Adolescent forensic psychiatry

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Abstract

Adolescent forensic psychiatry merges understanding of the developmental trajectories of personality and behavioural traits with assessment of risk and treatment of mental disorder in young people who are offending or harming others. This article describes the various mental health services that have developed in England to provide help for these young people across health, social care, and criminal justice, including medium secure mental health services for adolescents. The different disorders and behaviours that commonly present to adolescent forensic services, including conduct disorder, psychopathy, and sexually harmful behaviour, are also reviewed. Risk assessment is described briefly, with reference to structured assessment tools that can be used with young people in the assessment of violence, psychopathy, and sexual offending.

Keywords adolescence; forensic; in-reach; medium secure; mental disorder; Mental Health Act; offending; personality disorder; risk; violence

Adolescent forensic psychiatry is a relatively new field, but one with a growing number of practitioners from a range of professional backgrounds who provide services in many different kinds of setting from secure residential to the community, and from hospital to prison. It has roots in both child and forensic psychiatry, with a focus on the interplay between mental disorder, risk, and offending behaviour, and with assessment and management occurring in the context of the developmental and family background of the individual patient. This article will first describe the systems and settings within which adolescent forensic mental health is practised and then review current knowledge in the field.

The national adolescent medium secure network

After it had been recognized that there was a population of young people who were best treated for their mental health problems in conditions of security, a process began that led to the eventual development of six medium secure in-patient units spread across England, operating within the National Health Service (NHS) and funded centrally by the National Commissioning Group (NCG).

These units operate as part of a clinically managed network, taking referrals through a centralized system and admitting 12–17-year-old young people who have both displayed behaviour that creates serious risk for others and who are liable for detention under the Mental Health Act. This created an easier path to access to mental health services both for young people too difficult to manage in open adolescent units and for those detained in prison or appearing before the courts.

Each unit has a multidisciplinary team, with clinicians from psychiatry, psychology, social work, occupational therapy, and nursing contributing to the care and management of the client group. All units also have specialized educational and occupational services so that the young people, who may be in hospital for a year or more, can continue to develop academic and work skills, and have at least part of their day that is as close as possible to that experienced by their peers in the community.

All of the units provide assessment and treatment for those with serious and enduring mental illnesses such as schizophrenia and bipolar disorder. Some of the units, such as the Roycroft unit in Newcastle, also offer expertise in the management of emerging personality disorders, and further expansion is under way to provide services for those who also have learning difficulties.

'Outreach' and 'inreach' adolescent forensic services

Not all young people in need of adolescent forensic services require admission and there is increasing provision of mental health services by teams that work from an NHS base into different kinds of non-NHS facility where young people are resident.

Young people up to 18 years of age who are deemed to present a risk to themselves or others can be held for periods on Secure Accommodation Orders under the Children Act 1989 in local authority secure children's homes (LASCHs), although those under 13 years require the permission of the Secretary of State. Those who have reached the age of 10 years (the age of criminal responsibility) and who have committed offences may be held on remand or serve custodial sentences in LASCHs, secure training centres (STCs) or young offender institutions (YOIs).

There is a high prevalence of psychiatric morbidity in this group,[1,2] with significant numbers – perhaps even the majority – displaying evidence of mental health problems, with substance misuse, conduct disorder, personality disorder and emotional disturbance being common.

The kind of service that the young detainees can access is still highly variable across the country, with some institutions having access only to lone working mental health professionals, although an increasing number have full, highly specialist, multidisciplinary teams; those providing input to the Huntercombe YOI in Oxfordshire and Ashfield YOI in Bristol are regarded as examples of good practice.[3]

Community forensic child and adolescent mental health services

Young people under the care of child and adolescent mental health services (CAMHS) can present with risky and uncommon

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symptoms or behaviours that cause clinicians concern, such as very severe self-harm, sexually harmful behaviours, and violent ruminations. For these young people, some CAMHS can now refer to community adolescent forensic teams (FCAMHS), whose members have particular expertise in risk assessment and management of the complex area of overlap between psychiatric and psychological symptoms and offending behaviour.

For those whose behaviour has led them into formal contact with the criminal justice system, the Crime and Disorder Act 1998 set out a strategy for development of multi-agency youth offending teams (YOTs), and the Children's National Service Framework (NSF), announced in 2001, set the aim of integrated services for those with complex needs. Through this legislation an expectation was created that health authorities, through CAMHS, would commit resources to young offenders with the aim of ensuring that the needs of those with complex problems would be met and consequently offending behaviour reduced. This work is sometimes helped and sometimes hindered by legislation such as Antisocial Behaviour Orders (ASBOs) and Parenting Orders, which make statutory requirements of young people and their families to attend programmes designed to change behaviour associated with offending.

In practice, as with in-reach teams, provision is variable: some YOTs have only lone health workers who may not even have mental health training, whereas others have access to a full range of mental health professionals. The ASSET risk assessment tool developed by the Youth Justice Board, together with the Screening Interview for Adolescents (SIFA) and the Screening Questionnaire Interview for Adolescents (SQUIFA),[4] have been developed to assist youth justice workers in the assessment of mental health problems and in signposting those most in need of help to the appropriate services.

Pathways to care

Although the different services that young people may encounter have been described separately above, any individual young person may move between these health services, as well as many others (Table 1), with decisions about where and how young people are looked after usually having little to do with need.

Gender differences

Most young offenders are male, although the sex ratio is falling;[5] it was approximately 6 : 1 In 2001, according to Home Office criminal statistics for 10–18 year olds. The full explanation for this has yet to be discovered, but certainly the conditions associated with offending, such as conduct disorder and hyperactivity, are more common in boys than in girls. Young women are referred less often to adolescent forensic psychiatry, and a significant proportion of those who are referred show repetitive self-harm rather than offending behaviour.

Serious mental illness

As with adult forensic services, adolescent forensic psychiatry is concerned with the identification and treatment of conditions such as schizophrenia and bipolar disorder in those who have committed offences. However, diagnosis of these conditions in adolescence is generally more difficult than in adulthood. It is recognized that a significant number of young people who initially appear to be developing conduct problems are later shown to have been developing schizophrenia with an insidious onset[6] and there is now a well established literature setting out the association between conduct problems and schizophrenia.[7] Symptoms suggestive of schizophrenia and bipolar disorder may co-occur, and the affected young person may also be using illicit drugs, the effects of which further complicate the presenting picture.

Services that offending adolescents may encounter

- Adolescent inpatient
- Secure hospitals
- Forensic CAMHS
- Generalist CAMHS
- Young offender institutions
- Youth offending teams
- Secure training centres
- Specialist schools
- Social service area teams
- LASCHs
- Voluntary sector
- Adult mental health

CAMHS, child and adolescent mental health services; LASCH, local authority secure children's home

Table 1

Conduct disorder, impulsivity, and delinquency

The majority of offending, including persistent and serious offending, is not committed by those with serious mental disorders. The most commonly occurring psychiatric disorder in 5–15 year olds is conduct disorder (found in 5% of young people in Meltzer's study[8]), defined by the presence of a 'persistent pattern of behaviour in which the rights of other are violated'.[9,10] Adolescent conduct problems have repeatedly been shown to predict later offending,[11] with earlier onset and a wider range of antisocial behaviours increasing later risk.

Conduct disorder has a significant co-morbidity, frequently occurring alongside hyperkinetic disorders and substance misuse, each of which also carries independent additional risks for offending.[5,12] This group of disorders is often characterized by a particular pattern of distorted cognitions and affect that includes:

- hostile attributions
- a focus on aggressive cues
- poor verbal problem-solving
- labelling one's own arousal as anger.[13]

Given this pattern, it is easy to see how those affected have high levels of offending, and this presentation is common in young people in contact with the criminal justice system and in those whom adolescent forensic psychiatrists are asked to assess.

Conduct disorder is difficult to treat, often arising from a combination of inherent neurobiological deficits and early exposure to a chaotic, abusive and neglectful environment.

