathways' has been used to describe:
  - more general descriptions of a patient's care journey
  - high-level process maps of services
  - And processes of care. (*Hall and Howard, 2006*)
  
- Care pathways are also known by different names, including:
  - care paths,
  - critical paths,
  - managed care pathways
  - and care continuum pathways (*Denton et al, 1999*).

## Criminal Justice Care Pathway – In England (Sainsbury Foundation) What does yours look like?

EARLY INTERVENTION	CRIMINAL JUSTICE DECISION MAKING	THROUGH-CARE AND RECOVERY
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	Prevention	Pre- Arrest	Point of Arrest	Arrest/Pre-Court	Bail, remand and sentencing	Custody/detention	Community
Critical Partners	<ul style="list-style-type: none"> <li>- Sure start workers</li> <li>- Schools</li> <li>- Children’s Trust and social care</li> <li>- YOS Crime Prevention</li> <li>- Families/ Carers</li> </ul>	<ul style="list-style-type: none"> <li>- YOS Crime prevention</li> <li>- Targeted Youth work</li> <li>- Neighbourhood policing</li> <li>- Community Support Officers</li> <li>- CMHT’s</li> <li>- Families/ carers</li> <li>- Faith groups / BME community support</li> </ul>	<ul style="list-style-type: none"> <li>- CAMHS</li> <li>- Social care</li> <li>- Police</li> <li>- CMHTs</li> <li>- Families/Carers</li> </ul>	<ul style="list-style-type: none"> <li>- CAMHS</li> <li>- CJLD schemes</li> <li>- CPS</li> <li>- Custody Sergeant</li> <li>- Forensic Medical Examiners</li> <li>- CPNs</li> <li>- Psychiatrists</li> <li>- Appropriate adults</li> <li>- Families/ carers</li> </ul>	<ul style="list-style-type: none"> <li>- YOTs</li> <li>- CAMHS/ CMHTs</li> <li>- Sentencers</li> <li>- CJLD worker</li> <li>- Court Duty Officer</li> <li>- Bail support workers</li> <li>- Social care</li> </ul>	<ul style="list-style-type: none"> <li>- Prison in-reach and healthcare</li> <li>- Substance misuse workers</li> <li>- Secure care</li> <li>- Safer custody</li> <li>- Forensic services</li> <li>- Psychology</li> <li>- Chaplaincy</li> <li>- Families/carers</li> </ul>	<ul style="list-style-type: none"> <li>- YOT’s/CAMHS/ RAP/ CMHTs</li> <li>- Housing dept. and tenancy support</li> <li>- Employers</li> <li>- Substance misuse</li> <li>- Primary Care</li> <li>- Probation</li> <li>- Families / cares</li> <li>- Faith groups/ BME community support</li> </ul>
Mechanism	<ul style="list-style-type: none"> <li>- Common assessment Framework (CAF)</li> <li>- Positive activities</li> <li>- Youth Support workers in schools</li> <li>- Youth inclusion programmes</li> <li>- Multi agency preventative panels</li> </ul>	<ul style="list-style-type: none"> <li>- Youth inclusion and support programmes</li> <li>- Multi agency preventative panels</li> <li>- Proactive and skilled primary mental health care</li> <li>- Training</li> <li>- S. 136</li> </ul>	<ul style="list-style-type: none"> <li>- CAF</li> <li>- Training and mental health awareness</li> <li>- Crisis Intervention Teams (CIT)</li> <li>- S. 136</li> <li>- Triage</li> </ul>	<ul style="list-style-type: none"> <li>- Training</li> <li>- Assessment/ referral</li> <li>- CJLD scheme presence</li> <li>- Information sharing</li> </ul>	<ul style="list-style-type: none"> <li>- CJLD triage report</li> <li>- Psychiatric report</li> <li>- Mental health options (MHTRs; CTOs; Guardianship Orders; Hospital Orders; Voluntary hospitalisation)</li> </ul>	<ul style="list-style-type: none"> <li>- Multi-disciplinary referral meetings</li> <li>- MAPPAs/ MAPPPs</li> <li>- Parole process</li> <li>- S.117/ CPA</li> <li>- Brief interventions</li> <li>- Treatment programmes</li> <li>- Assessment for transfer to hospital</li> </ul>	<ul style="list-style-type: none"> <li>- CPAs. 117 licence</li> <li>- Benefit advice</li> <li>- Housing advice</li> <li>- Employment Opps</li> <li>- Education/ training/ courses</li> <li>- MAPPAs/ MAPPPs</li> <li>- Advocacy and support</li> <li>- Leisure activities</li> </ul>
Objectives	<ul style="list-style-type: none"> <li>- Early identification of risk factors and supporting protective factors for vulnerability, mental health, and offending</li> </ul>	<ul style="list-style-type: none"> <li>- Identify vulnerable people pre-crisis</li> <li>- Direct / alert mental health services</li> <li>- Prevent vulnerable people from coming into contact with the criminal justice system</li> <li>- Support carers and families</li> </ul>	<ul style="list-style-type: none"> <li>- Facilitate police discretion</li> <li>- Create options for police officers other than arrest (CPAs; S. 136)</li> <li>- Eliminate service exclusion policies</li> <li>- Increase partnership working with CMHTs</li> </ul>	<ul style="list-style-type: none"> <li>- Identification of mental health problems</li> <li>- Appropriate use of cautions</li> <li>- Appropriate referral to CMHTs</li> <li>- Timely mental health reports</li> </ul>	<ul style="list-style-type: none"> <li>- Improved understanding and use of mental health options by the court</li> <li>- Avoidance of remand and imprisonment where appropriate</li> <li>- Coordinated packages of holistic care</li> </ul>	<ul style="list-style-type: none"> <li>- Continuity of holistic care</li> <li>- Liason in and out</li> <li>- Screening</li> <li>- Safety</li> <li>- Appropriate transfer to hospital</li> </ul>	<ul style="list-style-type: none"> <li>- Social inclusion</li> <li>- Reduce reoffending</li> <li>- Improve health outcomes</li> <li>- Support stabilisation, aspirations and positive lifestyle change</li> </ul>

# Criminal Justice Care Pathway –What does yours look like?

EARLY INTERVENTION				CRIMINAL JUSTICE DECISION MAKING		THROUGH-CARE AND RECOVERY	
	Prevention	Pre- Arrest	Point of Arrest	Arrest/Pre-Court	Bail, remand and sentencing	Custody/ detention	Community
Critical Partners							
Mechanism							
Objectives							



## **Key elements of an integrated care pathway:**

- Developed by all stakeholders
- Plan of anticipated care
- Includes measurable outcomes
- Defines standards of care to promote consistency and equity
- Follows a timeline
- System of integrated recording
- Incorporates evidence-based guidelines
- Crosses organisational and professional boundaries

Hall and Howard (2006)

## **Key enablers for mental health care in the offender supervision pathway are ensuring that:**

- Relevant mental health information about the young person is available at all stages of the care pathway; information-sharing protocols are required.
- There is appropriate staff training to identify mental health needs (specifically emotional, mental health and substance misuse needs).
- Justice system staff know when and where to refer.
- The professional's obligation is to respond to mental health needs is not frustrated by systemic obstacles.

## **Any care pathway, when adopted, should be evaluated regularly with respect to:**

- efficacy of mental health screening and assessment;
- efficient communication of information flow; and
- barriers to implementation (e.g. confidentiality).



# In summary

- There is a need for a change in culture at local and national governmental levels so that evidence-based interventions are demanded and their effectiveness regularly monitored.
- At present there are considerable opportunities in most countries to switch from currently used interventions to more effective ones without incurring extra expenditure.
- Finally, by way of prevention, we need further studies of how to better identify, screen and effectively intervene with young children at risk of antisocial behaviour.
- In Britain in a *Lord of the Flies* situation we have dumped our boys on desolate estates giving them nothing to do except fight each other. We need a fundamental societal change.