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EU-Project "FACT FOR MINORS. Fostering Alternative Care for Troubled minors"

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Final Report

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1. Preface:

1.1. The "Project Context"

Mental health problems in minors and young offenders is creating an increasing interest given the high prevalence of psiquiatric and personality disorders in this population. Since 2006, an Educational Therapeutic Unit (TU) exists in Catalunya, situated in the Educational Center Ti.llers, created under a collaboration agreement between the Justice and Health Departments and the Order of Saint John of God (Sant Joan de Déu), (PSSJD from now on). The TU is the result of an interdepartmental, multiagency agreement. The Health Department awarded the TUs' management to PSSJD, which provides the professionals for direct care for minors under judicial order of therapeutic internment. The facilities and support services (laundry, food, etc.) are under the jurisdiction of the Department of Justice. It should be noted that the Education Department recognizes a specialized head teacher for this population. Document management in relation to the juvenile court is in the hands of professionals from the Justice Department, though, professionals from the Health Department have access to the judicial information, fulfilling the confidentiality requirements legally established. Professionals from the justice department only have access to the clinical information when required by the legal authorities.

The therapeutic unit (TU) is specialized in mental health and addictions in youth population. It is in charge of carrying out evaluation, psychodiagnostic, psychotherapeutic attention and intensive psychoeducation in a residential context of educational therapeutic community. The TU is mixed, it has 12 places for males/females from 14 to 21 years old in which the judge values there is a need for specialized treatment and/or psychodiagnosis, which is included in the sentence sometimes because of the presence of a mental disorder or a high risk of developing a mental or addiction problem. The unit also serves other cases which, according to the criteria of the therapeutic team,

and at the request of specialized mental health professionals from the various centres or programs of Juvenile Justice with the relevant judicial authorization, are deemed to present a diagnosed mental disorder or serious risk factors of developing a disorder and are therefore likely to benefit from multidisciplinary treatment. Nevertheless, in the event of clinical decompensation, referral is made to a community crisis unit (adolescent crisis unit for those underage, and acute care unit for those 18 or above). All the attended cases are under the competence of the Community General Management Penal Enforcement and Juvenile Justice, for the commitment of offences, serving internment measures. Besides all the mentioned above, the TU clínical team also carries out the ambulatory care program in juvenile justice educational centers. The clinical team give suport and clinical advice to the educational programs carried out in the educational centers, this improves coordination between PSSJD professionals and justice professionals.

The therapeutic programme which takes place in the TU complies a high interaction with the attended youth, who receive individual psychotherapy daily coming from the psychologists and psychiatrists, psychoeducative training from the social educators, personal and somatic treatment care by the nursery staff and training activities for basic daily life and community integration from the social integrators and clinical assistants. They also develop family care in different intensity levels depending of the detected needs in the nuclear family, taking place both in the therapeutic unit and in their community address. The therapeutic programs of the unit are designed with the aim of assuring total care of psychiatric and psychological disorders, taking into account the biological, psychosocial, and spiritual factors that come into play. This total care is organized around coordinated interventions through an Individualized Therapeutic Project (PTI) created by a multidisciplinary team. The care model is that of an Educational Therapeutic Unit. The individual therapy has a psychodynamic, cognitive-behavioural, and systemic orientation, based upon the assessment made for each case. The TU views the involvement of the family as an indispensable element in clinical improvement and the return of the

individual to community. The TU offers intensive, multidisciplinary attention, which includes activity in the residential environment of the minor as much as possible, in light of the risk assessment in terms of relapse and recidivism. The TU is the reference model for therapeutic internment for the population of all of Catalonia affected by internment measures in closed educational centres.

Between 2016 and 2017 the average time of internment in the TU was of 4 months. During 2017, the shortest internment time was of 1 month, the maximum internment time was of 10 months. During this time an important therapeutic attachment is established, both with the family and with the attended adolescents. For years an informal follow-up has been made, maintaining a telephonical or face to face contact with the youth who have entered the TU once they go back to community.

In Catalonia, even though there already are child-youth health centers, as well as specific care programs for minors' with mental health problems and transgressive behaviors in community, there is a group of adolescents with severe personality disorders, serious mental problems or substance abuse disorders who present bigger attachment issues in this community centers once they finish their internment. They are adolescents who present attachment problems, impulsivity and difficulty in problem awareness, as well as a precarious family and social context, factors that already make new attachments complicated. In other cases, there are problems with accessibility, sometimes because of the geographical distance or the need of immediate care which adolescents usually present, sometimes the existing resources do not adapt to the complex needs of this youth. This is why interventions which go beyond a unique service and clinical needs are necessary. Greater coordination between professionals of the different departments is also necessary, not only between the justice and health departments but also between the minors protection system, social services, education and labour.

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A specific evaluation about offending recidivism in youth attended in the TU between years 2010 and 2013 developed together with the Justice Department of the Catalan Generalitat, developing a follow-up until 2016, showed that recidivism in adolescents with mental health problems and /or addictions who had been fulfilling internment in the unit, took place in 50% of the cases during the first 6 months after release. This research also demonstrated that the main risk factors related to recidivism were: history of physical and/or psychological abuse , exposure to violence at home, low academic performance, failure managing stress and anger, impulsivity and having participated in violent acts before the judicial internment. There are also protection factors which stand out for community reintegration, regarding the existence of pro-social adults who support the adolescent.

Youth attended in the TU receive a biopsychosical, educational and intensive therapeutic approach in a therapeutic community model, they create important attachments with the professionals of the unit. The reintegration procedures, even though they start minimum 2 months before release, assume a very sudden change, from an intervention where all the adolescents' needs are covered in a community context to an intervention with less suport, where adolescents with greater personal or context deficits develop drug abuse relapses, clinical decompensations, problems at family level, poor adeherence to treatment and offensive recidivism. Because of all the exposed information, in agreement with the agents who are involved with adolescents attended at the TU when they are in a community context in probation programs, it was thought convenient to start a pilot project for community follow-up of 6 months duration, both with the adolescent after release and with the family and actors who are involved in the treatment and rehabilitation of the youth , it' s a program focused to encourage attachment, create bonds and minimize fragmentation between the diferent interventions in the move from internment to community care.

1.2. The actors involved

Presently in Catalonia there are several teams that work directly with juvenile offenders with problems of mental health and addiction, all under the aegis of the Department of Justice and the Department of Health. Below we outline the roles and responsibilities of the professionals involved in the internment centers.

Psychiatrist (Department of Health – Parc Sanitari Sant Joan de Déu) is in charge of developing Psychiatric assessment, diagnosis, and psychopharmacological treatment, assessment of mental competence, psychotherapeutic treatment of the patients and their families, family care, participation in the preparation of the individual treatment plan, coordination with medical services, communication with the courts concerning the use of restrictive measures, healthcare coordination with the network of mental health and addictions in the community, preparation of periodic psychiatric reports for the judicial authorities in conjunction with the multidisciplinary team, preparation of psychiatric reports for the network of mental health and addictions in the community in coordination with the psychiatrist assigned to the case and the social worker from the Department of Health.

Clinical psychologist (Department of Health – Parc Sanitari Sant Joan de Déu) will develop assessment and psychodiagnosis, providing elements toward an understanding of the behaviour that helps develop an individualized therapeutic attitude for each patient in order to encourage clinical improvement, individual and group psychotherapy, and support therapy for the patient and the family, family attention and therapy, Preparation of periodic reports for the judicial authorities in coordination with the multidisciplinary team, preparation of clinical psychological reports for the community mental health and addictions network in conjunction with the psychiatrist and the social worker, participation in the preparation of the individual treatment plan.

Social worker (Department of Health – Parc Sanitari Sant Joan de Déu) will manage judicial information concerning the minors, socio-familial assessment and diagnosis, and preparation of social history, analysis and identification of risk situations and of individual and/or family social needs. Intervention and orientation, identification of cases possibly susceptible to judicial incapacitation, management of incapacitation protocol, processing follow-up and coordination with the various participants (prosecution, guardianship foundations, family members, etc.), participation in preparing the individual treatment plan, writing-up of the social report, social care of family: information and orientation, support and follow-up, and advice and orientation in cases of incapacitation and guardianship, social management and advice concerning user documentation and residence permits, financial aid, etc, interdepartmental coordination, coordination with the community network of mental health and addictions and Social Services primary care.

Social teachers (Department of Health – Parc Sanitari Sant Joan de Déu) are responsible for the assessment of individual social, educational, and vocational capabilities and deficits of the minors: daily activities, social abilities, ethical values, etc, planning, implementation, carrying out, and follow-up evaluation of the socio- educational intervention, maximizing educational and pedagogical sequences for each patient, generating educational contexts to encourage learning, responding to difficulties and fundamental cultural disadvantages in order to foster socialization, fostering integration and long-term assimilation of knowledge, helping to develop the ability to exist in society and in the community of adolescent through the planning of community activities (social, recreational, and educational), active accompaniment in the community to assist in effective reintegration.

Psychologist (Department of Justice) Study of the personality of inmates. Managing the application and rectification of appropriate psychological methods for the study of each

inmate, Interpretation and assessment of psychometric tests and projection techniques, keeping the professionals on the team informed about problems detected and orienting them about the resources that may be used to confront these, Identification of the most appropriate resources to confront and treat mental health problems and drug dependencies, and coordination with the relevant professionals, preparation of psychological reports for the judicial and prosecution authorities, attendance in hearings called by the competent judicial bodies or the prosecution authorities, carrying out of specialized action plans (in the case of sex crimes, for example), familiarization with the psychosocial resources available in the community network, collaboration in the use of resources available in the community network.

Social worker (Department of Justice) will implement familiarization with the family and social situation of interned minors, and preparation of a social diagnosis and its maintenance, preparation and application of strategies to bolster the external family environment of the minors, participation in individual treatment and coordination with the Semi-open professionals to insure their intervention following internment.

Teachers (Department of justice) Attending to the minors in the residential unit and learning what their needs are, participation in the preparation of the individual treatment plan, participation in the preparation and application of action programs focused on minors and follow-up on the behavioral evolution of the minors.

Care for Minors' delegate (Department of Justice) Monitoring of socio-educational support during the period of judicial measures, advocacy of correct fulfilment of penalties, measures, and obligations imposed by the authorities. Informing of the judicial authorities concerning the evolution and fulfilment of the terms of judicial probation, assisting in the social reintegration of the minors, facilitating access to social and community resources available for the needs of the attended population, Involvement

with and sensitization of the community in the process of carrying out probationary measures.

Head teacher (Department of Education) Responsible for the academic training of the minors, coordination with the community educational centers which the minor has attended, informing the family about the schooling situation and needs of the minor, coordination with the mental health professionals concerning the specially adapted educational needs of the minor.

It is important to mention that during the judicial internments there are coordination mechanisms with weekly meetings with Health and Juvenile Justice professionals in order to join interventions, give one unique message to the youth and maintain common objectives. There are two levels of coordination between the diferent departments: On one hand, the actors from both departments (Justice, Education and Health department) that are involved directly in the intervention, and, on the other hand, the coordinators of both departments that supervise the intervention plan that are being carried out and the difficulties that can appear in terms of coordination between the different professionals.

2. Project objectives:

Before 2016, the coordination with the community mental health network and the professionals of open environment was developed with a maximum of 1 or 2 contacts before release. We could observe the mental health network had difficulties to create an effective attachment with this patients after release, specially if the youth didn't attend the first or second visit, the case was then lost and open environment professionals were responsible of the follow-up of the patient, this way there were important difficulties

within the minos' treatment, this is why alternative care is necessary in order to develop a better quality care.

Our main objective was to propose an alternative care program after ending internment. From the TU we have proposed a pilot project in order to develop an alternative care program. The release protocol of adolescents treated in the TU is always activated 2 months before ending the legal measure. The social worker is the actor in charge of boosting, managing and coordinating the attachment with the specialized mental health and addicitions services in community, and with the care for minos delegate, which will finish the probation program. Also, the educational team of the TU and the teacher will activate the attachment with the community training resources. In case of underage adolescents the relevant meetings with the childhood and adolescence care teams will be made.

The new intervention will be activated during the first six months after release from the TU, it pretends to develop a new follow-up and coordination model between professionals from the Justice, Health and Labour departments, social services and families of Catalonia, in order to improve the care of minors who suffer mental health and addiction problems in probation programs. The two **priority objectives** of the intervention are:

1.Promote and consolidate the attachment with the community mental health and addictions network, avoiding clinical relapses and trangressive behaviors through interviews and follow-ups with the adolescent and his/her family in community. The intervention will be done by the psychiatrist or psychologist in charge of the case during their internment in the TU.

2.Improve the coordination between community actors who are involved with the minor who is following a probation program in order to:

-Improve the coordination and the trasnfer of information between the judicial, Health and minors protection system.

-Produce synergies in the interventions of the different professionals in order to strenghten the consistency of the intervention plan, consolidating one unique individual interdepartmental program.
-Establish the duties and roles of each professional in the intervention.
-Obtain a unique treatment and intervention plan in agreement with all the professionals involved in the adolescents' care.
-Determine if the existence of a unique interdepartmental case manager is important.
-Detect possible situations which suppose ethical conflict during the interdepartmental coordination.

The social worker and the clinical psychologist will be in charge of organizing this coordination.

3. Capacity building and the two levels of intervention

3.1 National level: experimentation:

a) Strengths and weaknesses of the existing model at the national level

Across Europe, much effort has been made over recent decades to ensure high-quality longer-term care for people with severe mental disorders, which helped to advance mental health care in many countries. These include improvements in the living conditions in psychiatric hospitals, the development of community services, the integration of mental health care within primary care, the development of psychosocial, the protection of the human rights of people with mental disorders and the increasing participation of users and families in the improvement of policies and services.

However, much more has still to be done. In some countries, although progress has been made in the transition from psychiatric hospitals to community care, the resources allocated to the new services are very limited and responses to psychosocial needs are very scarce. The goal would be to develop recommendations for action at EU-level that may lead to a more effective implementation of the desired shifting to community-based mental health systems and services.

In order to improve the community role in juvenile justice, we´ve developed the follow-up program within the framework “Fact for Minors” project, that have helped to enhance the collaboration between the Justice and Health departments and improve a community approach. Thanks to the great collaboration, between these departments adolescents can receive the special care they need, a whole team works towards achieving their well-being while they fulfil their legal condition. Good communication between both Justice and Health departments makes developing the adolescents life outside the centre easier when planning visits with their families or developing hobbies the youth enjoys outside the centre. Within the TU the social worker schedules many outings to the community every week for the adolescents, last year more than 800 were scheduled, this way even adolescents with long-time legal measures can develop a healthy life outside the center, this way once they leave they will already have certain routines and autonomy.

Anyway, our model has also got weaknesses. One of the most noticeable ones is the fact that the care for minors’ delegate does not have training in mental health and many times find it rather complicated to intervene with these adolescents, this is why this project can provide support to community. Case managers with a specific specialization in mental health would be very helpful in order to help this population properly and also to do a strong support when finishing their internment.

Another important weakness is the fact that there are still many internments, our objective would be to develop different strategies to have less internments and more case managers in order to promote alternative care in community.

b) Different theories for practices capable of increasing the quality of the work carried out by network members and through multi-agency cooperation;

In the Therapeutic Unit, we work within a care model with the following characteristics: the biopsychosocial paradigm is followed, psychodynamic comprehension is used and it works within a Therapeutic community environment. The therapies employed are psychodynamic, systemic and cognitive-behavioural. In many occasions, more than one therapist works together with the child, therefore, it is common to sometimes have the figures of therapist and co-therapist with the adolescent.

Finally, we must mention our multidisciplinary team, made up of different professionals: psychologists, social educators, social worker, nurses, psychiatrists, teachers, social integrators and volunteers, we try to have the best coordination and communication so as to give the best support to the youth.

Within our theoretical background these are the approaches we use: Biopsychosocial, multidisciplinary team, the Bronfenbenner Ecological Systems Theory, Attachment Theory, Psychological Resilience and Corrective emotional experience. The theoretical approaches used in the Therapeutic Unit are described next:

Bronfenbenner Ecological Systems Theory [1]talks about different systems:

Microsystem: institutions and groups that most immediately and directly impact the child's development.

Mesosystem: Interconnections between the microsystems

[1] Bronfenbrenner, U. (1976). The ecology of human development: history and perspectives. Psychologia, 19(5), 537-549.

Exosystem: Links between a social setting in which the individual does not have an active role and the individual's immediate context.
Macrosystem: Describes the culture where individuals live
Chronosystem: The patterning of environmental events and transitions over the life course, as well as sociohistorical circumstances.

The Attachment Theory[2] is focused on the existence of a relationship with at least one primary caregiver for the successful social and emotional development. Depending of this relationship the following classification is used: secure, anxious-ambivalent, anxious-avoidant and disorganized.

Psychological Resilience[3] is described as the individual's ability to successfully adapt to life tasks in the face of social disadvantage or highly adverse conditions**.** Also, the ability of making realistic plans and taking steps to follow as well as the existence of a positive self-concept and confidence in one's strengths**.** Communication and problem-solving skills are as important as the ability to manage strong impulses and feelings.

Lastly, within the **Corrective Emotional Experience**[4], in the face of the emotional conflicts of the patient, the therapist reacts in a different way than the people who were present in the past.

[2] Developmental Psychology (1992), 28, 759-775. Reprinted in from R. Parke, P. Ornstein, J. Reiser, & C. Zahn-Waxler (Eds.) (1994). A century of developmental psychology. (Chapter 15, pp. 431-471).
[3] American Psychological Association. The road to resilience. Washington, DC: American Psychological Association; 2014. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx
[4] Corrective emotional experience (2004). David Hartman, MSW and Diane Zimberoff, M.A. Journal of Heart-Centered Therapies, 2004, Vol. 7, No. 2, pp. 3-84

c)Test sites and the primary actors involved

Therapeutic Unit Els Til-lers is involved within multiple departments, essentially the Health and Justice Departments, within them are the mental health and addiction services in community which the adolescents visit after finishing their internment and Child Protection (DGAIA).

The primary actors involved are the clinical psychologist and psychiatrist, the social worker, care for minors' delegate and justice professionals, each of them developing a key intervention in each of the adolescent's cases, described further above in (1.2 Actors involved). Good communication and effective involvement from all these actors is needed in order to help the adolescent in the Unit and after release, this is why our pilot project is necessary and useful, one of the main aims to accomplish is to promote communication within all services and actors involved with the case, it creates an attachment between the youth and the new services in charge of the youth once he/she leaves the TU.

d) Experimentation of strategies and practices within the identified settings

The youth attended in the TU usually have many risk factors, as we mentioned earlier on 50% of the youth in juvenile justice in Catalonia commit other crime or crimes after release. In order to try and achieve all the aims proposed for each adolescent once he leaves the unit we developed our pilot Follow-up program with the following methodology:

Inclusion criteria in the discharge follow-up program: All adolescents with release from the TU of the EC Til.lers from April 2017, who give their consent to participate in the discharge follow-up program will be consecutively included. The duration of the community follow-up pilot intervention will be of 6 months minimum.

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Intervention methodology for adolescents' with mental health problems who have entered the TU:

The clinician (psychiatrist or psychologist) of the adolescents' with release from the TU will carry out at least 8 follow-up interviews with the adoelscent during a period of 6 months, following the next proposal:

First month: 2 follow-ups, face to face interviews, fortnight frequency
Second month: 1 follow-up, face to face interview, clinical actor-adolescent and an interview/ meeting with actors in charge, care for minors delegate and adolescent.
From 3rd until 6th month: 4 follow-up interviews, monthly frequency.

In the follow-up interviews the adolescents' psychopathology will be evaluated, drug abuse relapse and fulfillment and adherence to the prescribed treatment. Social and family support will also be evaluated (Annex 1). Depending of the detected needs a proposal of actions and coordination will be developed, always in agreement with the adolescent, focused to maintain and consolidate his/her emotional, physical and social well-being.

All this intervention will be focused towards decreasing the anxieties produced from release and community reintegration considering the specific needs that each adolescent communicates to the clinical professionals in charge in the TU.

Contact will be made at least telephonically with the family. Being the social worker responsable of this task, according with the programmed follow-up visits with the adolescent. Counselling remains possible depending on the detected needs and agreed together with the adolescent.

Interdepartmental coordination methodology:

The social worker is in charge of the interdepartmental coordination and he will be responsable for:

-Obtain full information through telephonical contact with the community professionals who are involved with the adolescent who has finished his internment in the TU.

-Schedule an interdepartmental meeting every 2 months with the care for minors delegate and the clinical professional from the TU, in order to evaluate the fulfillment of the rehabilitation and reintegration objectives agreed in the external plan and agree on new actions depending on the detected need.

-Inform the rest of professionals who are involved in the case of the agreements made in order to achieve them.

Document with consensus agreements and a therapeutic interdepartmental plan will be the vital documents for the correct development of our program.

All interventions will be carried out with the adolescents' and legal tutors' agreement in case of underage adolescents. In case of minors under the Child Protection guardianship, their consent will also be required.

e) The national advisory board and actor network: To what end?

In the framework of the project "Fact for Minors" many useful ideas to improve the care to this population were given. For instance, during the Focus groups the idea of creating spaces for ethical reflection was promoted. Creating this space would be a very positive idea since given the complexity of the cases, professionals sometimes encounter themselves with cases or situations they had never had in the past, in this moments doubts may arise, and ethical space for reflection could be of great help. One good example is Case L, which we presented in our meeting in Oporto. This female was 18 years old, suffered Alcohol dependence, a Conduct disorder, ADHD and Borderline personality, she

had an IQ:70 and her Judicial cause was domestic abuse. This adolescent developed a brutal impairment and was unable to develop an autonomous lifestyle. After leaving the TU she went in and out of different services, all ending up in failure because they weren't adapted to what she needed, one night she appeared in the door of the therapeutic unit at 4am. This situation could be a very good example of the need of an ethical reflection space, professionals involved in this case could explain the situation to other professionals and together could find a better solution or at least a more ethical one to work with cases as complex as the one explained.

In the framework of the "Fact for minors" project, in February of this year an ethics workshop was developed in the justice department. During 2 days, Doctor Josep Ramos Montes[5] talked about "Ethics within integral intervention in young offenders with mental health problems", professionals from all services involved with this population attended the workshop including sanitary, child protection, and justice professionals.

3.2. Transnational level:

a) International meetings: A comparison of procedures, practices and experiences

During our meeting in the different countries we've heard many great ideas to organize different kind of procedures and practices, aiming for a better quality of care for these complex adolescents.

In behalf of this, during our meeting in Oporto, there were many ideas, promoting community actions was the main aim in most of them, trying to avoid as much as possible the internments in closed centers, enhancing an alternative care. In that sense, Finland

[5] http://etica.campusarnau.org/2009/ca/personal/57-ramos-montes-josep.html

proposed the idea of therapeutic internments for youth with mental health problems, individualized treatments, focused on the needs and difficulties of each adolescent, trying to keep the internment as short as possible, the necessary time to give the individual the necessary tools and care he/she needs. Community work was promoted, the need for a case manager figure was mentioned various times in order to develop the therapy with the shortest internment time as possible.

Alternative care was seen as a good future prospect to reduce internments and empower the stay of the youth in community, counting with the necessary support to build a Vital Proyect which will allow the adolescent to consolidate the improvement made during the internment and her/his personal and social well-being. This is why it is important that the network who takes care of these adolescents is connected, integrated and well communicated, an adequate communication is necessary between the different agents involved in the case, this way the youth won't suffer a break in their vital cycle.

b) The transnational advisory board and actor network: To what end?

From our point of view the transnational advisory board has been ideal to share different experiences with the project partners and improve the care model taking into account the ideas and opinions of the different professionals involved in cases with these complex adolescents .

The follow-up project was developed after attending these meetings and listening to the pros and cons of the different services in other countries. The different approaches proposed throughout the meetings have allowed us to define and develop the follow-up intervention proposal, always bearing in mind the topic of alternative care project and multidisciplinary approach.

In the TU we think it is important to consider the possibility of creating common policies in Europe related to the care of minors with judicial problems, for example, it would be positive to equal the age of assuming legal responsibility.

4. Results

a) National capacity building results: What did we learn from the experimentation?

Our follow-up Project began on April 2017, almost a year ago, due to the duration of the program (6 months minimum) not all of them have ended, depending on the discharge dates some cases are more or less advanced in the follow-up process.

From the beginning of the pilot project 13 follow-up procedures have taken place with a total of 40 meetings (25 individual meetings and 15 multidisciplinary meetings), during the individual interviews with the youth and their families, the existence of an attachment has been observed, thanks to this attachment this complex adolescents have been able to explain difficulties or problems that in other contexts wouldn't have been detected, therefore, with the adolescents' consent, the proceeding actions and arrangements together with all the actors involved have been able to take place. After an internment period, it is far more noticeable that a more intense support is needed to consolidate the attachment of the youth with community . Both adolescents' and their families evaluate positively the received support. Currently, a questionnaire is being developed to assess the adolescents and their families level of satisfaction. This questionnaire and the obtained results will be attached to the final report. Developing a simple and short instrument for these adolescents in order to evaluate their preferences, interventions they find useful or how they feel about the working system, things they would change etc. (this are only some of the things we would like learning about) is one of our targets, we believe their opinion is important to create a new alternative model which improves their quality care.

During the multidisciplinary meetings, the need of working within this cases in an interdisciplinary way has arised, not just with a unique professional or service. In order to create and develop the program, it has been necessary to work on the definition of the different roles of every professional involved in the case, since, in some occasions, the objective of the program has been perceived as an intervention and not a way of easing multidisciplinary coordination. In most cases a joint intervention program has been able to be agreed on, this has eased the implication both of the professionals, the youth and the families attended. This way, through the multidisciplinary meetings, the presence of discontinuity in care has become evident in some cases were different departments intervene. These meetings have eased communication even in these situations, this is something that has been very positively evaluated by professionals, since the negative effects of the absence of departmental integration are reduced. A satisfaction questionnaire provided by the Project Fact for Minors will be passed to gather information offered by the different agents involved in the intervention. In the present we haven't gathered all the data we wished but we are aiming to evaluate all the professionals involved in these adolescent's cases in order to get feedback and develop changes to improve the situation.

Number of participants who started the follow-up program	Number of meetings (face-to-face/ phone contact)	Treatment adherence	Recidivism	Drug relapse (Abuse)	Drug relapse (Dependence)
13	40	High: 61,5%(8) Medium:7,6% (1) Low: 15,3%(2) None:15,3% (2)	30,77% (4)	23%(3)	46% (6)

Table 1: Number of participants, meetings, treatment adherence, recidivism and drug relapse (abuse and dependence) within follow up project: April 2017-March 2018

b)Multi-actor and multi-agency work: Limits and capacity

Within the context of our follow-up pilot project we observed some advantages and some disadvantages or limits. The main advantages are:

-Continuity of treatment

-Flexibility in care and attention

Adolescents and their families can count with a good support network, emotional support. Also, in a moment of conflict, they can receive assistance from the TU professionals, 80% of them perceive it as good help, families evaluate it positively and cases which have no family or residence have a resource. This project also involves the creation of a coordinated network which offers the necessary support. It is important to mention that, in cases referred to centers which offer an adequate support, we´ve observed that 2 months' follow-up is enough.

Adolescents who have suffered chronic stress present important difficulties when making attachment, which explains that the transition to community services may be more complicated and will require more support when establishing these new attachments

In the TU a different attachment experience is offered.

Coordination meetings have facilitated a clinical diagnosis which, because of the changing symptomatology of this population, usually requires a longitudinal vision, this way the patient receives one unique and integrated message, this facilitates continuity of care and fulfillment

Limits/disadvantages

Adolescents who have continuously suffered adverse situations have problems with attachment, within this population if an attachment isn't created there is no follow-up, the patient is then lost. In order to create a strong attachment a minimum of internment time in the TU is required for it to be significant enough with the professionals of the unit to accompany the release.

We must consider that mental health centers with higher pressure on health care present greater problems when creating an effective attachment with this youth, sometimes they don't have enough time to make a proper attachment with adolescents who may not attend their first visit, sometimes they won' t attend their second visit, this way the case is lost. This means that, if the youth doesn't link, they don´t do a follow- up of the case. We´ve seen that in these situations, more support is needed.

We have observed that the network isn't prepared for such complex cases. From the coordination observed with the adult health network, we found out there is a lack of knowledge of the added complexity these cases suppose: adolescents of legal age, not linked previously to the adult mental health network with problems in juvenile justice are cases with a level of severity the network hasn't previously encountered.

Apart from the disadvantages already mentioned, we have encountered some difficulties with the informed consent in cases administered by the Child protection: the necessary arrangements were done so there would be only one available speaker for these cases. We also found difficulties when sharing information, this is why contact between professionals of the same category is needed in order to create synergies. It is necessary

to formalize the procedure at an interdepartmental level to speed up the management of cases

b) What is the appropriate intervention model? The role of institutional actors and other involved actors

From our point of view, after developing our follow-up project, we conclude the appropriate intervention model would be one which allows the Justice and Health departments to work together hand by hand, respecting each other's needs and working protocols and having an effective collaboration in order to help the youth under the best conditions as possible. An appropriate intervention model will also offer a comprehensive, multidisciplinary and coordinated care, empowering community intervention, this way internments in closed justice centers would be reduced and the integration of the youth in their context would be facilitated, counting with the necessary supports, adapted to their personal, clinical and social needs. The roles of every agent involved in the intervention of the youth should be adequately defined, taking into account the service and department each one belongs to. This way, it would be possible to individualize and create a joint intervention program where the figure of a case manager would be appropriate in order to coordinate the intervention, beyond the features of each service and professional.

5. Prospects for the future

Future aims are establishing a proper follow-up formalized program with an interdepartmental agreement in order to consolidate the program and make it more effective, empowering the case manager figure and/or the (Individual follow-up program)

IFP figure. In the future we should try to minimize and/or limit the internment time in closed centers to avoid isolation at such an early and delicated age since during this period, youth create their identity, also to fight against the stigma the internment procedure implies.

We aim to develop more community intervention programs, also, achieve more programs within community through agreements with other departments such as Labour and Education Departments and Social Services.

Another future project is the development of a transit to the adult life program for youth with mental health problems and high social and family vulnerability, for that matter,

our team has started a new project to make this idea a bit closer to reality this is why we have organized a flat for these adolescents once they finish their internment from December 2017, it is thought to be a good way of motivating an autonomous functioning. This project has been created for those adolescents which have nowhere to go once they finish their internment period in justice or youth who need a time to organize their lives until they are autonomous. During the early months there will be a social educator for 3 hours per day during the evening to help the youth organise and to supervise their daily lives.