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

Section 10: Mental Health

June 2018

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1. Introduction

It is without question that social workers working in the youth justice and related services have a pivotal role in prevention, early intervention and care planning for young people who have needs in the area of mental health. The complex needs of this particular group are now well-established. As discussed below, there is growing evidence that many young people presenting with risk of harm to themselves or others also have histories of serious childhood adversity, and that both risk and adversity are associated with a greater likelihood of developing mental health difficulties later in childhood or adulthood (Hahn et al., 2015). In children and young people with such complex needs, early identification, or differentiation of mental health from additional needs, is vital to inform timely and effective intervention and therefore prevent escalation in difficulties over time.

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

The aim of this section is to offer advice and guidance to practitioners working in youth justice services or with young people presenting with risk behaviours. It is not a review of the evidence base, nor is it a comprehensive summary of all mental health problems and their treatments. The primary purpose is to provide key information for practitioners to raise awareness of some of the more common mental health presentations encountered in youth justice and related services. This includes a brief introduction of the policy context, an overview of the typical structure of mental health services and some information on what we know about mental health needs relevant to children and young people and how these are classified. This section will conclude with some general guidance on how practitioners might respond to vulnerable children and young people in their day-to-day work.

2. Background and Context

Over approximately the last 15 years in Scotland, there has been a growing emphasis on promotion of a multi-agency approach to maximising mental well-being in children and young people. This has largely focussed on exploring service-based opportunities to prevent and respond to mental health needs in an integrated way and at the earliest point possible. These aims and principles have been encapsulated in a range of strategies and policy documents released over this period. Notably, The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (Scottish Executive, 2005), which built on the earlier recommendations of the Scottish Needs Assessment Programme report (Scottish Executive, 2003), and proposed that all agencies have a role in supporting the

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

GIRFEC principles were further reflected in the wider Mental Health Strategy for Scotland (Scottish Government, 2012) which aimed to improve mental health outcomes through the introduction of HEAT targets (Health, Efficiency, Access, Treatment) and supporting initiatives such as The Matrix: A guide to delivering psychological therapies for children (NES, 2015). HEAT targets were designed to optimise access to mental health assessment and treatment but have since been replaced by Local Delivery Plan (LDP) standards. LDP standards are priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance. The current performance on standards specific to the needs of children and young people is documented on the Scottish Government website. The Matrix guide supports delivery of the above standards by providing guidance on common mental health needs in children and young people and outlining evidence based approaches to meeting these needs. Importantly, while much of this focuses on the role of specialist psychological or mental health practitioners in delivering or supervising intervention in NHS contexts, it nonetheless highlights that specific practitioners, with a range of experience and training, can be supported by specialists in delivering interventions and at various levels of intensity. These interventions can range from self-help and information sharing to highly specialist intervention - depending on level of need. While a specific role for social work practitioners is not outlined, what is clearly indicated is that early intervention, mental health promotion and working to basic psychologically informed principles should be relevant to all practitioners. These broad aims clearly correspond with GIRFEC agendas, and health and social care integration. The Scottish Government has recently published their Mental Health Strategy: 2017-27 (Scottish Government, 2017), which is the first national strategy since the integration of health and social care. It aims to achieve parity between mental and physical health provision and one of the key areas of focus is prevention and early intervention. Their ambitions for prevention and early intervention are as follows:

- Every child and young person to have appropriate access to emotional and mental well-being support in school
- Appropriate, evidence-based, parenting programmes should be available across Scotland
- Evidence-based interventions to address behavioural and emotional issues in children and young people should be available across Scotland
- Mental health support and treatment for young people involved in offending who have mental health problems should be available across Scotland

- Mental health training for non-mental health staff should be available across health and social care services
- Training in first aid approaches for mental health should become as common as physical first aid

In the context of the above legislation and policy drivers, shared themes of early intervention, awareness of mental health, evidence based approaches and interdisciplinary and interagency working, all point to the fact that social work staff are key partners in a mental health response, given their role in assessing need and supporting our most vulnerable children and families.

2.1 Mental Health and Offending Risk

It is well established that the population of young people involved in more serious or chronic offending behaviour are some of our most vulnerable young people in terms of their social, educational, emotional, physical and mental health needs, and the poor outcomes associated with these vulnerabilities.

There is limited research on the mental health needs of children and young people involved in youth justice services in Scotland, although this is growing (Dyer & Gregory, 2014; Mental Welfare Commission, 2014) and has been summarised in Key messages from the Centre for Youth & Criminal Justice. Nonetheless, enhanced need in this population has been well established elsewhere (Almond, 2012). For instance, UK population-based studies of children and young people have found prevalence of mental health problems to be between 10% (Green et al., 2005) and 20% (Social Work Inspection Agency, 2006) of the general population. In contrast, the rate of mental health problems of those involved in youth justice tend to be significantly greater than that of the general population, between 25% and 81% (Mental Health Foundation, 2002), with those in custody having the highest rates of up to 95% (Lader et al., 2000). Up to date research into the prevalence of child and adolescent mental health needs is due to be published by the Mental Health Foundation in 2018.

The most common mental health difficulties for both the general population and the population of young people who offend are conduct disorders, emotional disorders, attention disorders, and substance misuse (Mental Health Foundation, 2002), which captures the full range of emotional, social, and behavioural difficulties. However, the complexity within the youth justice population can be understood to be relative to the higher frequency of difficulties, the greater severity of the problem, and multiple problems occurring at the same time (comorbidity). An additional factor complicating understanding of individual mental health needs in this population (and children in general) is the potential for under-identifying internalising difficulties (such as anxiety or depression), as these may be obscured by, or manifest as, externalising problems (such as behavioural difficulties). Finally, the question of what way, if any, mental health difficulties relate to high risk behaviours adds further complexity.

With regards to understanding why young people who offend may be at increased risk of the above mental health problems, there has been a growing body of research linking early traumatic or adverse childhood experiences not only with increased risk of serious offending across the lifespan (Hahn et al., 2015), but also with increased risk of developing a range of mental health problems in adulthood (Varese et al., 2012; Read & Bentall, 2012; Couper &

Mackie, 2016). The extent to which difficulties in adulthood are linked to experience of the above disorders in childhood or indeed the exact mechanisms involved in these links and factors associated with resilience continues to be explored in current research. Regardless, these findings nonetheless serve to underline the complex needs of this group of children and young people, but also a possible genesis in early adverse experience, which further supports the current focus on prevention and early identification of need (Keyes et al., 2012).

3. Child and Adolescent Mental Health Services: Scotland

In Scotland, as in the rest of the United Kingdom (UK), NHS Child and Adolescent Mental Health Services (CAMHS) are generally delivered as part of a tiered health care system for children and young people aged six to either 16 years or 18 years depending on the area. The tiered approach is designed to help services organise and target their resources in the most helpful way. Service tiers are differentiated by level of severity or complexity of needs of the young person and/or family. Complexity has slightly different meanings depending on the service but usually means two or more problems (e.g. obsessive compulsive disorder and substance use) or very severe problems (like psychosis). There are some variations in how a tiered model is applied across health board areas; however, the basic premise is that as we progress from Tier 1, the more complex the actual or hypothesised mental health need, the more likely the need for specialist skills to meet that need, and possibly, the longer the duration of intervention. The tiered system of mental health care also encompasses other agencies, systems and people who may not be specialist mental health practitioners:

- Tier 1 represents **universal** services provided by practitioners who are not mental health specialists. Examples include GPs, teachers and social workers. The role of Tier 1 representatives in mental health care can include promoting good mental health, offering advice, identifying problems early in their development through monitoring, supported intervention and referring to or liaising with specialist services as necessary.

- Tier 2 comprises specialist mental health services that assess and treat **mild to moderate** difficulties such as low mood or anxiety. Where available, Tier 2 CAMHS are usually organised through GP or other community based services and, where available, would usually be the first point of contact for Tier 1 practitioners if they have concerns about a young person.

- Tier 3 will respond to **moderate to severe** difficulties such as more serious depression or anxiety disorders or, conditions such as attention deficit hyperactivity disorder, eating disorders or Autism Spectrum Disorder/learning disabilities. Tier 3 services are also usually accessed in the community.

- Tier 4 mental health services are highly specialist and respond to the **most severe and complex of needs** which typically require multi-disciplinary and multi-agency support. Examples include inpatient services, day units and some intensive home-based treatment services. Specialist mental health practitioners working in these services usually have additional training or significant experience in key areas (for example: forensic clinical psychologists or social workers with Mental Health Officer status).

While the configuration of services across tiers can vary by area, every health board has a local CAMHS, to which children and young people can be referred. Depending on the locality, CAMHS may reflect a Tier 3 service, or a joined Tier 2/3 service. More populated localities will have Tier 4 teams. The only health board currently with a forensic CAMHS service specialising in working with young people at risk of serious offending and related mental health needs is Greater Glasgow and Clyde (which covers eight local authorities in either part or full).

4. Mental Health Difficulties: Classification and Diagnosis

Traditionally, both the American Psychiatric Association (APA, 2013) and the World Health Organisation (WHO, 2010) have produced classification systems. Both offer diagnostic criteria for mental disorders and, in general, they can be considered largely analogous. These systems can be thought of as a dictionary for mental disorders. However, the task of identification is more complex. For example, the experience of mental ill-health or emotional distress can be considered normative at times. As such, rather than discerning if a problem is simply present or absent, there is a need to consider severity. If it is present, can it be considered mild, moderate or severe? Guidance here is less clear.

The prevailing classification systems do not offer guidance on how to understand or prioritise difficulties when an individual meets the diagnostic criteria for multiple disorders. Nor do they comment on how different difficulties develop, or are maintained, or how they interact with each other over time. This is important to bear in mind in terms of youth justice, as we know that complexity and co-morbidity of mental health difficulties is the rule, rather than the exception when working with young people at risk of causing harm to themselves or others. It should also be borne in mind that 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 youth justice 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. 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 young person, their history and experiences can make a significant contribution to the development of a highly individualised case conceptualisation.

5. Mental Health Difficulties: Identification

5.1 Anxiety

Anxiety is a relatively common childhood difficulty, which can be thought of as a collection of affective, cognitive, biological and behavioural symptoms as outlined below. Broadly speaking, it can be thought of as a fear reaction in response to some feared stimulus (e.g. needles, separation from caregiver, thoughts of illness, negative evaluation, failure, etc.). 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. Not all will be discussed in depth though. To facilitate identification, common features of anxiety will be outlined, followed by a brief description of how anxiety manifests in each of the different anxiety problems.

In an anxious child or young person, practitioners might note the following:

Affect

- Worry
- Nervousness
- Distress
- Hypervigilance

Physical

- Racing heart
- Stomach pain
- Dizzy
- Shaking
- Short of breath
- Hyperventilation
- Restlessness
- Sleep difficulties

Cognitive

- Catastrophic thinking
- Poor concentration
- Thoughts/beliefs that underpin specific fears

Behaviour

- Verbalisation of worries
- Avoidance (of feared stimulus)
- Withdrawal
- Checking things are okay
- Reassurance seeking
- Controlling behaviours
- Maladaptive coping strategies – use of alcohol/substances; self-harm
- Diminished school attainment

In terms of the differing anxiety presentations, brief but severe episodes of anxiety may be experienced as a panic attack, during which acute physical symptoms become so intense that an individual feels as if they are losing control, are choking, or may die. Following the experience of a panic attack an individual may become highly anxious about having another and adjust their lifestyle in the hope of preventing further instances. This often involves avoiding going outdoors, or doing so alone, which is called agoraphobia.

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

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

For more in-depth information, NICE have produced various guidelines, which can be consulted depending on the specific anxiety in question. In addition, NHS Education Scotland have also developed an on-line training resource – An introduction to Cognitive Behavioural Therapy for Anxiety.

5.2 Attention Deficit Hyperactivity Disorder (ADHD)

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

Cognitive

- Distractible
- Short attention span
- Poor planning abilities
- Poor time estimation
- Delayed internalisation of speech

- Learning difficulties
- Memory deficits
- Poor school performance
- Low self-esteem
- Lack of conscience
- Difficulty seeing consequences of behaviour

Affect

- Poor self-regulation
- Excitable
- Poor frustration, tolerance or anger
- Low mood

Behaviour

- Highly active
- Poor motor coordination
- Difficult to contain
- Risk taking behaviour
- Underdeveloped adaptive behaviour

Physical

- Immature physical size and bone growth
- Minor physical abnormalities
- Neurological soft signs
- Allergies
- Increased respiratory/ear infections/inflammation
- Accident prone and high rate of injury

Interpersonal

- Relationship difficulties with parents, teachers, and peers

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

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

ADHD and traumatic stress in their assessment. Further guidance on ADHD is available via the Scottish Intercollegiate Guidelines Network (SIGN, 2009).

The Matrix: A guide to delivering psychological therapies for children (NES, 2015) details a summary of the most evidence based interventions in terms of ADHD (and other mental health concerns), which generally indicate high intensity school interventions, parent training, and education and drug treatment.

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

5.3 Autistic Spectrum Disorder (ASD)

ASD is defined by substantial impairment across three domains:

Social

- Atypical social development, especially in terms of interpersonal reciprocity

Language/Communication

- This may relate to both verbal and non-verbal communication and the pragmatics of language

Thought/Behaviour

- Rigidity of thought and behaviour, ritualistic or stereotyped behaviours, difficulties with social imagination

According to the 10th version of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), ASD is one type of disorder under the umbrella term of 'pervasive developmental disorders'. ASD is an enduring, life-long disorder, with no cure. The degree of impairment associated with a diagnosis of ASD can vary from mild to severe. ASD is often differentiated into either Autism or Asperger's Syndrome. Those with Asperger's share the clinical features of ASD, but tend to have better language skills and no intellectual impairment. As elaborated on in Carr (2006), the clinical features of ASD are:

Interpersonal

- Inability to empathise with others
- Lack of understanding of social rules
- Lack of reciprocity in social interaction
- Avoiding eye contact
- Poor understanding of non-verbal communication

Affect

- Inappropriate or incongruent emotional expression
- Occasional intense emotional responses to change
- Likely anxiety surrounding social interactions

Behaviour

- Absence of imaginative play
- Stereotyped or repetitive behaviour patterns, including routines or rituals
- Resistant to change, or apparently controlling
- Behaviour problems in childhood
- Tendency towards specific or obsessive special interests

Language

- Developmental language delay (Autism)
- Lack of social conversation
- Lack of creative use of language in conversation
- Echolalia (automatic repetitious verbalisations)
- Pronominal reversal (referring to self as “he”, “she”, or “you”)
- Neologisms (use of words that only have meaning for the user)
- Other language idiosyncrasies

Cognition

- Likelihood of impaired IQ (approximately 75% of individuals)
- Non-verbal IQ better than verbal IQ (Autism)
- Extraordinary skills in a specific area
- Difficulties with social problem solving
- Rigid thinking style
- Obsessive thought patterns
- Absence of theory of mind

Physical

- Risk of epilepsy later in development
- Wetting or soiling in younger children
- Risk of self-injurious behaviour (head-banging or biting)
- Poor muscle tone

Sensory

- Troubled by auditory or visual information, e.g. loud or multiple noises or bright lights
- Auditory filtering (appears not to hear things or have poor attention)
- Sensation seeking (touches certain things, makes noises, especially excitable during active tasks)
- Strong aversion to certain smells, tastes, or textures
- Tactile sensitivities

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. Diagnosis must be made via a multi-disciplinary assessment, which might include speech and language therapists, occupational therapists, nursing, psychiatry, paediatricians, or psychologists. Individuals with ASD are thought to lack Theory of Mind, or the ability to understand the mental states of others. This mechanism may underpin an apparent lack of empathy in the moment. It does not mean that ASD children cannot care about others.

ASD tends to be identified early in infancy or early childhood; however, it can go undiagnosed. ASD impacts upon all aspects of the child or young person's life and it is crucial to understanding their risks and needs. Some features of ASD, for example, difficulty with regulating emotions or taking on the perspective of others, are shared by complex traumatic stress responses. Other features, such as lack of empathy or behaviour problems are shared by relatively unusual but severe and concerning personality traits, such as psychopathic traits. Given the high instance of childhood maltreatment in the population of children and young people engaged in the youth justice system, and the relatively high occurrence of psychopathic traits identified in the adult criminal justice population, it is realistic for practitioners to expect to encounter cases where such complex differentiations need to be made i.e. between traumatic stress, ASD, or psychopathic traits. When this dilemma arises, in-depth multi-modal assessment is indicated and should be sought via local specialist mental health services.

The literature with regard to ASD and violence risk is not definitive; however, emerging clinical wisdom suggests that besides drivers associated with lack of empathy, individuals with ASD who engage in violent conduct may do so when denied access to their special interest, in the context of change, or in response to sensory vulnerabilities. Understanding the presence and relevance of ASD is important, particularly in relation to legal issues, as ASD may undermine a child or young person's competence to understand and engage with legal proceedings. Where there is a query of ASD, it should be carefully considered and local ASD specific services, or CAMHS services, may have a role in assessment. CAMHS may be more appropriate for complex children and young people where other diagnostic considerations may also need to be eliminated or formulated alongside a potential ASD diagnosis.

There is a SIGN guideline to which the reader can refer for further information. The National Autistic Society has guidance on working with individuals with ASD who are also engaged in criminal proceedings.

As already stated, there is no cure for ASD. It is an enduring neurodevelopmental problem; however, behavioural interventions in response to specific concerns associated with ASD, such as anxiety, sleep difficulties, or communication problems, may be of benefit. The majority of interventions in response to ASD will likely be undertaken by parents/carers, or by implementing systemic or environmental changes.

5.4 Conduct Disorders (CD)

CD are marked by a repetitive and persistent pattern of aggressive, defiant and antisocial conduct. A diagnosis of CD can be made when a child is aged six to 18 years. Younger children with conduct problems might be diagnosed with Oppositional Defiant Disorder (ODD). To meet the criteria for CD, a child's behaviour must be significantly out with what would be expected, given the child's age and/or stage of development. Such behaviours include:

Behaviour

- Fighting, with initiation
- Bullying
- Cruelty to others or to animals

- Destructive behaviour
- Stealing/robbery
- Lying
- Truancy, prior to 13 years
- Fire-setting
- Severe disobedience/defiance
- Easily annoyed/angered
- Spiteful/vindictive
- Resentful
- Weapon use
- Housebreaking/trespassing

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

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

The reader is referred to the relevant NICE guidance for a more in-depth consideration.

5.5 Depression

From a diagnostic perspective there are various sub-types of depression. However, broadly speaking, the following signs may be recognised by practitioners in a child or young person who is depressed (Carr, 2006):

Perception

- Perceptual bias towards negative events
- Mood congruent hallucinations (in severe cases)

Cognition

- Negative view of self, world, others, or the future

- Excessive guilt (e.g. self as burden)
- Suicidal ideation (in severe cases)
- Mood congruent delusions or beliefs (in severe cases)
- Distorted thinking
- Poor concentration (associated with onset of low mood)
- Hopelessness

Affect

- Depressed mood
- Inability to experience pleasure
- Irritability
- Anxiety and apprehension
- Tearfulness

Behaviour

- Psychomotor retardation or agitation
- Depressive stupor (in severe cases)
- Loss of motivation or interest

Somatic

- Fatigue
- Poor sleep (insomnia or excessive sleeping)
- Aches and pains
- Loss of appetite or overeating
- Change in weight (in severe cases)
- Diurnal variation in mood (worse in morning)
- Reduced libido

Interpersonal

- Deterioration in relationships
- Withdrawal or self-isolation
- Deterioration in school performance

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

5.6 Self-harm

Self-harm is considered to be any act where injury is purposely inflicted on the self, in the absence of suicidal ideation or intention (suicide will be considered at section 5.9). 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.

There are certain common features of a child or young person's journey through services when they engage in self-harm. When the difficulty is first identified or is thought to be particularly concerning, it usually prompts an urgent referral to CAMHS. Due to concerns about any associated threat to life, contact with CAMHS may be preceded by attendance at an Accident and Emergency Department. Attendance at Accident and Emergency may contribute to a reduction in, or cessation of the behaviour. Often, by the time of CAMHS assessment, the difficulties or distress are no longer as severe and the behaviour is therefore no longer relevant. The young person will no longer meet the criteria for CAMHS, or where intervention is offered, the young person no longer identifies with the concerns or does not engage and thus does not receive a service. This cycle may become repeated, and

consequently self-harm is often a difficulty managed via support from third sector, residential, or social work services where there is no active CAMHS involvement. The service response to self-harming behaviour should be multi-agency and acknowledge the support and interventions of different services at different points in time.

5.7 Post-Traumatic Stress Disorder (PTSD)

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. The following symptoms are common to PTSD:

Cognition

- Upsetting memories or intrusive thoughts
- Memory loss in relation to the trauma
- Flashbacks - feeling as if it is happening again
- Nightmares
- Concentration difficulties
- Trauma-centric changes in belief system

Affect

- Intense distress in response to reminders
- Anger or irritability
- Depression
- Anxiety
- Dissociation/emotional numbing
- Hypervigilance

Behaviour

- Loss of interest in activities
- Sleep difficulties
- Avoidance of reminders

Interpersonal

- Relationship problems
- 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. In terms of treatment, PTSD (Type I) tends to respond well to CBT tailored towards trauma and developmental stage.

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 (Cook et al., 2003) with the following symptoms:

Interpersonal

- Uncertainty about the reliability and predictability of the world
- Problems with boundaries
- Distrust and suspiciousness
- Social isolation
- Interpersonal difficulties
- Difficulty attuning to other people's emotional states
- Difficulty with perspective taking
- Difficulty enlisting other people as allies

Affect

- Difficulty with emotional self-regulation
- Difficulty describing feelings and internal experience
- Problems knowing and describing internal states
- Difficulty communicating wishes and desires

Cognition

- Difficulties in attention regulation and executive functioning
- Lack of sustained curiosity
- Problems with processing novel information
- Problems focusing on and completing tasks
- Problems with object constancy
- Difficulty planning and anticipating
- Problems understanding own contribution to what happens to them

Learning

- Problems with language development
- Problems with orientation in time and space
- Acoustic and visual perceptual problems
- Impaired comprehension of complex visual-spatial patterns

Behaviour

- Poor modulation of impulses
- Self-destructive behaviour
- Aggression against others
- Pathological self-soothing behaviours
- Sleep disturbances
- Eating disorders
- Substance abuse
- Excessive compliance
- Oppositional behaviour
- Difficulty understanding and complying with rules

- Communication of traumatic past by re-enactment in day-to-day behaviour or play (e.g. sexual, aggressive)

Physical

- Sensorimotor developmental problems
- Hypersensitivity to physical contact
- Analgesia
- Problems with coordination, balance, body tone
- Difficulties localising skin contact
- Somatic complaints
- Increased medical problems across a wide span, e.g. pelvic pain, asthma, skin problems, auto-immune disorders, pseudo seizures

Dissociation

- Distinct alterations in states of consciousness
- Amnesia
- Depersonalisation and derealisation
- Two or more distinct states of consciousness, with impaired memory for state-based events

Identity

- Lack of a continuous, predictable sense of self
- Poor sense of separateness
- Disturbances of body image
- Low self-esteem
- Shame and guilt

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 involved in the youth justice system tend to have significant histories of maltreatment. It is therefore suggested that complex trauma cannot be disregarded. Reflecting this, the new ICD-11, that is due to be published in 2018, will contain 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 Judith Herman in her seminal work (1992). 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 treatment.

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.

The Scottish Government commissioned NHS Education for Scotland (NES) to develop a National Trauma Training Framework. To date this work has resulted in Transforming psychological trauma: A skills and knowledge framework for the Scottish workforce being published in May 2017 and production of an e-learning resource.

5.8 Psychosis

The first episode of psychosis usually occurs for individuals in their late teens or early adulthood, with males tending to experience earlier onset than females. An episode of psychosis is usually preceded by a prodromal phase, which can be a period of weeks, months or even years during which a person experiences sub-threshold psychological or behavioural abnormalities in cognition, emotion, perception, communication, motivation or sleep. Changes in mood, social isolation or occupational or educational failures may also be observable, along with low frequency or intense delusional beliefs or hallucinations. These phenomena translate over time into a deterioration that precedes the onset of clear clinical symptoms of psychosis, which include the following typical features:

Perception

- Hallucinations (involving any of the senses)
- Breakdown in perceptual selectivity

Thought

- Thought disorder
- Delusional beliefs
- Impaired judgement and reality testing
- Confused sense of self

Emotion

- Prodromal anxiety and depression
- Inappropriate affect
- Flattened or impoverished affect
- Post-psychotic depression

Behaviour

- Prodromal sleep disturbance
- Prodromal impulsivity
- Prodromal repetitive compulsive behaviour
- Impaired goal-directed behaviour
- Catatonia, negativism, and mutism

Interpersonal

- Poor school performance
- Withdrawal from peer relationships
- Deterioration in family relationships

Again, NICE have produced guidance with regard to psychosis in children and young people, which can be consulted for more in-depth consideration. Early identification and intervention in response to the first episode of psychosis has a significant and positive impact on longer-term outcomes. Where there are concerns of this nature prompt referral to mental health services is recommended and such cases will be prioritised by CAMHS. In terms of evidence-based interventions, CBT for psychosis or related mood difficulties, and family interventions, are indicated.

With violence risk and psychotic presentations, command hallucinations (perceptions of being told to do something) or delusional beliefs (e.g. that they are being targeted or persecuted) may be relevant and critical in terms of violent conduct.

5.9 Suicide

Suicide is a significant public health concern. Suicide attempts can be thought of as self-harming behaviours with intent to die. Although uncommon in younger children, suicide is a leading cause of death amongst adolescent and young males (Goldney, 2008). Suicide attempts, or parasuicide, are relatively common, with lifetime cross-national prevalence rates of plans or attempts estimated to be 9.6% (Nock et al., 2008). Within the population of individuals using mental health services, 27% of mortality is due to suicide (Windfuhr & Swinson, 2011); and within custody in the UK, suicide is responsible for approximately half of the deaths that occur (Natale, 2010). The assessment of suicidal behaviour or intent is complex and involves the consideration of many factors across numerous domains. These include suicidal ideation/intent, available methods and lethality of same, precipitating factors, motivation, individual/psychological factors, mental health, historical factors and family factors.

Research has identified some key empirically derived risk factors associated with suicide which mental health services will consider (Logan, 2013), e.g. mental health difficulties, especially mood disorders; prior suicide attempts; substance misuse; prior self-harm; physical illness; and unemployment.

In terms of identification prior to a CAMHS referral, a set of consensus warning signs identified by the American Association of Suicidology (Rudd et al., 2006) is a guide:

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

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

NHS 24 on **111**
Samaritans on **116 123**
ChildLine on **0800 11 11**
Breathing Space on **0800 83 85 87**

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

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

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

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

6. Interventions

Social workers, support workers, and residential care workers are often left wondering how best they can 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. There are often certain commonalities with regard to the vulnerabilities underpinning mental health difficulties within the youth justice population and certain considerations in terms of response may be of value:

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

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

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

- **Normalise**
  Teenagers, 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 the youth justice system 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 (or risk), and they may not have the skills to build trusting relationships. Day-to-day interactions have the potential to act as interventions, in that anything that models how to be open, trusting, reliable, playful, consistent or responsible in relationships is of great benefit over time. This may involve reflecting aloud with the child or young person about your thinking, expectations, or intentions.

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

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

- **Regulate**
  Often a child or young person's problems stem from a difficulty with regulating behaviour and/or emotions and they may be overwhelmed by emotions or exhibit challenging or worrying behaviour. Regulation difficulties may be secondary to a neurodevelopmental concern (e.g. ASD, ADHD), attachment difficulties, or trauma, or some combination of all three. What the child or young person will need is support to regulate themselves, which at first or at times of crisis may require intense support. Acting as an external regulator involves multiple tasks and is usually contingent of having a positive relationship:

    - **Recognition** – Children and young people often have difficulties knowing what it is they are feeling, to know when difficult emotions are coming, what they are, why they happen when they do, and what to do about them. This leaves the child or young person in a vulnerable, powerless, and overwhelmed position. Practitioners can facilitate recognition by reflecting about the child or young person's perspective and experience, for example, "I can see by the expression on your face that you're angry right now", "I'm wondering if you're feeling worried?", "I think lots of people in your position would be feeling sad right now" and so on. This process will help them to label and recognise their emotions, which is a first step in regulation.

    - **Modulation** – Helping the child or young person to understand what triggers strong emotions and how they can cope with them is important in terms of making these emotions less overwhelming and therefore promoting self-regulation. This can be done without relating to past experiences or other situations and dealing with the present, for example, "I noticed when you lost that game, your mood seemed to change, and then you called your friend a name, I wonder if you were trying to let us know how angry you felt. Maybe next time, if you lose you try something different..." Such interactions serve to contain emotions, model empathy, curiosity, caring and help the child or young person to recognise the relationship between events, their feelings and behaviour.

With Scotland have produced a range of potentially useful resources. Their report on using the social work relationship to promote recovery may be particularly useful to practitioners (Mitchell, 2012).

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