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LEGAL AND MEDICAL PROCEDURES AND SAFEGUARDS REGARDING JUVENILE OFFENDERS WITH MENTAL DISORDERS

by

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Introduction

A Case Study from England

Sixteen year old Joseph Scholes hanged himself from the bars of his cell in Stoke Heath Young Offender Institution (YOI) in March 2002. Joseph had an unsettled childhood, allegedly suffering repeated and severe sexual abuse by a family member from the age of six and experiencing his parents' acrimonious divorce and bitter custody battle. At the time of his arrest, Joseph had been seeing a psychiatrist for some months and had been prescribed medication. He was showing clear signs of depression, with suicidal thoughts and self-harming.

Joseph had one previous conviction resulting from an altercation with ambulance staff when he had tried to kill himself by taking an overdose and jumping from a window. Because of his problem behaviour he was taken into care and placed in a children's home. Shortly after, he went out with a group of children from the home who had decided to steal mobile phones. They were caught and subsequently charged with street robbery.

As the trial approached, Joseph became more depressed. Two weeks before the trial, he slashed his face 30 times with a knife. The walls in his room had to be completely repainted as they were covered in blood.
Joseph pleaded guilty to three offences of street robbery. Although he had not used or threatened violence and his involvement was peripheral, he hoped that a guilty plea would result in less time in court and a more lenient sentence. He was sentenced to a two year detention and training order. The judge stated in open court that he wanted the warnings about Joseph's self-harming and history of sexual abuse drawn to the attention of the authorities.

Once sentenced, the Youth Justice Board (YJB) had responsibility for placing Joseph in a suitable institution. Although the YJB was told of Joseph's history and needs he was placed in Prison Service accommodation at Stoke Heath YOI.

Joseph was initially put into strip clothing and placed in a cell with a surveillance camera, reduced ligature points and high levels of observation. After a few days he was moved to a cell with no surveillance camera, with ligature points and with reduced observation. On 24 March 2002, Joseph retired to his cell, where he was later found dead, hanging from a sheet attached to the bars of his cell window.

The Joseph Scholes case raises three key questions. First should such a mentally disturbed boy have been sentenced to detention at all? There is clearly a need for a range of non custodial alternatives which have the confidence of the courts and the public so that wherever possible vulnerable juveniles can be supervised in the community whether waiting for trial or under sentence.

Second, once sentenced should he have been placed in a prison setting?

There is a clearly a need for a wide range of alternative placements for juveniles whose offending is such that the court considers detention unavoidable. Research suggests that between six per cent and 12 per cent of all prisoners need to be transferred to specialized institutions.

Third, once placed in a prison setting should he have been better cared for? Research suggests that of all prisoners between 30 per cent and 50 per cent need assistance from health care services.

The aim of this report is to identify some of the key issues involved in dealing with young people with mental disorders in the criminal justice system. The report begins with a section on the context of international law (more fully described in the annexes) and is followed by some data on prevalence. There is then a section on the impact of the prison setting followed by some detail about the mental health problems faced by young people in custody. This draws heavily from the World Health Organisation (WHO) website *http://www.prisonmentalhealth.org/* which provides much useful material about the topic. The report ends with some suggested key elements of an effective response to this problematic group of young people. This draws heavily on the WHO Europe report "Promoting the Health of Young People in Custody".

Context

The World Health Organisation has declared that all young people, regardless of situation, should have opportunities for healthy physical, social and mental development. It is an inherent part of their human rights. The Council of Europe in Recommendation (2004)10 says that:

1. Persons with mental disorder should not be subject to discrimination in penal institutions. In particular, the principle of equivalence of care with that outside penal institutions should be respected with regard to their health care. They should be transferred between penal institution and hospital if their health needs so require.
2. Appropriate therapeutic options should be available for persons with mental disorder detained in penal institutions.
3. Involuntary treatment for mental disorder should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder.
4. An independent system should monitor the treatment and care of persons with mental disorder in penal institutions.

Further relevant extracts from international instruments are contained at Annex A along with comments made by the Committee for the Prevention of Torture (CPT) on the issue since 2000.

Prevalence

The rates of mental disorder in adolescents are similar to or higher than those in adults. The rates of all mental disorders (psychosis, depression, post-traumatic stress disorder, substance misuse) are substantially higher in young offenders than in young people in the community and especially among young offenders in custody. The rates of developmental disorders such as autism and learning difficulties are also much higher.

This is to be expected as so many of them have experienced events in their lives that are known to increase the risk of mental health problems - poverty, social disadvantage, family dysfunction, low self-esteem, truancy and poor educational attainment are common. Many young people in the criminal justice system often lack support in their early life; have poor adult role models; poor personal and social skills, and have experienced physical and/or sexual abuse and neglect.

Prevalence of mental disorders among community and delinquent samples of adolescents

Prevalence of mental disorders among community and delinquent samples of adolescents		
Disorder or condition	**Community samples (%)**	**Delinquent samples (%)**
Conduct disorder	2-10	41-90
Attention deficit disorders	2-10	19-46
Substance abuse and dependence	2-5	25-50
Mental retardation	1-3	7-15
Learning and academic disabilities	2-10	17-53
Mood disorders	2-8	19-78
Anxiety disorders	3-13	6-41
Post-traumatic stress disorders	1-3	32
Psychosis and autism	0.2-2	1-6
Any disorder present	18-22	80
Source: Kazdin AE. Adolescent development, mental disorders and decision making of delinquent youths. In Grisso T, Schwartz RG (eds), Youth on Trial: A Developmental Perspective on Juvenile Justice. Chicago: University of Chicago Press, 2000, vol. 2, pp. 33-64.		
Evidence is summarised from a range of studies. The levels of disorders in adolescents held in detention centres or prisons tend to be towards the higher end of the range.		

Within the prison setting, there is often particular concern about self harm and suicide. In some countries such as England and Wales, suicide rates for 15-18 year old boys in prison are 18 times higher than in the normal population. Self harm and suicide attempts tend to be higher among girls and young women who are responsible for half the incidents in prison although representing only 6% of the population.

The Impact of the Prison setting

The World Health Organisation makes it clear that:

"The prison setting is not one which should be a first choice when trying to improve an individual's health and wellbeing, as all too often it may itself be a factor leading to deterioration in health. From a health viewpoint, whenever a sanction can be imposed in the community this will be the preferred option.

Prison can make the mental health of young people worse due to:

- overcrowding
- a dirty depressing environment
- lack of social support
- lack of control
- isolation
- lack of choice
- poor food

In addition, a significant group of young people are exposed to further victimisation (e.g. bullying, violence, unwanted sexual attention) while in prison.

Depending on how the institution is run, there may however be some beneficial effects from education and training that open up opportunities on release, from help for drug misuse, from a pro-social ethos with good relationships and role models, from encouraging strong, regular links with families, and from encouraging the young people to do things for themselves and to feel proud of any achievements they make. Promoting mental health therefore involves the development of regimes which:

- increase autonomy and control
- offer training in life and coping skills
- include a strong anti bullying strategy

The particular things which prison staff can do are to:

- look for signs of distress and steer young people towards help
- provide special arrangements for suicide and self harm
- be observant for bullying
- establish a personal officer scheme
- encourage listening/befriending schemes

Different levels of care are required depending on the mental health problems of the young people. The most common are discussed below. In the most extreme cases, young people need to be transferred from the prison setting. The laws in most countries allow this e.g. in Russia where the Penitentiary Rules for Juveniles say that if necessary medical aid cannot be rendered at treatment-prophylactic institutions and medical correctional facilities, the convicts may be committed to the territorial treatment-prophylactic institutions of the healthcare system. In many countries, there is a lack of secure facilities in the health care system. The Council of Europe Human Rights Commissioner found this to be the case when he visited the UK in 2004.

Young People and Mental Health

Emotional and behavioural disorders in young people are often symptoms of troubled relationships within the family, peer group or in the prison rather than symptoms of a disorder within the individual. For young offenders therefore medication plays a lesser role than in adult disorders (with the exception of attention deficit disorder). The efficacy and side effects of drugs are less certain and poor compliance and overdosing are common issues with adolescents. Interventions that attempt to change the young person's environment and relationships or help him/her to cope better with them play a greater role.

The larger part of management consists of residential staff, teachers, and others developing and carrying through a management plan. Interventions that aim to increase the young person's emotional resilience or increase their self-esteem are protective against further deterioration of mental state and should always form part of such a plan. Although particularly difficult to achieve in the prison context, the family should be

involved in treatment wherever possible, especially with a younger adolescent who still lives at home. Contact with any probation officer or social worker from the home area is also likely to be helpful. But the stigma of being diagnosed and treated for a mental disorder can be a major issue for adolescents, who are often particularly concerned too about their privacy and the confidentiality of discussions.

Assessment of young offenders

It is important that the health needs of each individual young person in custody are assessed and a plan made to address them. Such needs may range from specific health care issues to the wider determinants, such as education and social skills, which impact so fundamentally on their health. As many have missed out on normal schooling, the need for basic health education is likely. As for psycho-social assessment, an assessment which should take place as soon as an offender enters a custodial establishment should look at:

- psychiatric disorders, e.g. depressive disorder, substance misuse
- specific delays in development, e.g. dyslexia
- intellectual level, e.g. mild mental retardation
- medical condition(s), e.g. epilepsy
- psycho-social adversity, e.g. institutional upbringing
- functioning in day-to-day life, e.g. serious problems relating to others
- strengths and resources, e.g. enjoys art, has a trusting relationship with a probation officer in the home area

Specific Disorders

Conduct Disorders

Many young offenders meet the diagnostic criteria for conduct disorder simply by virtue of their persistent criminal activities. Unless their behaviour is regarded as abnormal by the individuals themselves, their peers or family, specific healthcare intervention is unwelcome and cooperation unlikely.

Management of these individuals is a matter for the establishment as a whole although it is important that health care professionals are able to support and advise other staff, identify those individuals who may benefit from further assessment and treatment for their behavioural problems by specialists, and participate effectively in the multidisciplinary management of individuals with more severe disorder, thus reducing or preventing associated problems such as psychiatric disorders, self-harm and violence, and reducing the probability of the individual developing lifelong personality disorder.

Conduct problems involve three overlapping dimensions: defiance of authority, aggressiveness and anti-social behaviour that violates other people's rights, property or person. These behaviours can be a part of normal child and adolescent development, so a diagnosis should only be made when the behaviours are extreme and persistent or result in impairment in everyday functioning.

Two groups of young people with anti-social behaviour have been identified.

- Late onset: anti-social behaviour begins during adolescence and is associated strongly with social factors such as a family history of criminality, the influence of peers and substance misuse. The early history is often unremarkable, with a conflict with authority, which may be normal within the delinquent subculture, becoming apparent as the child enters adolescence. Young offenders thought of by staff as 'normal' may fall into this category.
- Lifetime persistent: this group displays anti-social and disturbed behaviour often from early childhood. There is a much higher incidence of impaired social functioning, emotional problems, psychiatric illness, self-harm and substance misuse. The group is at particular risk of developing adult anti-social personality disorder.

A psychological approach to conduct disorders

Anti-social behaviour is in part learned and can be ‘unlearned’. However, this requires substantial motivation, effort and support - especially where the behaviours are long-standing, severe and persistent. Disruptive individuals tend to externalise distress and conflict. They may have trouble recognising fear or sadness in themselves. They also frequently have difficulties in using negotiation skills or problem-solving skills as alternatives to aggression. Adults who can model or teach these skills can be helpful. The long-term

prognosis is not good without intervention. Individuals do not 'grow out of it'. However, there may be improvements with appropriate management. Some factors known to help protect against a poor outcome may be available within a young offenders' prison. They include:

- having a caring, supportive relationship with at least one adult
- having friends who do not get into trouble
- experience of achievement in some sort of activity (e.g. sport, any form of education or training, a responsibility within the institution)
- absence of (or successful interventions for) learning problems, such as dyslexia
- absence (or successful treatment) of other mental disorders (especially substance misuse and attention deficit hyperactivity disorder [ADHD])
- experience of establishing a stable work record
- remaining at school until the age of compulsory school end or longer.

Behavioural management is most likely to be effective where the individual is of a younger age and does not have a 'callous, unemotional' interpersonal style, and where the regime and staff behaviours consistently support appropriate behaviours and do not tolerate inappropriate ones. Staff should be encouraged to do the following.

- Develop a regimen where staff model the appropriate behaviour, e.g. dealing with aggression by 'talking down' in the first instance, bullying is not tolerated and opportunities for constructive activity and achievement are plentiful.
- Encourage positive strengths, e.g. work, sport, art, education, continued family contact, other relationships. Anything that allows achievement and raises self-esteem is likely to be helpful.
- Where possible, develop a relationship with the young person, e.g. identify a shared interest and spend a short time as often as possible discussing or doing the activity together (e.g. football). Aim to interact with the young person in ways other than giving orders.
- Set clear rules and give short, specific commands about the desired behaviour, not prohibitions about undesired behaviour, e.g. 'please walk calmly' rather than 'don't run'.
- Where staff have a positive relationship with a young person, help him/her try to find alternative strategies to replace those that lead to trouble, e.g. 'If someone else confronts you, rather than hitting him first, ask why he is angry or go and tell someone you trust.' Praise and reward any progress.
- Provide consistent and calm consequences for misbehaviour. The wing minor report system can be used to mark overstepping behavioural boundaries. Avoid getting into arguments or explanations with the individual as this only provides more attention for the misbehaviour. Conversely, ignoring minor problems such as defiant language may be effective.

Specific Psychological treatment

Multimodal, well-structured, intensive, lengthy programmes that are cognitive-behavioural in orientation have proven most effective with adolescents who show severe anti-social behaviour and are at highest risk of developing adult personality disorder.

Treatments that have shown the most promise are listed below.

- Cognitive-behavioural programmes, especially multimodal ones incorporating anger control, problem-solving, self-control and moral reasoning ability.
- Multi-systemic therapy.
- Family therapy.
- Behavioural management training: more appropriate for a younger age group or where the adolescent is actively involved in developing and agreeing the programme.

Results are best if the programme is structured, the atmosphere warm, there are high expectations, there are positive staff and adolescent relationships, and the programme lasts for more than a year.

Attention deficit hyperactivity disorder (ADHD) and hyperkinetic disorder are disorders with a strong genetic component, characterised from an early age (before seven years) by disturbances in the areas of attention, impulsiveness and hyperactivity. These disorders are more common in boys.

Contrary to what was previously thought, a significant proportion of children with ADHD continue to have the disorder in late adolescence and some still show symptoms ten years later, though inattention is more frequently prominent in adults than is hyperactivity. The prevalence of ADHD in young offenders' prisons is not known. However, the fact that ADHD is frequently accompanied by conduct disorder, substance misuse and specific learning difficulties means that the prevalence is likely to be significantly higher than in the community. Some young people and adults with the disorder will be unrecognised.

This behaviour is not the patient's fault. It is most likely that genetic factors play a very important role in this disorder as 70-80% of cases are estimated to be inherited. The way that family, teachers, staff and others respond to the child is thought to interact with the behaviours and make more or less likely the development of associated problems such as delinquent and anti-social behaviour, substance misuse and underachieving at school.

Many hyperactive children make a satisfactory adjustment, but some continue to have difficulties into adulthood. The outcome is better if parents, teachers and other adults can be calm, accepting, have realistic expectations of the individual and avoid reinforcing the individual's disruptive behaviour.

Behavioural treatment is important and the role of parents, teachers and other adults/staff is central. It is important to persevere even though behavioural management is time-consuming and the results are not immediate. Medication may increase the effectiveness of other treatments such as behaviour therapy.

The patient's behaviour is likely to be causing problems in all areas - on the Residential Unit, in education and in the workplace. A consistent, multi-disciplinary plan that the patient is actively involved in developing is essential. Staff can be assisted with the following.

- To understand that the patient's behaviour is due to a disorder and not to wilful misconduct.
- To expect problems with concentration and therefore to set short tasks the patient can handle. Hyperactive individuals require particularly clear instructions. Short, specific commands about the desired behaviour are best rather than prohibitions about undesired behaviour e.g. 'please walk calmly' rather than 'don't run'.
- To focus on the immediate, consistent, positive response to desired behaviour rather than on critical comments or punishment for the undesirable behaviour.
- To create a predictable routine. The prison regime may be beneficial in this respect, but the individual will need help in planning activity during any long spells in their cell or association.
- To encourage staff (e.g. teachers, personal officers) to spend time with the individual engaged in activities that require attention (e.g. completing a jigsaw) and to give positive feedback or recognition when the individual pays attention.
- To minimise distractions (e.g. in education, have the individual sit at the front of the class, work one-to-one or in a small group).
- To keep the individual busy and encourage sports and other constructive activity.
- Where possible, to ignore non-dangerous, disruptive behaviour, e.g. defiant language.
- Monitor progress, identify problem areas and consider the options for addressing them. (For example, if problems arise during association, consider ways of reducing stimulation, e.g. talk with only one friend at a time.) Progress charts can help with this.

Emotional disorders in young people

Introduction

Emotional disorders are often associated with conduct problems. Many young people detained in custodial settings have had poor experiences of parenting and have not developed skills in identifying and managing their own emotional states. They tend to be impulsive and, when distressed, frequently use maladaptive coping strategies such as:

- aggressive behaviour
- deliberate self-harm
- substance misuse
- physical symptoms resulting from psycho-somatisation

Such young people frequently find it difficult to cope even with minor events. This renders them at increased risk of developing emotional disorders such as depression and anxiety disorders. Adults (officers, teachers, family, health professionals) often underestimate the degree of depression in young people.

In dealing with young people it is important to reassure the patient that he/she is not 'going mad'. Emotional disorders are common and help is available for their symptoms. Treatment consists mainly of helping the patient to deal with the problems that have triggered the disorder (e.g. bullying) or are maintaining it (e.g. problems with relationships with peers or debt). The patient has an important role to play in this, as have any adults (e.g. staff) that they can trust. More severe disorders may require a form of psychotherapy or family therapy. Medication only has a limited role.

A key task within prison is to assess the risk of suicide and self-harm. Close supervision by officers or friends, moving the patient to a healthcare centre or the use of a care suite may be needed. Important elements in successfully managing these cases include:

- collating information from as many informants as possible (with the patient's permission) including their family, residential staff, teachers and workshop supervisors. Identify current life problems or social stresses, including precipitating factors
- identifying any appropriate positive or enjoyable factors in the young person's life and helping them to increase access to these. Exercise and opportunities to be creative (e.g. art) may be helpful
- identifying someone the young person can confide in and encouraging him/her to seek practical and emotional help from others e.g. through additional telephone calls to their family and friends outside
- supporting the development of good sleep patterns and encouraging a balanced diet
- involvement of a range of staff in a management plan.
- recognising and addressing bullying - many vulnerable young people with emotional disorders are 'easy targets' for bullies
- encouraging the development of adaptive skills in coping with stress, e.g. talking to supportive staff members to elicit help in problem-solving, an activity to distract thoughts, relaxation skills, thinking skills courses
- avoiding removing resources that can be used to cope, e.g. radios, telephone contact, association, as this will lead to more use of maladaptive coping

Psychosis in young people

Healthcare staff in young offenders' prisons are very likely to see patients who are developing a psychotic illness for the first time and do not have a previous diagnosis as:

- the median age for the experience of a first episode of a psychotic illness is 19 years in men and 22 years in women (with 80 per cent falling within the range 16-30 years)
- there is some indication that psychosis is caused by a poorly understood combination of biological factors that create a vulnerability to experiencing psychotic symptoms. These symptoms often emerge in response to stress (e.g. the stress of imprisonment or bullying on the wing) or drug abuse in the vulnerable individual.

Often, there is a long delay before treatment begins for the first episode of psychosis. The longer the illness is left untreated, the greater the disruption to a person's family, friends, study and work. In addition, delays in treatment may lead to slower and less complete recovery.

Substance Misuse:

Substance misuse by adolescents is less likely to require medical treatment for dependence and more likely to be a symptom of a behavioural disorder. Treatment, therefore, will be less substance-oriented and will involve a broader range of interventions. For those young people who are addicted, there is a need for safe detoxification arrangements with 24 hour medical cover. A full range of provision should include

- universal prevention and education
- screening and assessment
- detoxification and treatment
- support and programmes
- resettlement

Key Elements of an Effective Approach

1. Young offenders with mental disorders should be eligible for a range of community based responses. For this group in particular custody should be a last resort.

2. A young person in custody should be provided with a safe, secure, caring and stimulating environment where he/she can be helped to develop and achieve his/her physical, emotional, educational and spiritual potential. An atmosphere of participation and consultation should encourage feelings of personal responsibility and empowerment and each young person in custody should have a care plan which reflects the needs of the individual.

3. Staff must be selected, resourced and trained so that young people in their care can take full advantage of opportunities in custody. There is a whole custody approach, so that all staff understand the developmental needs of adolescents and to help create a nurturing environment for the development of health and well being, plus a key worker or personal officer scheme.

4. Young people in custody have a right of access to good quality health services equivalent to those offered in the outside community and targeted to the assessed health needs and lifestyle risk factors of young people. Staff employed by the custodial/prison service must be able to conduct their professional work within the same ethical and good practice codes as bind their colleagues in the health services in the wider community.

5. Where appropriate the participation of the young person's family/parents or other suitable adults is strongly encouraged, not just as part of preparation for resettlement, but to maintain as wide a support network for each young person as possible.

6. There must be a comprehensive strategy for suicide and self harm prevention with specialist training for staff.

7. Screening for mental and other health problems should be carried out as soon as possible.

8. Where a young person has mental health needs a multi disciplinary care plan should be developed. And regularly reviewed.

9. In cases where mental disorder requires inpatient treatment, a young person should be transferred to a specialist hospital or other establishment.

10. In patient facilities should be provided within prison for those waiting for such transfer.

11. Disciplinary and behaviour management arrangements should not damage the mental health of juveniles. Isolation or segregation should not be used and restorative approaches to conflicts should be encouraged.

12. Arrangements for continuing care should be made when a young person leaves custody.

Annex A

International Instruments Relevant to Health of Juveniles

The International Covenant on Economic, Social and Cultural Rights, Article 12 establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Convention on the Rights of the Child, Article 24.1:
States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Basic Principles for the Treatment of Prisoners, Principle 9:
Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Principle 24:
A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

Standard Minimum Rules for the Treatment of Prisoners, Rule 22:
(1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

(3) The services of a qualified dental officer shall be available to every prisoner.

Standard Minimum Rules for the Treatment of Prisoners, Rule 25:
(1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is especially drawn.

Standard Minimum Rules for the Treatment of Prisoners, Rule 62:
The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Rule 1:
Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standards as is afforded to those who are not imprisoned or detained.

United Nations Standard Minimum Rules for the Administration of Juvenile Justice, Rule 13 (5)
While in custody, juveniles shall receive care, protection and all necessary individual assistance – social, educational, vocational, psychological, medical and physical –that they may require in view of their age, sex and personality.

Rule 26(1): The objective of training and treatment of juveniles placed in institutions is to provide care, protection, education and vocational skills, with a view to assisting them to assume socially constructive and productive roles in society.

(2) Juveniles in institutions shall receive care, protection and all necessary assistance – social, educational, vocational, psychological, medical and physical – that they may require because of their age, sex, and personality and in the interest of their wholesome development.

(4) Young female offenders placed in an institution deserve special attention as to their personal needs and problems. They shall by no means receive less care, protection, assistance, treatment and training than young male offenders. Their fair treatment shall be ensured.

United Nations Rules for the Protection of Juveniles Deprived of their Liberty, Rule 49:
Every juvenile shall receive adequate medical care, both preventive and remedial, including dental, ophthalmological and mental health care, as well as pharmaceutical products and special diets as medically indicated. All such medical care should, where possible, be provided to detained juveniles through the appropriate health facilities and services of the community in which the detention facility is located, in order to prevent stigmatization of the juvenile and promote self-respect and integration into the community.

50: Every juvenile has a right to be examined by a physician immediately upon admission to a detention facility, for the purpose of recording any evidence of prior ill-treatment and identifying any physical or mental condition requiring medical attention.

51: The medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition that may hinder the integration of the juvenile into society. Every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive health care and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms of physical or mental difficulties, should be examined promptly by a medical officer.

52: Any medical officer who has reason to believe that the physical or mental health of a juvenile has been or will be injuriously affected by continued detention, a hunger strike or any condition of detention should report this fact immediately to the director of the detention facility in question and to the independent authority responsible for safeguarding the well-being of the juvenile.

53: A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

54. Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug or alcohol-dependent juveniles.

55. Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be testees in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.

Annex B

Relevant Extracts from recent Committee for the Prevention of Torture (CPT) reports

Georgia 2004

The care of juveniles in custody requires special efforts to reduce risks of long term social maladjustment. This calls for a multi disciplinary approach drawing upon the skills of a range of professionals (including psychologists, pedagogues and social workers) in order to respond to the individual needs of juveniles within a secure educative and socio therapeutic environment. Juveniles deprived of their liberty should be offered a fill programme of education, sport, vocational training, recreation and other purposeful activities. Physical education should constitute an important part of that programme.

Latvia 2002

The custody and care of juveniles deprived of their liberty is a particularly challenging task. The staff should be carefully selected for their personal maturity and ability to cope with the challenges of working with and safeguarding the welfare of this age group.

Turkey 2001

The essential components of an appropriate custodial environment for juveniles are: accommodation in small units: a proper assessment system to ensure suitable allocation to units; a multi disciplinary team (preferably of mixed gender) selected and specially trained for work with juveniles; a full programme m of education for those below school leaving age, with emphasis on literacy and numeracy skills as well as further education and vocational training for older juveniles; a daily programme of sport and other recreational activities; association and social activities; facilities to allow juveniles to maintain close contact with their families

Germany 2000

In detention facilities for juveniles it is particularly important that the health care service offered to juveniles constitutes an integrated part of a multi disciplinary (medico-psycho social) programme of care. This implies inter alia that there should be close coordination between the work of an establishment's health care team and that of other professionals who have regular contact with inmates. The goal should be to ensure that the health care delivered to juveniles deprived of their liberty forms part of a seamless web of support and therapy.

Examples of Specific Practices relevant to mental health criticised by CPT

- Use of 4 point metal restraint on suicidal juvenile for 36 hours (Germany 2000)

- Juveniles never seen by a doctor (Turkey 2001)

- A general impression of gloom and dreariness particularly unsuitable for young persons (Lithuania 2004)

- Police officers called onto a ward to help health care staff restrain a juvenile patient (Iceland 2004)