



**fact for minors**



**GUIDELINES FOR THE STRATEGIC IMPLEMENTATION  
OF PROCESSES REGARDING CHILDREN WITH  
PSYCHOLOGICAL, PSYCHIATRIC OR PERSONALITY  
DISORDERS HOSTED BY ALTERNATIVE CARE  
COMMUNITIES AS A CONSEQUENCE OF PENAL  
MEASURES.**



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Edited by Cnca - Coordinamento Nazionale Comunità di Accoglienza, Italy [www.cnca.it](http://www.cnca.it)



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## **Fact for Minors**

Fostering Alternative Care for Troubled Minors

### **Partners:**

**CNCA, National confederation of socio-educational communities, Italy** (applicant);

**Psychoanalytic Institute for Social Research (IPRS), Italy;**

**Istituto Don Calabria, Italy;**

**Justice Ministry, Juvenile Justice and Community Department, Italy;**

**Christliches Jugenddorf Deutschland (CJD), Germany;**

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# INTRODUCTION

The provision of assistance to and safeguarding of minors with psychological/psychiatric disorders who have committed an offence has been widely discussed on a European and international level. Sentences involving such minors should foresee a custodial sentence in an alternative structure and not in a detention centre.

In addressing the issue, both on a European level and in individual countries, experts have highlighted what practitioners have already experienced on a day-to-day basis a clear discrepancy between the requirements of the justice system and those of the healthcare system. In other words, the extreme difficulty posed by the need to combine the duration of the legal process within the justice system and the need for care within the healthcare system.

Specifically, one of the most debated concerns in the European context is the absence of an integrated multi-disciplinary approach between the different services involved in the provision of care to minors with a psychological/psychiatric disorder subject to criminal procedures. In many European countries the provision of therapeutic and socio-educational care for young offenders falls under the purview of different institutions and services. Unfortunately, these institutions lack a common set of procedures, tools and terminology that would invariably help them work together. These shortcomings represent a significant obstacle for the

teachers, psychologists, psychiatrists, social workers, and other professionals involved rendering meaningful evaluations extremely complex if not impossible. The many international agreements, research studies and directives issued by the European Union on this topic demonstrate the attempt to direct policy making in each Member State to ensure greater protection of the rights of minors in the justice system.

A context analysis illustrates that not all countries, or the regions within those countries, have operational guidelines. Thus, they continue to operate with very few adequate protocols between juvenile justice services and the local healthcare system. The lack of common guidelines is particularly evident where alternative care is concerned. In this case, the minors in question are placed in alternative structures that not only use different organizational methods, but also distribute responsibilities among various subjects. A related issue is the difficulty in guaranteeing continuity of care for individuals who are about to become adults. The risk at this point is the failure to ensure equal rights, above all the right to healthcare, to everyone and failing to act in the best interest of the affected minors.

In the juvenile justice context, the segment represented by minors with psychological/psychiatric disorders entrusted to socio-educational care is a particularly delicate one. It is therefore necessary to underline that the responsibility for their care, education and reintegration falls on a variety of different sectors: the healthcare system, juvenile justice social workers and educational and alternative care facilities. The fact that the responsibility and care for these minors is so fragmented is a clear indication of the difficulties the practitioners involved have to face. Practitioners not only have to deal with complex operational procedures, diverse regional systems, different budgets and resources, but also contrasting methodologies and times allocated for interventions.

Therefore, the need to identify integrated work principles is clear. The same principles should be common to justice services, the healthcare system, alternative care facilities, and all other services, particularly in regards to:

- The type of collaboration between juvenile justice services and mental health services;
- The ability of the institutions involved to understand each other's needs and the changes taking place;
- How to converge research in order to guarantee a fruitful exchange and the best protection of the minor.

Socio-educational facilities (alternative care) occupy an important position in the relationship between juvenile justice services and residential facilities. A preliminary evaluation of the context in which the minor lives must be made in order to provide effective care. However, if the minor's context is a residential facility (i.e., an alternative care facility), then the evaluation and subsequent social/educational rehabilitation must be based on that context. Thus, these residential alternative care facilities (e.g., in Italy) find themselves operating both in the civil field, in conjunction with local services (primarily) and in juvenile justice. This means that they answer both to local authorities and to justice services when working with young offenders that require a specific set of interventions. This "mixed arrangement" implies that their objectives, where young troubled offenders are involved, are not always the same. In fact, in many cases the practitioners have to deal with very different procedures that are certainly not conducive to dialogue and collaboration or to good practice.

# GUIDELINE RECIPIENTS

The guidelines are intended for the following two primary groups:

1. Political/Strategic decision makers in the public and private sectors within the justice system and the health and social welfare systems;
2. Operational managers (i.e., practitioners) working on a local level, both private and public, in the planning and implementation of programs for the provision of care for minors and young offenders with psychological/psychiatric disorders.

**TARGET POPULATION** Minors and young adults suffering from a psychological or psychiatric disorder who have committed an offence and have been entrusted to specific care facilities (other than a detention centre) represent the target population in guideline application. This segment of the population is not significant from a numerical perspective, but the prevalence has been growing within the justice System. More specifically, young people who are vulnerable and suffer from social marginalization, a fragility exacerbated by a psychopathology or a more “nuanced” condition of psychological distress represent the target group.

# CONTEXT

In the European context, there is great concern on the part of the juvenile justice system and the mental health services regarding juvenile offenders who are in need of psychological or psychiatric support, especially since it seems that the number of such young people is on the rise in almost all European countries. The main principle underlying this issue is the right to be treated, or in general, the right to healthcare (and all the ethical and clinical aspects related to this principle) for those who are in the justice system and have thus been deprived of their “freedom”. The deprivation of one’s freedom (as a result of committing a criminal offence) should not also mean the deprivation of the right to healthcare. Applicable legislation, both internationally and in each member country, are extremely clear in this regard.

Furthermore, there is general acceptance within the juvenile justice system that the success of rehabilitation programs for young offenders with psychological issues depends on the provision of adequate psychological support. In these cases, the justice system must be able to work in conjunction with healthcare services to offer a multilevel and unified approach to service provision for these minors.

Three distinctive settings, as clearly stated in many official publications on the subject, are possible for young offenders with mental health problems:

**THE SUPPORT AND CARE OF MINORS WITH PSYCHOPATHOLOGICAL DISORDERS IN JUVENILE CORECTIONAL INSTITUTIONS** For minors suffering from psycho-pathological distress currently in the care of juvenile correctional institutions there is a joint effort between the justice system and the healthcare services: the multi-disciplinary team that takes care of the minor (e.g., penitentiary police, social workers, educators, cultural mediators, psychiatrists, psychologists) act in a specific and structured context that presents particular characteristics.

**MINORS TRANSFERRED FROM THE JUSTICE SYSTEM TO SPECIALIZED ALTERNATIVE CARE FACILITIES.** In some countries, specialized alternative care facilities represent the primary care facilities, as an alternative to regular juvenile detention centers, when dealing with extremely complex psycho-pathological cases. In other countries, minors are only transferred to these facilities temporarily during periods of acute distress caused by their disorders. These facilities, despite being secure facilities that highly limit the minor's freedom, are very diverse from every other point of view. The differences in protocol between the justice and the healthcare systems invariably demand that there be, for the minor's wellbeing, a common approach. Overcoming the different approaches used with these minors, setting aside mistrust and striving to develop more productive forms of communication between the two systems is key to successful outcomes.

**THE SUPPORT AND CARE FOR MINORS SUFFERING FROM PSYCHIATRIC DISORDERS IN ALTERNATIVE RESIDENTIAL CARE FACILITIES.** This setting is characterized by an extremely complex governance because responsibilities are shared between different sectors: juvenile justice services, healthcare facilities, residential educational facilities, local authorities, and the education board. This setting represents the primary focus of these guidelines. The aim in fact, is to understand how to integrate the three aspects of the care provision process: the legal/procedural aspect of taking a minor with psychological issues into custody, the course of treatment and rehabilitation.

It should be noted that in some countries residential alternative care facilities house a very diverse group of minors; minors may be placed in these facilities due to either civil, or judicial measures. In Italy, for example, minors are regularly sent to residential care facilities by the civil court because their family context is inadequate, or due to the unavailability of foster care. In other cases, such as in Spain and Portugal, there are residential care facilities exclusively for minors who have committed crimes. Moreover, some minors with behavioral problems due to social maladjustment may be placed in a residential care facility by social services. Finally, unaccompanied foreign minors may be placed in residential facilities or in dedicated services for at-risk youth.

In addition, in recent years the number of young offenders presenting psychological disorders, some of which display an impressive “set” of psychiatric symptoms, has gradually increased. Over time, practitioners in this field have learned to understand the demand for help on the part of these minors but in truth, they cannot be of much support when a psychiatric disorder becomes acute; the reality is that the presence of these particularly troubled youth within residential care facilities can put both staff and other minors at great risk. The challenge stems from the need to support youth with psychological/psychiatric problems during rehabilitation – the reason for their placement in alternative care facilities – and difficulty in meeting this objective. Unfortunately, residential facilities do not have the capability to provide the necessary services and supports creating a situation destined to fail.

The underlying, and interconnected, reasons include:

a) The **practitioners**. The practitioners who work in alternative care facilities may not have the necessary skills or competencies (e.g., ability to tolerate stress, empathy, ability to contain and be firm, ability to constantly respect the operational rules of everyday life within the facility) necessary to guarantee the level of stability and order conducive to the positive stay of the minors. The practitioners themselves are aware of their need to work in harmony with practitioners from other departments as well as other professionals.

b) **Collaboration between services.** Minors must be guaranteed adequate support from the juvenile justice system and neuropsychiatric services for minors both within residential care facilities housing young offenders with psychological and/or psychiatric disorders and other specialized facilities. The absence of this support implies that facility staff must work at a level that goes their capabilities thus not ensuring the proper care for the minors.

c) **Time to diagnosis.** Requests for diagnosis by alternative care facilities do not always result in prompt evaluations and diagnostic interventions. There may be significant delays between intake/request for diagnosis, diagnosis and the implementation of a treatment/rehabilitation plan.

d) **Lack of agreements between institutions at the national level.** The lack of a set protocol for the prompt taking into care of this target group within the alternative care facilities can lead to:

1. a deterioration in the minor's already fragile mental condition which could lead to hospitalization in an intensive care unit or a specialized hospital;
2. the possible increase in the minor's sentence albeit temporarily to "contain" an acute episode in their already disruptive behavior;
3. disruption due to transferal from one residential facility to another in an effort to remove difficult cases. An initial adaptation period is foreseen in all cases including the most complex. In fact, a certain level of flexibility always exists in order to respond to the minor's needs, regardless of facility rules. This not only benefits the minors themselves, but also the objective of rehabilitation. This rehabilitation "pact", however, can also be broken as a variety of reasons could convince practitioners operators that relocation of the minor represents the best course of action. Relocation in a new facility, however, inevitably leads to adaptation problems due to experiences in the previous facility. In many cases, the

repeated transfer of minors showing dysfunctional behavior due to psychological problems leads to a worsening of their condition.

4. Failure to continue rehabilitation/treatment once the minor has left the residential care facility.

# **GUIDELINES FOR THE STRATEGIC IMPLEMENTATION OF PROCESSES REGARDING CHILDREN WITH PSYCHOLOGICAL, PSYCHIATRIC OR PERSONALITY DISORDERS HOSTED BY ALTERNATIVE CARE COMMUNITIES AS A CONSEQUENCE OF PENAL MEASURES**

1. Minors who suffer from psychological/psychiatric conditions whether they are entrusted to juvenile justice institutions, or housed in alternative care facilities must be guaranteed the right to treatment. With this in mind, the justice system, acting on behalf of the minor's legal guardians, assumes the responsibility of ensuring the minors have access to the necessary medical and mental health treatment. Furthermore, the right to healthcare should be guaranteed to all minors without discrimination and be provided on an equal basis.
2. A preliminary evaluation of the context in which the minor lives must be made in order to provide effective services. However, if the minor's context is a residential facility (an alternative care facility), then the evaluation and subsequent social/educational rehabilitation must be based on that context. The treatment/rehabilitation plan, when possible, should also include the active involvement of the minor's family in order to facilitate reintegration in the minor's family/life context.

3. A full evaluation of the minor must be made by a multi-disciplinary team of practitioners in order to optimize care provision. The team should consist of social workers, educators, physicians, and psychologists. Upon completion of the assessment, the practitioners can plan the type of assistance needed. The justice system, which is responsible for carrying out the rehabilitation plan, should include the minor's family when possible. Prompt intervention by relevant specialists is required if there is reason to believe that the minor has a psychiatric disorder.
4. The provision of care to minors should be characterized by "various" levels of assistance based on the minor's disorder, its complexity and gravity, as well as a background context analysis. This implies the establishment of a comprehensive "therapeutic" system substantiated by the identification and networking of services utilizing an integrated, coordinated chain intervention model.
5. The possible diagnosis of a psychiatric disorder should neither infer that the young offender be stigmatized for his/her condition, nor should it be an obstacle in his/her reintegration process. The diagnosis should instead, be a necessary element from which to begin a positive re-educational course. A "timely" and continuously updated diagnosis plays a central role in the drafting of a personalized plan. The diagnosis has extremely important repercussions in the decisions regarding the minor's entire rehabilitation and care receipt.
6. "Timely intervention in moments of crisis" must be guaranteed. Healthcare staff should be able to recognize criteria for prioritizing care with a view to a positive rehabilitation outcome.

7. Minors should only be transferred to a more highly specialized institution for limited lengths of time and/or the time necessary for a child neuropsychiatrist to determine the best course of action. This is to ensure the minor has the best chance for a positive psycho-social rehabilitation and re-education.
  
8. The strength of collaboration between institutions can be defined as “the extent to which the representatives of different institutions have integrated their activities, shared their resources and responsibility towards the final results” [Goedee & Van Sommeren (2012), based on the ideas of Cropper et al. (2008)]. It is therefore necessary to pay special attention to the implementation of the various steps of the process in order to achieve a fully comprehensive approach.
  
9. The multi-agency approach must provide for different levels of responsibility (regional, local), the definition and implementation of effective network actions that contribute to define the identification of the actors and their responsibilities. These actions include:
  - a) the establishment of a set procedure to be carried out during intake and care provision by a team of practitioners;
  - b) identification of a method to assure information sharing;
  - c) exchange of “knowhow” between the various fields of expertise;
  - d) training of all practitioners and staff in a shared action plan;
  - e) support in the acquisition of tools allowing multi-agency co-operation;
  - f) development of a shared evaluation protocol in order to assess the outcome of the rehabilitation process; and
  - g) the establishment of a procedure to guarantee continuity of therapy and assistance once the minor has left the residential care facility.

10. Integration between departments is important for increasing organizational function. Coordination and the establishment of a strategic collaboration model should be ensured by a “multidisciplinary team” capable of dealing with all aspects relating to care provision for the minor as well as recognizing the early onset of psychological/psychiatric disorders.
11. A network, in order to be sustainable, must establish binding agreements and/or protocols. It should also foresee a periodic review of standards and adopted practices as well as the results obtained.
12. It would be beneficial to promote the study and research in this field as a means to monitor and follow up on the results obtained. In addition, it would be advisable to establish a dedicated IT system.
13. The involvement and coexistence of different departments in the intake process requires both a cultural and operational transformation. This can be achieved by co-planning and integrating training courses provided at the local level.

These guidelines aim to become the premise for the establishment of a shared protocol at European level. It is of the utmost importance to overcome the current fragmented approach in the provision of care for young offenders with psychological disorders. This is essential in order to assure the well-being of the minors and to address failures in guaranteeing their right to adequate healthcare. Finally, as per UN recommendations and various European directives, young offenders with psychological or psychiatric disorders should be placed in alternative care facilities as opposed to juvenile detention centers in order to reduce the negative impact of detention on their psychological well-being and the risk of recidivism.



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